Submission No. 151
AUTHORISED: 23/8/06

21/8/06
FAXED

OFFICE OF THE MINISTER FOR HEALTH

STANDING COMMITTEE
04 SEP 2006
OF HEALTH AND AGEING

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The Hon Alex Somlyay MP
Chairman
Standing Committee of Health and Ageing
House of Representatives
Parliament of Australia
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Dear Mr Somlyay

Commonwealth Parliamentary Inquiry into Health Funding
Northern Territory Government Submission

The Northern Territory has a number of features that has a significant impact on the availability, funding and resourcing of its health services. These predominantly pertain to its demographics, including its available labour market, and the significant burden of disease borne by Indigenous Territorians[1].

Current health service profile

Health services in the Northern Territory (NT) are predominantly provided by the Northern Territory Government (NTG), although there is a slow shift to service delivery by others, particularly in the more remote areas of the NT. In the acute care sector, public hospitals are based in each of the urban centres and are linked as the NTG Hospital Network. Both Royal Darwin and Alice Springs Hospitals are teaching hospitals, with Royal Darwin Hospital having the broadest scope of specialist services of the NT hospitals.

NT public hospitals are busy. The NTG Hospital Network has both the highest number of public hospital admissions and the highest number of presentations to emergency departments in Australia. The admission rate is more than twice the Australian average (481 versus 203 admissions per 1000 weighted population) and emergency department presentation rate three times the Australian average (682 versus 207 presentations per

[1] Data for this submission has been obtained from the The State of our public hospitals, June 2006 Report. Department of Health and Ageing. 2006: Private Health Insurance Administration Council (PHIAC), NT Department of Health and Community Services' Health Gains Unit, and the Australian Bureau of Statistics.

1000 weighted population). These numbers are increasing with admission numbers growing by 20% over the past eight years.

By contrast, the NT private health sector is small. There is only one[2] significant private hospital in the NT (Darwin Private Hospital), and the NT has the lowest proportion of private patients admitted to all (public and private) hospitals (16%) compared to the Australian average (46%). The potential to expand private hospital services has been previously explored on a number of occasions and to date has been deemed not viable. There are limited numbers of private medical specialists, General Practitioners and private providers of allied health and other ancillary health services such as physiotherapy and optometry. These are predominantly based in urban areas, limiting the option for access to these services for those who live outside these areas. The subsequently limited range of options for private health care undoubtedly has an impact on the uptake of private health insurance in the NT (currently 30.9% versus the national average of 43%[3]).

Primary health care services in both urban and remote areas are provided by private General Practitioners (GPs), NTG operated health centres, Aboriginal community controlled health services (part funded by both the NTG and the Australian Government) and some non-government organisations. Service provision in remote areas is comprised of locally based and visiting staff, and is costly, with travel costs accounting for approximately 16% of the total cost of medical consultations in these locations.

Public health services such as environmental health, health promotion and disease control are also predominantly provided by the NTG with some services provided by Aboriginal community controlled health services and some non-government organisations. The NT welcomes the recent Council of Australian Governments (COAG) focus on public health: promoting good health, disease prevention and early intervention and is an active participant in, as well as chair of the steering committee for, the *Australian Better Health Initiative*.

As indicated above, funding and resourcing of health services in the NT is predominantly in the government domain, with a significant proportion of this from the Northern Territory Government. This proportion has increased from 45% in 2001/02 to 53% in 2003/04, overtaking the Australian Government's contribution. Comparatively little funding flows to the NT from private health insurers due to our small private health sector; conversely approximately $10M per annum of Territorians' private health insurance contributions are not realised in the NT.

Public hospital services are funded, as elsewhere in Australia, through the Australian Health Care Agreements, with both Australian and NT Government contributions. Similarly, the Public Health Funding Agreement guides the joint funding of some Public Health services such as cancer screening and some HIV/STD prevention activities.

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[2] A Darwin GP 'expanded role" surgery which does minor day surgery is also classified as a private hospital by its need to register and meet regulations under Legislation (Private Hospital and Nursing Homes Act).

[3] Data from private health hospital insurance tables, PHIAC

However, it is the funding of both primary health care and specialist medical care through Medicare and the Pharmaceutical Benefits Scheme (PBS), and its sequelae in terms of service provision and access to health care, where there are significant differences between the NT and the rest of Australia. This gap is due to the limited numbers of GPs and specialists. Only 50% of the total expected Medicare payments (on the basis of population numbers) were accessed in the years 1993/94-2003/04, and only 30% of the total expected PBS payments. It is not surprising then, that there were just over half the number of Medicare services used by Territorians, compared with the Australian average (six, compared to eleven), and that in 2003/04 the per capita average for Medicare payments in the NT was $222, compared to the Australian average of $427. If the NT had the same age-adjusted usage patterns as the rest of Australia 2003/04, this Medicare shortfall equates to $23.1M. This gap has increased over the last ten years, and there are significant resource implications if this trend continues. Furthermore, given the degree of morbidity in the NT, it is likely that the true Medicare usage rate should be higher than the Australian average, and therefore this shortfall of $23.1M is an underestimation.

Although there has been some progress in the negotiations between the NT's Department of Health and Community Services and the Australian Government's Department of Health and Ageing around Medicare reform in the primary care sector, Australian Government initiatives which focus on enhancing Medicare funded services by private providers will continue to disadvantage the NT. For example, the recent COAG Mental Health initiative allocates a large proportion of the $538M package to relevant Medicare items. The NT will see little of this money as there is virtually a non-existent private specialist mental health sector and a shortage of GPs. It is estimated that the current NT Medicare/PBS rebate shortfall for mental health service is in the order of $5.2M per annum, and that the shortfall from this package will be in the order of an additional $800,000 per annum.

Although there are a range of Australian Government program funds for primary health care services, such as the Primary Health Care Access Program, these do not necessarily fund the same range of services as provided by GPs through Medicare, thus leaving a gap in both the quantum and type of service availability for Territorians, and most particularly those living in remote areas.

A key factor in the delivery of effective and efficient health services in the NT is a robust health workforce. The NT health workforce is comparatively small and concentrated in the major urban centres. There are a number of professions within the NT health workforce considered hard to recruit, such as nursing and some allied health professions. This is symptomatic of broader national shortages, but is considered to be exacerbated in the NT due to availability of training and education opportunities, perceived professional isolation and the increasing mobility of the health workforce as a whole. There are also particular issues regarding the number and distribution of GPs in the NT, influencing both the availability of Medicare funding and service availability as alluded to above. While it may appear on paper that there are "adequate" numbers of GPs when each practitioner is counted as an individual, this is not the case when service delivery is actually assessed, as many NT GPs work part-time. When this correction is included in the analysis of GP availability, the NT is under-resourced in terms of GPs.

The NT was pleased that COAG identified health workforce as an important agenda item in its recent deliberations, and welcomes some of the initiatives announced at the July 2006 COAG meeting. However, the NT believes that the Australian Government's focus on traditional occupations such as medicine and nursing reflects a lost opportunity for real health workforce reform to enable the health workforce to adequately service the future demands of the health sector. This is particularly the case in the NT, and in other rural and remote areas, which already face workforce shortages and subsequent service reduction.

Demographics of the Northern Territory

The Northern Territory has a very low population density – it has a population of approximately 198 500 (around 1% of Australia's population) scattered across 1 352 200 km^2. Approximately 59% of Territorians live in the major urban areas of Darwin (including Palmerston) and Alice Springs. The remainder is spread across the Territory - for example in regional towns, Aboriginal communities and outstations and cattle stations. There are significant differentials in the availability of services in general, and health services in particular, informed particularly by the size of the population grouping and its remoteness from a more major centre.

Twenty-nine percent of the Northern Territory population are Aboriginal people, a significantly higher percentage than in other jurisdictions. A greater proportion of Aboriginal (70%) than non-Aboriginal people (35%) live outside the major urban centres, and thus have less access to health services. The median age of Aboriginal Territorians is lower than non-Aboriginal Territorians - influenced by a higher birth rate, having children at an earlier age and a shorter life expectancy.

Overall, Territorians per se are the youngest Australians, with a median age of 30 years compared with the national average of 35 years. This population profile requires a different health service profile to that of an "older" population, with a greater quantum of demand for example on maternal and child health services, than on aged care services. This has implications for national resourcing processes that assume similar demographic spreads across jurisdictional populations.

A major component of the NT population is transient, coming to the NT for short-term work, for example that associated with major infrastructure developments or with the defence forces. This population may not have well established support networks or relationships with health service providers, potentially influencing their usage rates of these services. Furthermore, there is a significant influx of short-term tourists (particularly in the dry season) across the NT, many of whom access health services. Given that resourcing of services is usually on a residential population basis, this has the potential for under-resourcing of services.

Burden of disease

The Northern Territory has been identified as the Australian jurisdiction with the highest burden of fatal disease and injury. The main conditions contributing to this high burden of disease are cardiovascular disease, mental disorders, cancers, unintentional injury and chronic respiratory disease. The proportion of Territorians with intentional and unintentional injuries, acute respiratory infections and neonatal disorders is greater than

the Australian average. This degree of disease and injury has a significant effect on the resources required for an efficient and effective health service.

Furthermore, Aboriginal Territorians bear the brunt of this burden of disease and injury. As noted above, Aboriginal Territorians die earlier than non-Aboriginal Territorians; indeed Aboriginal Territorians' health status equates to that of non-Aboriginal Territorians who are 20 years older than they are – both in terms of the extent of disease and outcomes. The burden of disease attributable to cardiovascular disease, acute respiratory infections, diabetes and neonatal disorders is greater in Aboriginal Territorians than non-Aboriginal Territorians.

The causes for this burden of disease are well documented but include both physical and social determinants, such as poor physical environment; sanitation and hygiene; food supply, nutrition and activity; education, parenting and social and emotional wellbeing. Many of the interventions required to address these issues require at the least cross-sectoral partnerships, and in many cases whole of Government (including the three tiers of Government) involvement. The Northern Territory Government has been pro-active in encouraging this collaboration, and in exploring innovative approaches to health service funding, resourcing and delivery.

I trust that the information provided in this letter is of assistance to the Parliamentary Inquiry and look forward to hearing the outcomes of the Inquiry's deliberations.

Yours sincerely

Peter Toyne

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21 AUG 2006