



**NORTHERN TERRITORY VIEWS ON
2010 REVIEW DRAFT REPORT
ATTACHMENT 12**

COMMUNITY AND OTHER HEALTH SERVICES

September 2009

Key Points

- The Territory continues to have strong reservations about the subtraction model, in particular the assumption that an extra dollar of Commonwealth funding reduces Territory expenditure needs by the same amount. Rather, increased Commonwealth investment often requires additional state investment.
- Various iterations of the model through the Review period have highlighted the sensitivity of the model to its underlying assumptions. The resultant volatility is not consistent with the objective to achieve a reliable and sustained assessment of needs over time.
- The Territory strongly contends that the Commission must improve contemporaneity of the Indigenous weightings in the assessment model given the substantial increase (recent and planned) in Indigenous health investment. Judgement will need to play a part in determining weightings that are not out of date and so achieve a reliable assessment.
- The Territory considers there is a compelling case to treat by exclusion the Closing the Gap in Indigenous Health Outcomes NP so as not to override the intent of the NP to substantially improve health services for Indigenous people.
- The use of Medicare and National Health Survey data leads to an urban bias in the proposed age/sex weights.
- The Territory disagrees with the model's assumption that any component of the extra cost of providing the same level of Medicare services (by non-state providers) is not transferred to state governments but is met in full by individuals or the private sector.
- The Territory makes substantial top-up payments to both general practitioners and Aboriginal Controlled Community Health Organisations (ACCHOs) to compensate for the higher costs involved in providing services and the limited capacity to receive out-of-pocket contributions, due to the disadvantaged socio-economic status of the Territory's population.
- Given the above, the Territory considers that the Commission should review the model's assumptions of perfect substitutability and consider each state's circumstances individually.

Introduction

This submission outlines the Territory's views on issues raised in the Commonwealth Grants Commission's (the Commission's) 2010 Review Draft Report, Attachment 12, *Community and Other Health Services*.

The Commission proposes to assess community and other health expenses by:

- summing the community and other health expenses for the Commonwealth, non-government sector and the states;
- applying differential weights for Indigeneity, remote Indigeneity, age and sex to determine each state's share of total health expenses;
- subtracting the Commonwealth and non-government expenditure to determine each states assessed health expenses; and
- applying service delivery scale, dispersion and administrative scale factors.

This submission focuses on the Territory's concerns that the subtraction model does not yet adequately acknowledge the "non state average" nature of community health service delivery in the Territory.

Does the Assessment Model Recognise the Territory's Circumstances?

The Commission's proposed community and other health services assessment is premised upon a subtraction methodology. The conceptual validity of this methodology is contingent upon two main assumptions: (i) health needs in Australia are met by either the Commonwealth, states and territories or the non-government sector; and (ii) there is a perfect inverse relationship between Commonwealth, non-government funding and state government expenditure.

The Territory has consistently argued that the subtraction model is not effective in capturing the Territory's circumstances (i.e. its young, large and relatively remote Indigenous population and the nature of the Territory's health system including the lack of private providers) and as such these disabilities are not adequately addressed in the model. It is not credible to suggest that an extra dollar of Commonwealth funding reduces the Territory's expenditure requirements by the same amount. The Territory has previously submitted data that shows that state expenses have not declined with increased Commonwealth investment and in this

submission, re-presents information which shows clearly that additional Commonwealth investment requires additional state investment. New South Wales, Queensland and South Australia have also raised concerns about the “perfect substitutability” of the model.

The Territory is concerned at the extreme volatility that has been shown through various iterations of the model during the 2010 Review development. This volatility appears inconsistent with the objective to achieve a reliable assessment over time.

Community and other health services in both urban and remote areas in the Territory are provided by the Northern Territory Government (through the Department of Health and Families (DHF)), Aboriginal community controlled health organisations (ACCHOs), private general practitioners (GPs), and a small number of private providers and non-government organisations.

The Territory has comparatively few GPs. In 2007-08, the Territory had 52.6 full time workload equivalent (FWE) GPs per 100 000 people, which is nearly 40 per cent below the national figure of 87.2 FWE GPs per 100 000 people¹. This is also reflected in the number of Medicare services accessed per 100 000 people in 2008-09 between states and territories (Table 1).

Table 1: Medicare services processed per 100 000 population, July 2008 - June 2009

	NSW	Vic	QLD	WA	SA	Tas	ACT	NT	Australia
Medicare services per 100 000 population	1 479	1 369	1 328	1 389	1 161	1 216	1 096	796	1 364

Source: DOHA Medicare Statistics as at September 2009.

More than twice the number of GPs currently provide services in Darwin and Alice Springs than in remote parts of the Territory². While some of these GPs operate as private practitioners, others are employed by DHF and ACCHOs. The latter may be eligible to claim Medicare rebates for the services they provide through an exemption from the Health Insurance Act Section 19(2). This income is returned to the employer. DHF also engages some GPs to work in remote locations as contractors as part of its workforce strategy for difficult to recruit locations. These arrangements

¹ Productivity Commission’s *Report on Government Services 2009*, Table 11A.3.

² Headcount from General Practice Network NT listing of GPs
<http://www.gpnnt.org.au/site/index.cfm?display=39049> Accessed 01/10/09

include incentives such as housing, vehicles, Medicare revenue to a given threshold and travel expenses. DHF estimates these incentives may be in the order of \$2 million per annum.

To compensate for the relatively low provision of community health services provided by general practitioners, DHF operates 7 urban community health services, and 52 remote community health centres³. A further five urban health services and 32 health centres in remote areas are operated by ACCHOs. ACCHOs receive primary funding from the Commonwealth (predominantly through the Office of Aboriginal and Torres Strait Islander Health (OATSIH)). Although there are a range of Commonwealth Government program funds for primary health care services, they 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 services available for Territorians, and most particularly those living in remote areas.

The Territory also provides funding for community and other health services provided by ACCHOs (around \$13.8 million in 2008-09). Territory ACCHOs also provide services other than community health for which they receive Commonwealth and Northern Territory Government funding. The nature and quantum of Aboriginal and Torres Strait Islander grant funding impacts on the third step of the subtraction model. The Territory's concerns as to how this is recognised are outlined below.

Remote community health centres are the sole providers of health care in the majority of remote areas of the Territory. They provide primary health care such as chronic disease management and public health services such as immunisation. They also provide emergency treatment which in urban locations would be provided in hospital emergency departments. The nature of these services, the clients and workforce provide particular challenges that are not equally present in other states.

The pivotal role that community health services play in redressing the high burden of chronic disease and injury that Indigenous Territorians bear⁴ is recognised by recent initiatives by both the Territory and Commonwealth Governments such as those associated with the Northern Territory Emergency Response (NTER) and its subsequent Closing the Gap in the Northern Territory National Partnership (NP) and

³ Northern Territory Department of Health and Families Annual Report 2007-08.

⁴ Thomas DP, Condon JR, Anderson IP, Li SQ, Halpin S, Cunningham J, Guthridge SL. Long term trends in Indigenous deaths from chronic diseases in the Northern Territory: a foot on the brake, a foot on the accelerator. *MJA* 2006;185:145-49.

the Closing the Gap in Indigenous Health Outcomes NP. These initiatives represent significant investments by both the Commonwealth and the Territory.

The Closing the Gap in the Northern Territory NP includes funding of \$131 million over three years for improving child and family health, including funding for the Remote Area Health Corps, follow-up services for dental and ear, nose and throat conditions identified through the child health checks, expanding the Mobile Outreach Service dealing with child-abuse-related trauma and continuation of alcohol and other drug treatment and rehabilitation services.

The Closing the Gap in Indigenous Health Outcomes NP aims to close the gap in health outcomes between Indigenous and non-Indigenous Australians by focusing on five priority areas: tackling smoking; primary health care that delivers; improving the patient journey; making health everyone's business; and transition to adulthood. While the amount the Commonwealth will invest in the Territory is not yet known, it will contribute \$805.5 million nationally. The Territory Government is required to contribute \$175.9 million over the four years of the National Partnership. The large amount of funding to be spent in the Territory under the NP reflects the disproportionate number of remote Indigenous people in the Territory, the higher costs of delivering services in the Territory and the level of funding required to increase access to health services in remote Indigenous communities across the Territory.

The Territory considers that adjustments are required to the model as outlined below to adequately recognise the impact of the disabilities states such as the Northern Territory face, particularly those that pertain to the delivery of remote Indigenous health services. The Territory's concerns are outlined at the relevant step of the model.

Step One – *Estimate Total National Expenses*

The Territory agrees that total national expenses include state expenses for community and other health services, Commonwealth expenses pertaining to medical services (particularly Medicare) and Aboriginal and Torres Strait Islander health grants and non-government expenses on medical services, dental services, other health practitioners and public health.

Step Two – Estimate Total Expenses in Each State

The Territory agrees that it is critical that the socio-demographic profile of a state's population is recognised in the apportionment of total expenses to each state, and particularly so in the Northern Territory with its significantly younger, more Indigenous population.

Age/Sex Weights

The Commission has derived the age/sex profile for total community and other services by weighting the age/sex profiles for six components of community health expenses. The Territory believes that the data used to determine the age/sex weights at the component level are significantly biased towards the urban population, and therefore lead to an urban bias at the aggregated level. This effect is magnified for the Territory as it has particularly high usage of community health services by young children, which is not reflected in the National Health Survey or Medicare data. The Territory has previously provided details of a study undertaken in East Arnhemland which showed that Indigenous children had a mean presentation rate of 16 per year, compared to Medicare data which showed an average of 9 services for children aged 0-4⁵.

The age/sex weights for each component of community health expenses are derived using either Medicare data or the ABS National Health Survey (the exception is public health). In both instances, there is a bias towards the urban population.

- The bias in the Medicare data is because of the greater access to private services (Medicare funded) in urban areas. The lack of private health providers in rural and remote areas means greater reliance on state government community health services.
- The bias in the National Health Survey arises as only households in urban and rural (but not remote) areas were surveyed. In the Territory only 137 people were surveyed, with 104 of these in Darwin. The ABS has acknowledged that the

⁵ Clucas DB, Carville KS, Connors C, Currie BJ, Carapetis JR and Andrews RM. *Disease burden and health-care clinic attendances for young children in remote Aboriginal communities of northern Australia*. Bulletin of the World Health Organisation 2008;86: 275-281.

sample size for the Territory was small and consequentially the data for the Territory is unreliable (and subsequently not published)⁶.

The age/sex weights for public health are based on the use rates for cervical and breast screening. Cervical and breast screening only accounts for 13 per cent of total public health expenditure⁷, and also has an urban bias⁸. However, the largest component of public health expenditure is organised immunisations (33 per cent)⁹ which have a very different age/sex profile to that of cervical and breast screening. Organised immunisation is targeted at children and high-risk groups (such as the Indigenous population many of whom live in remote areas).

The bias in deriving the age/sex weights described above is likely to lead to imputed lower utilisation rates for the young population and overestimate the rate for the older population. The Territory acknowledges the limited availability of national data sets that adequately capture use and cost of remote services. A national data approach means the only option available is the use of data sources that generally focus on the urban population. While the use of 'urban' data as a proxy for all regions may not have large implications for most states, it will have a material impact on the Territory because of its highly dispersed population in remote and very remote areas. The Territory therefore considers that the Commission apply judgement to recognise that the weight derived underestimates the cost of services that occur as a result of its younger, more remote population.

Indigenous weight

The Territory believes that the proposed Indigenous weight will underestimate the Indigenous share of total community and other health expenses during the 2010 Review assessment period. This is due to timing differences between the data used to derive the Indigenous weight and the assessment year the weight is applied to.

The Commission uses data from the Australian Institute of Health and Welfare (AIHW) publication *Expenditure on health for Aboriginal and Torres Strait Islander peoples* to derive the Indigenous weight. The most recent edition of the AIHW publication reported data for 2004-05 and was released in February 2008. It is

⁶ ABS, National Health Survey: Users' Guide. 4363.0.55.001 Pages 7-8.

⁷ AIHW 2009, *Health expenditure Australia 2007-08*

⁸ AIHW 2008. *Australia's Health 2008*. p476

⁹ AIHW 2009, *Health expenditure Australia 2007-08*

understood that data for 2006-07 will be made available prior to the completion of the 2010 Review. The lag in AIHW data will have implications for the Commission's stated objective of making the assessments better reflect the circumstances of the states in the years when the relativities are used to distribute GST revenue.

The considerable increase in investment in Indigenous health that flow from the two NPs described above will have a significant impact on health expenditure across Australia, but particularly in the Territory, in the current and forthcoming years. Indeed, the funding allocated for the Closing the Gap in Indigenous Health Outcomes NP in 2009-10 represents over one-fifth of total Indigenous community and other health expenditure in 2004-05.

There will also be an additional increase in expenditure arising from these initiatives given the "case finding" and follow up treatment needs that occur when Indigenous health services are enhanced. The Territory has previously outlined this flow on effect (both in terms of community health and hospital services) that arose from the NTER, when Indigenous child health checks were performed in remote communities across the Territory and subsequent primary health care and specialist treatment were required. Based on conservative estimates by DHF, the flow-on impacts from the additional 708 children identified with ear complications from the health checks were:

- up to 15 576 extra nurses/Aboriginal Health Workers services;
- an additional 1770 medical practitioner services;
- an additional 708 referrals to hearing services; and
- about 500 referrals to ear, nose and throat specialist services.

The above only relates to ear complications identified through the intervention. The overall flow-on impacts of the health checks on Territory health services are significantly greater.

The large investment through the Closing the Gap in Indigenous Health Outcomes NP and the subsequent flow-on impacts will significantly change the Indigenous share of total health expenditure. The Territory considers that the Commission should use judgement to adjust the Indigenous weight to ensure that it reflects the circumstances of the year that it is applied to. The Indigenous weight could be

adjusted by increasing the base Indigenous expense data, reported in the most recent AIHW publication, by the additional funding amounts under the NP and then recalculating the Indigenous share of total health expenses. Given the significant increase in Indigenous expenditure in recent years, past trends are likely to understate growth in government investment.

Steps Three and Four - Commonwealth and Non-government Expenses in States

The Territory draws the Commission's attention to the fact that the Commonwealth has agreed that the Closing the Gap in the Northern Territory NP payments should not affect the relativities.

The Closing the Gap in Indigenous Health Outcomes NP also impacts this component of the subtraction model. Treatment by inclusion of payments made under this NP (i.e. Commonwealth payments of \$805.5 million, and state payments of \$771.5 million for 2009-10 to 2012-13) will lead to perverse outcomes, particularly for the Territory given that it is required to contribute \$175.9 million over the term of the NP, the second highest level of investment behind New South Wales (\$180.4 million). Under the current proposal, the community and other health services assessment will override the intent of the NP to significantly boost service provision in selected areas to address Indigenous health outcomes.

The Territory considers the proposed community and other health services assessment is not sufficiently dynamic to ensure that the assessed needs reflect state circumstances during the term of the NP (i.e. the considerable increase in health expenditure on the Indigenous and particularly remote Indigenous population and state differences in the matching requirements). If this assessment is adopted as is and the NP payments are treated by inclusion, the Territory Government will be assessed as needing to spend less on community health than if the National Partnership payments were excluded. Such an outcome is inconsistent with the intent of the NP.

In addition, the Territory believes the Commission should further examine the nature of the Aboriginal and Torres Strait Islander grants provided to ACCHOs. These organisations not only play a significant role as providers of essential primary health care in urban, rural and remote areas across Australia, but also have a significant social role in the community and allocate funding to programs not related to

community health. Over half of grant funding provided to ACCHOs is directed at health programs, however about 30 per cent of grant funding is allocated to community or social programs such as family violence, child protection, youth services, community housing, cultural art performances, employment support and assistance for people with financial difficulties¹⁰.

The Commonwealth ATSI line in the subtraction model should only include funding that is specifically directed at community and other health services. The Commission should confirm the details of the funding included in the assessment to ensure that it only captures the relevant expenses.

As noted above, the Territory provides significant location-related funding to ACCHOs and GPs. The Territory disagrees with the model's assumption that all costs arising from non-state provision of community and other health services are met from Medicare and out-of-pocket payments. The additional cost of delivering services in the Territory due to location-related influences are, in part, borne by the Territory Government, as shown above, and should be explicitly recognised in the model.

Non-government medical services primarily capture an individual's out-of-pocket expenses incurred when services cost more than the Medicare rebate. Total out-of-pocket expenses are distributed between states based on their share of Medicare payments. While the Territory has lower rates of Medicare funding as outlined above, the approach adopted by the Commission overstates the out-of-pocket expenses incurred in the Territory, given that community health services in remote areas in the Territory are predominantly provided by Territory Government-managed health centres or ACCHOs. Neither the Territory Government nor the ACCHOs charge a fee for patients accessing health care in their centres reflecting the disadvantaged socio-economic status and health need of the population. While Territory Government and ACCHOs claim Medicare rebates on some items, the additional costs of servicing the remote population are borne by the Territory Government or ACCHOs. In other states, general practitioners provide the majority of primary health care services and are able to charge above the Medicare

¹⁰ Dwyer J, O'Donnell K, Lavoie J, Marlina U, Sullivan P. 2009. *The Overburden Report: Contracting for Indigenous Health Services*, Cooperative Research Centre for Aboriginal Health, Darwin.

rebate and average costs are lower reflecting lower average health needs and levels of remoteness and higher average socio-economic status of the population.

Subsequent to the Draft Report, Commission staff sought comments from states on the treatment of bulk-billing incentives and indicated a preference for these to be excluded from MBS payments. The Territory disagrees with this approach as it considers that adjustments would also need to be made to the national average age/sex and Indigenous weights in the top line of the model to reflect where bulk-billing incentives were most likely to impact. Such data is unlikely to be available.