Northern Territory Department of Health submission to the Inquiry into the National Health Reform Amendment (Independent Hospital Pricing Authority) Bill 2011

High cost of hospital care

The Northern Territory has traditionally had a recognised high cost base for the provision of hospital care. This is for several reasons:

- Remoteness
- Low economies of scale
- High burden of disease – especially in the indigenous communities
- High costs of assisted patient travel
- High costs of attracting specialists

Much of this is not recognised within a "nationally efficient price" and therefore various loadings will be required in some form to keep the Territory on an even footing nationally.

Changes in Demand Profile

The Territory has a young age cohort, and as the population ages the burden of hospital care supply requirements will increase at a greater rate than population growth and CPI. This change in demographics will need to be explicitly recognised in the national agenda and the territory share of Acute care funding will likely need to increase as a result.

Classification failure

The Territory's unique population mix will create challenges for national classification, as the high rate of chronic illness will not be identified in the early iterations of the ABF. Over time the territories contribution to the national agenda will rectify these classification failings, but in the short term there will need to be recognition of what is often termed "classification compression"

Community Service Obligation recognition

The CSO is being defined nationally for small and remote hospitals, allowing these hospitals to avoid some of the financial pressures of a full ABF, due to their inability to manage costs as larger hospitals can.

The Territory would benefit from the CSO definition being expanded to include services for which there is no ability to meet nationally efficient prices. This will occur from time to time in many subspecialties across the Territory due to the pragmatic nature of identification and retention of specialists, with the expensive and adhoc provision of service being managed utilising travelling VMOs creating a very expensive service delivery mechanism. This occurs in Royal Darwin Hospital and Alice Springs Hospital, more so than in the traditionally classified CSO sites of Katherine, Tennant Creek and Gove Hospitals.