FUTURE DIRECTIONS AND POLICY ISSUES FOR THE NORTHERN TERRITORY DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

Presentation by Mr Ray Norman, Secretary
February, 1992
1. **OVERVIEW OF DEPARTMENTAL OPERATIONS**

The Department's mission is to improve individual and community well-being. This is pursued through providing and funding a broad range of services. A fundamental aim is to maximise the health and welfare outcomes given the resources available, and taking into account Government policies on quality of service delivery, equity, the role of government and specific priorities. A major challenge is to achieve an appropriate balance between the responsibilities of Government, the community, the family and the individual. The Department fosters a strong non-Government sector and attempts to facilitate processes for communities to identify and tackle their health and social problems.

In 1990/91 Departmental expenditure was $221 million (including Consumer Affairs), with receipts of $35 million. The break-up of expenditure is depicted in Figure 1. 56% of the Department's expenditure is directed into hospital services. 13% of expenditure related to Commonwealth Special Purpose Payments. Expenditure in 1991/92 will increase to $238 million.

The Department has an average staffing level of 3390 and provides grants for an additional 600 workers.

As with other Departments, Health and Community Services faces considerable challenges in delivering services to the NT's dispersed population. An example of the dimensions of this issue is that expenditure on all forms of patient transport exceeded $13 million or 5.9% of the budget in 1990/91. Other dispersion costs, such as the cost of other travel, communications and unproductive travelling time are also quite substantial.

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**Figure 1**

**Break-up of Departmental Expenditure 1990/91**

- Hospitals 56%
- Primary Health Care 20%
- Other Health 10%
- Aged and Disability 7%
- Family & Children's 7%

Consumer Affairs not included and Corporate Services allocated between program areas.
2. **THE FISCAL ENVIRONMENT AND THE ETHICS OF RESOURCE ALLOCATION**

Over the next decade there will be increasing demands for health and welfare services, whilst resources available for health and welfare services are unlikely to increase. This imposes an imperative that the Department continually search for ways to manage future demands, improve the efficiency of its services and allocate resources to areas in which they will have the greatest impact on health status and welfare outcomes.

It is important that decisions on the allocation of resources, the introduction of new technology, or the reform of service delivery, are driven by a consideration of the impact on health and welfare outcomes, equity and the economic implications. There are some hard decisions to be made, many of which will raise acute ethical and political issues. For instance, consider the hypothetical situation where an additional $75,000 was available. Where would we allocate this money, and by what criteria should we make this decision? Table 1 sets out some alternative uses for the $75,000.

Table 1 What will $75,000 buy in Health Care?
(All costs are approximate only, see Attachment A)

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.19 lives through a Mammography Screening Program for Breast Cancer</td>
<td>($400,000+ for each life saved)</td>
</tr>
<tr>
<td>Neonatal Intensive Care for one premature baby weighing 1,000 grams or less</td>
<td>($75,000 per baby)</td>
</tr>
<tr>
<td>1.7 patients on Renal Dialysis for one year</td>
<td>($45,000 per patient)</td>
</tr>
<tr>
<td>11 Hip Replacements</td>
<td>($7,000 for each hip replacement)</td>
</tr>
<tr>
<td>25 Hospital Admissions in the NT</td>
<td>($3,000 per admission)</td>
</tr>
<tr>
<td>250 Quit Smoking Courses</td>
<td>($300 per course)</td>
</tr>
<tr>
<td>375 Pap Smears in remote communities</td>
<td>($200 per smear)</td>
</tr>
<tr>
<td>1172 Pap Smears in urban areas</td>
<td>($64 for each smear and follow-up)</td>
</tr>
<tr>
<td>1786 Home Visits by a Community Health Nurse</td>
<td>($42 per visit)</td>
</tr>
</tbody>
</table>
Sources:

Mammography Screening: Feasibility Study for NT Participation in the National Program for Early Detection of Breast Cancer. The estimate of $400,000 per life saved is based on the most optimistic assumptions, that is that 8.7 lives will be saved over five years. More recent costings suggest that the cost per life saved is of the order of $800,000 to $900,000.


Hospital Admissions: Based on total expenditure for NT hospitals and number of admissions for 1990/91. The figure is not adjusted for outpatient episodes. According to HUCS, NT costs are approximately 23% higher than the rest of Australia (both for the per patient cost and the per bedday cost.)

Pap Smears: Cervical Cancer Screening Evaluation Steering Committee, Australian Health Minister's Advisory Council, Page 80. The average cost (including follow-up) for pilot projects aimed at rural/remote Aboriginal and TI women was $279, although this appears to have included certain "start-up" costs.

Home Nurse Visits: Estimate based on salary and on-costs for a nurse of $50,000, and an average of 6 visits a day for 40 weeks of the year.

* * *

Three principles seem to be common in discussions of these difficult issues. They include:

1. We need to know what works and what doesn't.

2. We need to choose options after considering both the potential health and welfare benefits, and their cost. We also need to consider the equity implications.

3. We need to make sure that once we have chosen an option that it is implemented properly, which includes evaluation.

In the future, decision making for the health and community care area will require criteria that reflect a more rational and consistent approach.
3. FUTURE DIRECTIONS

Demographic Influences

Between 1990 and 2005, the NT population is predicted to grow by at least 21%. It also estimated that the Aboriginal population will increase from 23.9% to 25.8% of the NT population.

An important feature of this growth is that the aged will make up a much larger proportion of the NT population. Between 1990 and 2005 it is estimated that NT residents aged over 60 years will increase by 106% (See Figure 2). Whilst the NT will still have proportionately fewer aged residents than the rest of Australia, this increase will lead to additional demands for acute care hospital beds, assessment services, integrated community care services and residential services. Hospital admissions for persons aged 65-74 are 83% higher than for the whole population, whilst for persons aged over 75 admission rates are 166% higher (See Figure 3). The elderly also consult their doctor more often (See Figure 4).

Figure 2

Increase in Aged Population of NT
1990-2005

![Aged Population Graph]

Source: Applied Population Research Unit Projections, Low Series

2. Estimate is based on projections made by the Applied Population Research Unit (University of Queensland) for NT Treasury. These estimates are the "Low Series", which CRESAP used. They are conservative.
Figure 3

Hospital Admissions by Age
Rates per 1,000 Population

![Hospital Admissions by Age](chart)

Source: Australian Institute of Health

Figure 4

Doctor Visits by Age
Rates per 100,000 Population

![Doctor Visits by Age](chart)

Source: Australian Institute of Health
The NT currently has 4.6 acute care beds per 1000 population compared to an Australian rate of 5.2 acute care beds per 1000. The age structure, social composition and superspecialties make direct comparisons with the NT difficult. However in a national context, a target of 3.3 acute care beds per 1000 has been proposed (based on international comparisons.) Such a target will present challenges for all State and Territory Governments. However one implication is that the NT will not need to expand hospitals, despite population growth and ageing.

However, the elderly place even greater demands on community care services and it is in these areas that Departmental programs will face considerable additional demands. The ABS survey of Handicap and Disability in 1988, revealed that over 50% of the Australian population aged over 80 years had some form handicap or disability (See Figure 5). Establishing mechanisms for properly assessing the needs of the elderly, and providing support in ways that complement informal care and minimise the need for institutional care, will one of the Department's most significant challenges in the years to come. There will need to a shift in resources towards services for the frail aged and disabled. It is estimated that pensioner concessions expenditure will increase by $2-3 million in real terms, although if all eligible pensioners began to claim their entitlements we might see even greater increases. Services such as oncology (cancer treatment) and palliative care will become even more essential with an ageing population.

**Figure 5**

Percentage of Population with a Handicap or Disability by Age

![Percentage of Population with a Handicap or Disability by Age](source: ABS 4120.0)

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Aboriginal Health Status

The principal strategic imperative for the Department must be to achieve major sustainable improvements in the health status of the Aboriginal population. It is a challenge that is difficult to underestimate.

Mortality rates for NT Aborigines are 4 times that of other Australians, average life expectancy 20 years lower and infant mortality rates are 3.7 times higher.

As well as mortality, there is ample evidence of the poor morbidity experience of Aborigines. Rates for many specific diseases are much higher. Aborigines are twice as likely to be admitted to hospital. Whilst only 24% of the population, Aborigines account for 50% of beddays in NT hospitals. As well as currently observable diseases, the effects of smoking (lung disease and vascular disease) and renal disease will have enormous resource implications in the next decade. This trend may already be evident in rates of hospital admissions for diseases of the respiratory system, diseases of the circulatory system and stroke (See Figures 6, 7 and 8). Table 2 summarises out some of the evidence concerning the gap between the health of Aborigines and other Australians.

Table 2 The Aboriginal Health Deficit

<table>
<thead>
<tr>
<th>Factors by which Aboriginal ill-health exceeds non-Aboriginal ill-health</th>
<th>Other NT Residents</th>
<th>Other Australians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aborigines Compared to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality</td>
<td>4 times</td>
<td></td>
</tr>
<tr>
<td>Mortality, 30-34 years</td>
<td>10 times</td>
<td></td>
</tr>
<tr>
<td>Mortality, 25-50 years</td>
<td>&gt;6 times</td>
<td></td>
</tr>
<tr>
<td>Infant Mortality</td>
<td>3.7 times</td>
<td></td>
</tr>
<tr>
<td>Perinatal Mortality</td>
<td>4.2 times</td>
<td></td>
</tr>
<tr>
<td>Gestational Diabetes</td>
<td>3-4 times</td>
<td></td>
</tr>
<tr>
<td>Babies less than 2500 grams</td>
<td>2 times</td>
<td></td>
</tr>
<tr>
<td>Still Births</td>
<td>2 times</td>
<td></td>
</tr>
<tr>
<td>Crude Hospital Morbidity</td>
<td>2 times</td>
<td></td>
</tr>
<tr>
<td>Hospital Admissions for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infectious and Parasitic Diseases</td>
<td>6.8 times</td>
<td></td>
</tr>
<tr>
<td>Endocrine, Nutritional and Metabolic Diseases</td>
<td>4.6 times</td>
<td></td>
</tr>
<tr>
<td>Hospital Admissions for diseases of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood/Blood forming Organs</td>
<td>4.3 times</td>
<td></td>
</tr>
<tr>
<td>Respiratory System</td>
<td>3.3 times</td>
<td></td>
</tr>
<tr>
<td>Circulatory System</td>
<td>2 times</td>
<td></td>
</tr>
<tr>
<td>End Stage Renal Failure</td>
<td>&gt;7 times</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>&gt;10 times</td>
<td></td>
</tr>
<tr>
<td>Leprosy</td>
<td>&gt;10 times</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>&gt;15 times</td>
<td></td>
</tr>
<tr>
<td>Sexually transmitted diseases</td>
<td>&gt;15 times</td>
<td></td>
</tr>
<tr>
<td>Diarrhoeal Diseases</td>
<td>&gt;10 times</td>
<td></td>
</tr>
<tr>
<td>Shigella infections</td>
<td>&gt;28 times</td>
<td></td>
</tr>
<tr>
<td>Meningococcal Infections</td>
<td>&gt;13 times</td>
<td></td>
</tr>
</tbody>
</table>
Figure 6

NT Hospital Admissions Rates
Diseases of the Respiratory System

Rates are World Standardised Rates

Figure 7

NT Hospital Admission Rates for
Diseases of the Circulatory System

Rates are World Standardised Rates
Figure 8
NT Hospital Admission Rates for Cerebrovascular Disease (Stroke)

A key challenge in terms of maximising the impact of the Department's expenditure on health status and in avoiding unnecessary expenditure in the future, will be to direct our resources to those activities which will prevent or reduce the prevalence of disease and consequently reduce hospital admissions.

Many of the conditions for which Aborigines are admitted to hospital in the NT are preventable. By developing and strengthening primary health strategies, strengthening the local co-ordination of service delivery, better planning, paying attention to environmental health factors, facilitating community responses to health problems, the NT has an opportunity to reduce future demands for hospital admissions and other health services. Targeted strategies for particular conditions and behaviours will be vital. A crucial link will be to assist communities to take responsibility for their health and social problems.

Certain diseases will require particular attention, and some of these are discussed below.
End Stage Renal Disease

The incidence of End Stage Renal Disease is over 7 times the national average. This is largely due to a very high incidence amongst Aborigines. The number of people requiring renal dialysis has doubled in the last few years and it is anticipated that this number will double again in the next 2 years. (See Figure 9).

One indicator of the size of the potential problem is that some studies have shown that around 30% of Aborigines in remote areas have protein in their urine, which is an early indicator of renal disease. If we assume that a third of these people will not be alive in ten years time, and that a tenth of the survivors will develop end stage renal failure within that period, then we will have over 140 people requiring renal dialysis by 2002. At $45,000 per person per year the cost of renal dialysis will reach $6-7 million (See Figure 6). This is a conservative estimate. If, for instance, 30% of the survivors proceed to End Stage Renal Disease, expenditures would be in the order of $17-18 million. Such an increase would be consistent with the exponential growth in people requiring dialysis, witnessed over the last decade.

Figure 9

Projected Number of Patients Requiring Renal Dialysis, 1991-2001
Transplantation is a cost-effective alternative to dialysis, although the size of the donor pool, particularly for Aborigines, constrains this alternative.

However there are opportunities to intervene earlier in the disease cycle. It is not clear why renal failure is so high in Aborigines. Diabetes is clearly implicated, although some researchers believe that impetigo, that is school sores, which is endemic in many Aboriginal communities, may be an important cause. Environmental measures, better housing and behavioural changes in communities will be the main initiatives that will reduce the prevalence of skin disease. Of course such measures will have spin-offs for many other diseases. Whilst further research is required, preventive measures, which will require additional resources initially, appear to be imperative.

Diarrhoea

The incidence of diarrhoeal diseases caused by salmonella and shigella infections in the NT is the highest in Australia. Outbreaks of other diarrhoeal diseases occur regularly in rural communities, and large numbers of children are urgently evacuated to hospital for treatment. The hospital related costs are estimated to be $3 million per year in the NT.

Prevention programs have to address water and sanitation in rural communities, coupled with developing culturally sensitive education programs.

Other Diseases

Other strategies are required for a wide range of diseases and problems including diabetes, sexually transmitted diseases and tuberculosis.

Alcohol

Alcohol costs the NT community $150 million each year. A co-ordinated strategy designed to change alcohol use patterns and strengthen rehabilitation is essential.

The effect of alcohol pervades every aspect of health and social life and has repeatedly been defined by Aboriginal people as a priority concern. The Department proposes to train Aboriginal alcohol educator teams. These teams will develop and deliver an alcohol education program in Aboriginal communities which is modelled on the internationally recognised and highly successful NT AIDS/STD program. The program recognises the key challenge is to assist communities to take responsibility for their own problems and develop their own solutions. This program complements urban based services as well as the grants recently awarded to community based organisations which are aimed at alcohol intervention and treatment programs.

Our targets are:

To reduce:
- the incidence of alcohol related disease
- the burden alcohol abuse places on the health sector.
- numbers of Aboriginal people drinking dangerously.
- vandalism, injuries and deaths, attributed to alcohol misuse.
- nutritional problems attributed to alcohol misuse.
alcohol related apprehensions by police
and to increase:
. community intolerance of disruptive behaviour.
. school attendance among children where non-attendance is attributed to
  alcohol misuse

HIV/AIDS

The HIV/AIDS epidemic is possibly one of the greatest new threats to public
health that has emerged in this century. Whilst the NT has avoided a high
incidence of the disease, there is a critical need for vigilence and preventive
strategies. It is known that people who have been exposed to other sexually
transmitted diseases have an increased risk of the HIV virus. The NT has very
high rates of sexually transmitted diseases, and this is particularly the case with
our Aboriginal population. If HIV virus were to spread into our Aboriginal
population, demands on the health system would increase dramatically.
Preventive strategies represent our best opportunity to avoid this scenario.

Mental Health

Mental health services will be significantly enhanced by the provision of the
building of a new secure unit and, hopefully, eventually the new Mental Health
Act.

Environmental Health

Environmental health issues are obviously important. Apart from the direct
economic impact in such matters as diarrhoeal and other infectious diseases in
Aboriginal communities, there will be increased demands for consideration of
health issues in environmental planning. This area is likely to require
reallocating of resources if we are to meet community demands.

Technological Advances

As medical technology advances, there are increasing opportunities to undertake
diagnostic techniques and treatments that were not previously available.
Increasingly the consumers of health services are better informed and demand
that advances in health care will be made available. Technological advances in
health care can reduce hospital stay. For example lithotripsy is a procedure in
which kidney stones can be removed without surgery. Shock waves are used to
break the stones into fine gravel. However technological advances often involve
large capital expenditures and require a more skilled labour force. Consequently
it is important there are objective assessments of the value of technology. We
need to ask "What should be done?" rather than "What can be done?"
Social Attitudes

Consumers of health care are also demanding improvements in the quality of care received.

Allocating resources in health raises many emotional and ethical issues and Governments can have pressure applied to introduce services which have not necessarily been scientifically demonstrated to be of benefit to patients. A good example is the case of breast cancer screening. Early uncontrolled trials of mammography screening suggested that there were potential benefits for women both under and over 50 years of age. Subsequent controlled trials in Scandinavia and Edinburgh have shown that benefits only accrue in relation to women over 50 years. New screening techniques and treatments might change this situation, although there is no clear evidence that women under 50 can benefit from a mass mammography screening program. The Commonwealth initiated some pilot Australian trials in order to determine the potential benefits of a program for Australian women, yet because of political agendas announced a program which included women under 50 years of age. Women's health issues are important and there are opportunities of improving the health status of women that have to be taken up. However, whether we devote resources to interventions whose benefits are questionable, is an difficult ethical and political issue.
Hospital Services

Between 1987/88 and 1990/91 direct expenditures on hospitals increased by 3% in real terms, whilst patient admissions to NT hospitals increased by 6%. The real cost per patient has decreased by 3% (See Figure 10). A significant contributor to these efficiency gains has been a 7% decrease in the average length of stay. These efficiency improvements have been achieved despite rises in award salaries in excess of the average. Between the March quarter 1987 and the September Quarter, 1991, average weekly earnings rose by just under 25% in the NT. In the same period the most a base grade nurse could earn rose by 54%, whilst the increase for senior grade nurses was of the order of 68%. These increases reflected Australia-wide adjustments that were required to deal with a crisis in the supply of nursing staff.

Figure 10
Figure 11
Cost per Patient and Bedday
NT Hospitals, 1988-1991

Cost per Patient  Cost per Bedday

$3400  $600
$3200  
$3000  
$2800  
$2600  
$2400  
$2200  
$2000  
$2000  $400


Year

Per Patient  Per Bedday

Costs expressed in real 1988 values

Figure 12
Average Length of Stay
NT Hospitals, 1988-1991

Year


Days

- 15 -
One of the proposals being actively encouraged by the Commonwealth in casemix funding of hospitals. Casemix funding involves reimbursing hospitals according to the patient's diagnosis. A hospital treating a high percentage of acutely ill patients requiring constant medical review would be reimbursed at a higher rate than a similar size hospital treating patients with milder illnesses. This proposal will produce incentives for hospitals to reduce costs that exceed national reimbursement rates.

Casemix funding will have significant implications for how hospitals are managed. In the first place it will be imperative that there are good information systems relating to all the areas of hospital activity. Policies and mechanisms for closer management of admissions and discharges will be required, and their implementation will require sensitive negotiation with clinicians. The full implementation of casemix management will take several years. The Commonwealth, however, is keen to use Casemix as the basis for funding the new Medicare Agreement from 1 July 1993. Most States will resist this vigorously, although they have indicated a willingness to implement "casemix" systems as an internal management tool.

There are several areas in which further efficiency gains can be made within hospital services and these include the following:

**Greater use of day surgery and non-hospital facility:** Increased use of day surgery in hospital and procedures in private general practice surgeries will be encouraged by the strict implementation of admission criteria. The national trend is to increase the use of non-hospital facilities for operative procedures. Progressively more complex surgery will be carried out safely without the need to admit patients. This will have the effect of placing more demands on community and home based care.

**Discharge Management:** Planning for discharges will need to be more formalized - partly as a response to casemix management and facilitated by an improved hospital information system.

An example of the extent to which this planning can progress is the current management of HIV positive patients in major teaching hospitals. Periods of admission are arranged only for those procedures which must be carried out under medical supervision. Other therapy, including administration of intravenous drugs, is carried out in a non hospital setting.

A policy statement on the point at which Government no longer takes responsibility for providing care will need consideration. The issue is: Is Government prepared to take responsibility for caring for the individual through the acute phase for illness or trauma until they are 100% well or is the individual expected to be responsible for themselves immediately after the acute phase.

The ability to better control admission and discharge policies will depend on availability of community care options, which can provide an appropriate and cost effective alternative for pre-admission and post-discharge care.

**Doctors and costs:** An important challenge will be to encourage a much greater awareness by clinicians of the resource implications of their decisions and practices. Providing clinicians with information on costs is a first step. Guidelines developed by the various professional groups, which identify the value of diagnostic and treatment options, will also lead to improvements. Ultimately clinicians will become responsible for managing budgets.
Greater role for the private sector: There are clear opportunities to contract out certain aspects of hospital functions. These extend into clinical areas as well. In some areas of ill health, particularly those relating to surgical procedures, private medical practitioners may be able to provide a similar service for individual patients at a lower cost than a public hospital doctor. Such a service, however, may not allow for training of junior doctors, teaching of nursing staff, or emphasis on preventative measures.

Quality of Care: Concern for the impact of these measures on the quality of services needs to be dealt with through a variety of processes including quality assurance, utilisation review and clinical audit.

The Private Health Sector

The NT has a much smaller private health sector, compared to the rest of Australia. The private sector in the NT faces enormous challenges related to economies of scale and additional costs due to isolation. Many aspects of the private sector, such as general practice, pathology and pharmaceuticals are subsidised by the Commonwealth.

Since the commencement of Medicare there has been a national decline in private health insurance resulting from several factors including:

- The absence of charges for patients treated as public patients in public hospitals.
- Increases in charges made by private hospitals.
- Declining coverage by private insurance, which also relate to:
  - A change in the risk profile of the insured population.

By 1990 43.1% of the Australian population had private health insurance and older people comprised 22.1% of the insured.

This decline in private health insurance contributors has implications for public hospitals as it places additional burdens on the public sector. It could also diminish the viability of Darwin Private Hospital.

Since the commencement of Darwin Private Hospital, private beddays in the NT have increased to 14% of all beddays compared with a national rate of 39%. Darwin Private Hospital is currently operating at 40% of its approved capacity.

Closure of the private hospital would necessitate an increase in beds in Royal Darwin and an estimated increased expenditure of around $4 million.

Role of the non-Government sector

During the next few years an ongoing theme will be to articulate Government expectations through explicit agreements with funded organisations, and to focus on the outcomes and quality of services provided by these organisations. This is an imperative to which many non-Government agencies may object.

Family Dislocation, Family Violence and Family Dysfunction
Family Dislocation, Family Violence and Family Dysfunction

Over the last two decades there have been increases in family breakdown, reconstituted families, single-parent families, levels of family violence, both between spouses and against children, and youth homelessness. At the same time expectations of the responsibilities of families, the wider community and government have changed.

In the future, a greater focus is required on those measures that will prevent family break-up, domestic violence and child maltreatment. Interventions include improving the support available to families for example through child care and enhancing parenting skills.

Remote Areas

The most important challenges lie in how we achieve better co-ordination of planning and service delivery for our remote populations. This issue cuts across Departmental boundaries.

Improved Co-ordination and Focus in Community Care

Improved co-ordination in community care needs to be achieved through a variety of strategies including the integration of Community Health Centres and Welfare Offices. The legislative framework for Adoptions and Child Welfare are undergoing review.

Improved Human Resource Management

65% of Departmental expenditures relate to the employment of people. There are opportunities to make significant improvements in the way this resource is managed. Strategies include:

. The work guidance program, which carries Departmental objectives down into the way staff and supervisors operate on an everyday basis.
. Better work design
. Better direct, control and management of our training and staff development functions. A particular focus is to improve managerial skills.
. Better strategies for dealing with "hard to place" individuals.

A vital link in implementing these activities will be to have in place much better information, and PIPS is crucial in this respect.

The Impact of Commonwealth Programs

Under the Commonwealth's Medicare and Pharmaceutical Benefits Scheme, the health sector in the NT receives $20 million less than would be expected based on Australian rates. This pattern arises from the lack of private medical services in the remote areas, due to severe diseconomies in remote areas and problems in attracting private practitioners. To an extent, the Department substitutes for the absence of these services, although wherever possible we have encouraged and at times subsidised private practice.

The Commonwealth, through ATSIC, has a propensity to fund independent health services without consultation with the NT Government. For example in July 1991 ATSIC funded the Darwin Aboriginal Medical Service without a
The Commonwealth, through ATSIC, has a propensity to fund independent health services without consultation with the NT Government. For example in July 1991 ATSIC funded the Darwin Aboriginal Medical Service without a defined charter and without consultation. We now hear that a decision has been made to establish an East Arnhem Medical Service, again without consultation. The Commonwealth spends approximately $3m on these services which the Grants Commission includes as Territory expenditure.

The Northern Territory funds 14 health services. I believe that the NT should negotiate with communities to enable them to control their health services as soon as possible - subject, of course, to the communities properly understanding their functions and obligations. The alternative appears to be that the Commonwealth will do it anyway.

Fragmentation of the Health System: Defining State/Commonwealth roles

In 1976 the Coombs Inquiry reported that:

"[T]here is an immediate need to rationalise the mosaic of health and welfare services which is marked by duplication of roles and responsibilities and which stimulates rather than reduces the need for institutional care."

In 1992 funding, planning and service provision responsibilities for health and welfare in Australia are more fragmented and more complicated than ever. A key challenge for the 1990s will be to institute fundamental reforms that will promote greater efficiency and integration of health and welfare services and eliminate waste and duplication. Health services consume 8% of GDP in Australia, and a failure to address this issue has serious ramifications for the overall competitiveness of the Australian economy.