



**NORTHERN TERRITORY VIEWS ON  
2010 REVIEW DRAFT REPORT  
ATTACHMENT 11**

**ADMITTED PATIENT SERVICES**

**September 2009**

## **Key Points**

- An interstate location factor should be included in the assessment to reflect that Darwin has the characteristics of an outer-regional town rather than those of a major city in terms of private sector provision and scope of specialist admitted patient treatment availability.
- Private patient user charges should continue to be assessed using the current hospital patient fees assessment.
- AIHW data understates non-hospital patient transport costs to the Territory. The most recent state data should be used to develop an adequate cost weight which better reflects patient transport expenses.
- Both interstate and intrastate patient transport expenses should be differentially assessed to reflect the high proportion of expenses incurred by remote and very remote patients and by patients who require specialist treatment only available interstate.

## **Introduction**

This submission details the Territory's views on issues raised in the Commonwealth Grants Commission's (the Commission's) 2010 Review Draft Report, attachment 11, *Admitted Patient Services*.

The Commission proposes to assess Admitted Patient Services expenses differentially by age, Indigeneity and socioeconomic status (SES). This is supported by the Territory, as is the decision not to differentially assess Cultural and Linguistic Diversity (CALD). All admitted patient user charges, including patient transport fees and other user charges are proposed to be offset against category expenses. Patient transport costs are proposed to be assessed differentially by assessing hospital patient transport costs incurred from admitted patients and applying a factor to a fixed proportion of non-hospital patient transport costs.

## **Challenges of Providing Admitted Patient Services in the Northern Territory**

The Territory notes that the Commission has decided against recognising a small jurisdiction disability. However, the Territory faces a number of circumstances which create a unique environment for Admitted Patient Services provision. These circumstances include the limited number of tertiary hospitals in the NT, the comparatively narrow scope of specialist services available, the low use of public hospitals by private patients, limited private hospital services and the well known socio-demographic and locational challenges for health service provision more broadly. The Territory believes that these factors should be acknowledged appropriately in this assessment.

The Territory has only two teaching hospitals, Royal Darwin (RDH) and Alice Springs Hospital (ASH) which have 353 and 189 beds respectively. It also has three small regional hospitals located in Katherine, Nhulunbuy and Tennant Creek. The Territory has a comparatively narrow profile of medical specialties available in its teaching hospitals compared to those available in all other states. For example, of the 17 surgeons operating at RDH, 7 are general surgeons, with the remainder in the following specialities: Maxillofacial, Otolaryngology Head and Neck surgery, Ophthalmology, Orthopaedics, Plastic surgery and Vascular surgery. Similarly at ASH, there are 3 general surgeons operating and 3 in the specialties of Ophthalmology, Orthopaedics and Otolaryngology Head and Neck surgery. While the general surgeons are able to cover a broad range of surgical work, complex specialty surgery is not available in either RDH or ASH (for example cardiothoracic or neurosurgery) which must be undertaken interstate.

Because of this, there are frequent transfers of patients from both RDH and ASH to interstate hospitals where the surgical expertise and appropriate post-operative care is available. Similarly, there may be direct admissions of Territorians to interstate facilities for specialist treatment. While arrangements are in place for cross-border reimbursement of admitted patient services, this does not include the costs of patient transport. This high level of interstate patient travel has significant implications for this assessment.

Private sector involvement in admitted patient services is also limited in the Territory, both in terms of private patients in public hospitals and as patients in private hospitals. In both instances, this is linked to low rates of private health insurance.

**Table 1: Private Health Insurance Coverage 2008**

	NSW & ACT	Vic	Qld	SA	WA	Tas	NT	Aust
Coverage '000	3356	2292	1810	714	1075	214	74	9534
% Population	45.8	43.1	42.1	44.5	49.5	42.9	33.6	44.5

Source: Private Health Insurance Administration Council (PHIAC)

In the Territory, the limited number of specialist medical staff means that choice of doctor is limited. Choice of treating doctor, as well as choice of accommodation services is one of the reasons that people choose to be admitted as a private patient. This lack of choice together with the allocation of rooms in public hospitals on the basis of clinical need explains the lower number of private patients in Territory hospitals compared with other states<sup>1</sup>.

Furthermore, Darwin Private Hospital, which is the sole private hospital in the Territory, only provides a limited range of services compared with private hospitals interstate. A comparison of private hospital services in Darwin and interstate has been previously submitted to the Commission and is included as Attachment A. This situation means that it is more likely that patients will present to Darwin's public hospital as a public patient, and as such the Territory has further limited capacity to raise revenue from private patients.

### **Darwin as a Capital City**

In essence, Darwin's characteristics relevant to admitted patient services are more similar to an outer regional town than a capital city because of its small population, limited range of services and lack of a comprehensive private hospital. The Commission's assessment recognises that there is a higher propensity to use public hospital services as remoteness increases. This is clearly demonstrated by AIHW data which was provided by ARIA in Position

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<sup>1</sup> Private Health Insurance Administration Council. Operations of the Private Health Insurers Annual Report, 2007-08.

Paper 2008/18. AIHW data is not available by SARIA. However the Commission's assessment fails to recognise that under ARIA, Darwin is characterised as outer regional and the assessment should start from this point rather than classifying Darwin as a Highly Accessible centre with the characteristics of a Sydney and Melbourne in terms of private sector provision. The Territory considers that this should be corrected by the development of an interstate location factor.

### **User Charges**

As highlighted above, the Territory has little capacity to raise user charges from private patients. The reality in Territory public hospitals is that there is very little difference between being a public or private patient. The Territory can neither insist on patients using their private health insurance when being admitted to one of its public hospitals, nor control access to private hospital services. The National Health Care Agreement (NHCA), signed by all governments in 2008 continues to enshrine one of the original Medicare principles that a patient has the right to be treated as a public patient regardless of their insurance status.

It is therefore hardly surprising that patients with private health insurance choose to be admitted as public patients, and receive treatment for free, rather than paying for an almost identical service. Indeed as outlined in the NHCA it is compulsory for public hospitals to “ensure that eligible persons who have elected to be treated as private patients have done so on the basis of informed financial consent”<sup>2</sup>.

While the Territory agrees that the disabilities applying to admitted patient services also apply to user charges that can be generated from this population, it disagrees that user charges per se should be netted off the category expenses. Rather it believes that state's capacity to raise private patient revenue should be recognised in the assessment. This was recognised in the 2004 Hospital Patient Fees assessment which uses a

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<sup>2</sup> Council of Australian Governments. National Health Care Agreement, Para 25(d) pg A9. 2008.

simple and material methodology reproduced in Table 2 below. There have been no changes to disabilities relating to user charges in the Territory since the 2004 Review; as such the Territory believes that the methodology should be continued in the 2010 Review.

**Table 2: Hospital Patient Fees Assessment 2009 Update \$ per capita**

	NSW	VIC	QLD	WA	SA	Tas	ACT	NT	AUST
Assessed Revenue	49.48	47.44	48.26	46.72	50.58	52.04	39.67	34.03	48.28
Assessed Difference	-1.20	0.84	0.02	1.56	-2.30	-3.76	8.61	14.25	

Source: Commonwealth Grants Commission 2009 Update

### **Patient Transport**

The Territory agrees with the assessment of patient transport expenses in the admitted patient services category. Significant components of patient travel costs are associated with hospitalisation. Patient transport comprised 11.39 per cent of the 2007/08 Territory admitted patients' budget<sup>3</sup>, largely due to the Territory's relatively high remote population. Detail of travel from remote areas to accessible areas is not captured by AIHW cost data and as such the Territory is concerned that the Commission's approach understates actual patient travel costs, based on comparisons with state data.

The Territory strongly supports the Commission's inclusion of non-hospital patient travel costs in this assessment. Remoteness is the biggest driver of non-hospital intrastate patient transport expenses. In 2008, 84 per cent<sup>4</sup> of Territory intrastate PATS expenses were incurred for flights from remote areas. Territory data indicates that the Commission's split of hospital and non-hospital costs of 65 and 35 per cent respectively is inaccurate. Territory data indicates that the non-hospital proportion is 70 per cent<sup>5</sup>.

<sup>3</sup> Sourced from Northern Territory Department of Health and Families

<sup>4</sup> Ibid.

<sup>5</sup> Sourced from Northern Territory Government Accounting System

Table 3 shows patient travel costs in 2008. Excluding St John Ambulance expenses, the vast majority of expenditure relates to non-hospital travel for patients from remote and very remote areas. St John Ambulance services cover urban areas but also include the remote and very remote centres of Nhulunbuy, Tennant Creek and Alice Springs, indicating that the Territory's proportion of 70 per cent is conservative.

**Table 3: Patient Travel Costs by Program – Northern Territory 2008, \$M**

<b>Program</b>	<b>Cost</b>
Patient Assistance Travel Scheme (PATS)	15.823
Aerial Medical Service	8.101
Northern Territory Aerial Medical Services Nursing	2.603
Royal Flying Doctor Service	3.317
St Johns Ambulance	12.772
<b>Total</b>	<b>42.616</b>

Source: Northern Territory Department of Health and Families

The draft report indicates a factor of 17 for the assessment of remote non-hospital patient travel costs. The Territory notes Commission staff comments on the incompleteness and unreliability of data used to calculate this factor. State data from 2007/08 suggests a higher factor of 22 is more representative of actual costs. The Territory does not support the use of a four year average due to the unreliability and incompleteness of state data preceding 2007/08. Furthermore, because of these data issues, the Territory does not support the Commission's proposal to fix the cost weight for the period of the review and proposes annual data updates of states' patient travel expenses.

The Territory proposes the differential assessment of interstate patient transport. In 2007-08 the Territory spent \$15.82 million on PATS, \$6.1 million or 38 per cent of which was interstate travel<sup>6</sup>. The Territory considers that interstate patient travel expenses are unavoidable and should be assessed and considered part of professional isolation as outlined in the Territory's April 2009 supplementary response to CGC papers 2008/14 and 2008/15-S.

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<sup>6</sup> Ibid.

## ATTACHMENT A

Differences between the private hospital sector in Darwin and other capital cities can be seen when a comparison is made between the scope of services provided by Darwin Private and those provided by other Healthscope private hospitals in other capital cities (see below). There is a significantly narrower scope of services available in Darwin. Both Darwin and Prince of Wales Private Hospitals are co-located with a teaching hospital while Mount Hospital is the only Healthscope hospital in Western Australia. It should be noted that other cities have numerous private facilities offering even broader services than those shown whereas there is just the one facility in Darwin.

**Table: Comparison of Healthscope hospital services – Darwin, Sydney, Perth and Hobart<sup>7</sup>**

Service	Darwin PH	Prince of Wales PH Sydney	Mount Hospital Perth	Hobart PH
Accident and Emergency				✓
Angiography	✓	✓	✓	✓
Angioplasty		✓	✓	
Breast Surgery			✓	
Cardiology	✓	✓	✓	✓
Cardiothoracic Surgery		✓	✓	
Colorectal surgery		✓		
Ear, nose & throat	✓	✓	✓	✓
General Medical Care		✓		✓
Gastroenterology & Endoscopy		✓	✓	✓
General surgery	✓	✓	✓	✓
Gynaecology	✓	✓		✓
Haematology			✓	
Intensive Care		✓	✓	<sup>8</sup>
Neurosurgery		✓	✓	
Obesity Surgery and Weight control services			✓	

<sup>7</sup> Accessed from <http://www.healthscopehospitals.com.au/info/general/Home/get/0/0/>

<sup>8</sup> Hobart Private Hospital has a critical care unit, which is slightly lower care than an Intensive Care Unit

Obstetrics	✓	✓		✓
Oncology		✓	✓	
Ophthalmology	✓	✓		✓
Oral & Dental Surgery		✓ <sup>9</sup>		✓
Orthopaedics	✓	✓	✓	✓
Paediatrics	✓	✓		
Plastic, Reconstructive & Cosmetic Surgery	✓ <sup>10</sup>	✓	✓	✓
Rehabilitation	✓			✓
Renal Medicine		✓		
Respiratory Medicine		✓	✓	
Sleep studies	✓	✓		✓
Urology	✓	✓		✓
Vascular Surgery		✓	✓	✓

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<sup>9</sup> Includes facial maxillary surgery

<sup>10</sup> Cosmetic and reconstructive surgery only