CHAPTER FOUR

ACUTE CARE

1. The Report reached the following conclusions about the provision of acute care services to Indigenous people.

   (i) Indigenous people are hospitalised in public hospitals at about twice the rate of non-Indigenous people. Hospital separations increase with remoteness.

   (ii) Expenditure on acute care services for Indigenous people per capita is about twice that of expenditure on acute care services for non-Indigenous people. Expenditure per Indigenous person increases with remoteness.

   (iii) The Commonwealth is limited in its ability to influence the distribution of acute care funds to regions.

   (iv) Support services, such as patient assisted transport and accommodation schemes and emergency transport, are crucial if Indigenous people are to have equitable access to acute care services.

Funding of Services

2. States receive funds for acute care from the Commonwealth through the Australian Health Care Agreements. Table 4-1 shows the grants provided through the agreements to each State in 1988-99. The bulk of the funding occurs through the base grant, which reflects factors such as population growth and ageing, hospital output costs, private health insurance coverage and growth in demand. Within base grants States also received amounts for national mental health, palliative care and quality improvement projects. National Health Development funds are provided in addition to the base grant.

3. The States are responsible for the distribution of acute care funds to regions. Attachment H shows the key features of each State's method of distributing acute care funding to regions.

Table 4-1 GRANTS TO STATES THROUGH THE AUSTRALIAN HEALTH CARE AGREEMENTS, 1988-99[(a)]

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
	$m	$m	$m	$m	$m	$m	$m	$m	$m
Total base grant	1862.3	1327.9	994.3	521.9	475.4	122.8	67.5	61.1	2384.1
Including:									
Mental health	16.7	12.3	9.1	4.8	3.9	1.2	1.0	1.0	50.0
Palliative care	9.6	7.0	5.0	2.6	2.4	0.7	0.4	0.6	28.4
Quality improvement	25.8	18.9	13.5	7.0	6.3	1.9	1.1	0.6	75.0
In addition to base grant:									
National Health Development Fund	86.0	63.0	45.0	23.0	21.0	6.5	6.4	1.9	252.8
Total	2000.4	1429.1	1066.9	559.3	509	133.1	76.4	65.2	2790.3

(a) Some other minor adjustments are not included in this table.

Source: Australian Health Care Agreements — New South Wales, Victoria, Queensland, Western Australia, South Australia, Tasmania, Australian Capital Territory and Northern Territory.

Expenditure

4. Table 4-2 shows State expenditure on admitted patient services by ARIA classification. It shows that expenditure per Indigenous person increases with remoteness. This is the result both of the increased Indigenous hospital separations and the increased cost of providing services in remote areas.

Table 4-2 EXPENDITURE ON ADMITTED PATIENT HOSPITAL SERVICES PER INDIGENOUS AND NON-INDIGENOUS PERSON BY ARIA CATEGORY, 1998-99

	Indigenous		Non- Indigenous		
ARIA category	Amount	Per Indigenous person	Amount	Per person	Indigenous relative to non-Indigenous
	$m	$	$m	$	
Highly accessible	120	692	7743	510	1.4
Accessible	82	1028	1300	606	1.7
Moderately accessible	43	1048	463	632	1.7
Remote	43	1652	134	617	2.7
Very remote	136	1582	93	595	2.7
Total	424	1051	9733	532	2.0

(a) ARIA categories do not add to the total as $3.2 million of Indigenous expenditure and $74.4 million of non-Indigenous is excluded because no ARIA code could be allocated.

(b) Expenditure where Indigenous status is not reported has been allocated between Indigenous and non-Indigenous using the same proportion as for identified separations in the remote regions.

(c) Figures have been adjusted for under-identification.

Source: AIHW, *Preliminary Findings of the Report on Expenditures on Health Services for Aboriginal and Torres Strait Islander People 1998-99*, (forthcoming) AIHW/DHAC, Canberra, 2001.

5. ***Rural and remote hospitals.*** The *Report on the National Aboriginal and Torres Strait Islander Casemix Study* conducted in rural, remote and regional hospitals indicates that Indigenous people have a different pattern of service use from non-Indigenous people in rural and remote areas. According to the study 67.6 per cent of separations for renal dialysis were Indigenous and the remainder non-Indigenous[1]. This is in contrast to all separations of which 33.9 per cent were Indigenous and the remainder non-Indigenous. 33 per cent of Indigenous admissions to hospital are for dialysis[2].

6. The study also found difference in average costs between Indigenous and non-Indigenous patients. After excluding admissions for dialysis the average cost per Indigenous inpatient was $2 173 per episode compared to $1 816 per non-Indigenous inpatient[3].

Measuring Need

7. ***Hospital separations.*** Hospital separations do not necessarily measure need for acute care services because they measure met need rather than need as such. They also reflect factors other than the need for hospital services, such as poor access to primary health care or poor environmental health conditions. However, hospital separations do reveal that the Indigenous population uses hospitals at a greater rate than the non-Indigenous population. Data also show types of diseases that Indigenous Australians are most likely to be treated for.

8. Attachment I, Figures I-1 to I-8, show hospital separations by State by RRMA. They demonstrate the greater use of hospitals by the Indigenous population and that hospital separations increase with remoteness. They also show that hospital separations are most likely to provide treatment for diseases of the kidney and urinary tract (renal dialysis), pregnancy and childbirth, diseases of the respiratory system and diseases of the digestive system.

9. ***Distance to hospital.*** Distance to hospital can be considered a measure of access to hospitals. CHINS[4] contains information on the distance of discreet Indigenous communities from hospitals. It should be noted that only 28 per cent of Indigenous Australians live in discrete communities. Table 4-3 shows some results of the survey by State.

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1 Brewster and Associates, *National Aboriginal and Torres Strait Islander Casemix Study Report*, Commonwealth Department of Health and Family Services, Canberra, 1997, p46.

2 Brewster and Associates, *National Aboriginal and Torres Strait Islander Casemix Study Report*, Commonwealth Department of Health and Family Services, Canberra, 1997, p43.

3 Brewster and Associates, *National Aboriginal and Torres Strait Islander Casemix Study Report*, Commonwealth Department of Health and Family Services, Canberra, 1997, p2.

4 *Community Housing and Infrastructure Needs Survey*, produced by ABS on behalf of ATSIC, Canberra, 1999.

Table 4-3 DISTANCE OF DISCRETE COMMUNITIES TO HOSPITAL

	Within the community	<10km	10-24km	25-49km	50-99km	100-249km	>250km	Total collected
NSW	1	34	6	16	7	3		67
Vic				1	1			2
Qld	8	20	13	20	17	31	40	149
SA	1	10	4	6	4	5	76	106
WA		32	27	18	25	133	50	285
Tas				1				1
NT		32	21	24	36	176	381	681[(a)]
Total	10	128	71	86	90	348	547	1291[(a)]

(a) Includes 11 not stated.
Source: Derived from the *Community Housing and Infrastructure Needs Survey*, produced by ABS on behalf of ATSIC, Canberra, 1999.

10. The table shows that 895 communities are located 100 kilometres or more from the nearest hospital. Most of these communities are located in the Northern Territory, but there are also a significant numbers located in Western Australia, Queensland and South Australia.

11. If Indigenous people, particularly those in remote areas, are to be able to access hospital services, access to patient transport and support facilities is required. It is also necessary to ensure that hospitals are not unduly alienating to Indigenous people.

12. The Commission therefore concentrated on services surrounding acute care that facilitate access to hospitals by Indigenous people. These services are:

- patient assisted travel schemes;
- medical emergency services; and
- measures taken to make hospitals more culturally accessible.

13. ***Patient assisted travel schemes.*** Patient assisted travel schemes are vital if Indigenous people in rural and remote areas are to access acute care services. Variations in procedures and eligibility criteria across States affect the access to acute care and specialist services. Key administrative criteria that vary are:

(i) the minimum distance for receiving benefits;

(ii) which services payments are received for, in particular specialist, dental and allied health services;

(iii) retrospective claims are approved of in New South Wales, Victoria, South Australia, and Tasmania but not elsewhere;

(iv) the level of patient contribution towards travel for health care cardholder varies; and

(v) the type of accommodation that will be subsidised.

14. The first submission from NACCHO[5], as well as consultations, also raised the following concerns about patient assisted travel schemes.

(i) Eligibility criteria are too restrictive, in particular the rigid distance criteria.

(ii) The schemes are not flexible enough to meet the needs of Indigenous patients. There is little ability or discretion to consider the individual needs of the patients, particularly the severity of their condition, their socio-economic status, and the urgency of addressing a service.

(iii) Many patients are unable to access the schemes and those who do may still be faced with economic hardship because full reimbursement is not provided.

(iv) Patient travel across State borders can create difficulties as to which jurisdiction is responsible, and entitlements differ between States.

(v) There are problems with the administration of the schemes, including inconsistent application of guidelines, poor availability of information about the schemes to both users and administrators, and poor quality of data available from the schemes.

15. ***Access to medical emergency services.*** Access to a medical emergency service is a measure of access to acute care services. According to CHINS, over 14 000 people in 589 discrete communities (mainly remote communities in Western Australia and the Northern Territory) do not have access to an emergency airlift service[6]. Table 4-4 shows access to emergency airlift services by ARIA for discrete communities.

Table 4-4 ACCESS OF COMMUNITIES[(a)] TO MEDICAL EMERGENCY AIR SERVICE BY ARIA CATEGORY

	Highly accessible	Accessible	Moderately accessible	Remote	Very remote	Total
Access	9	14	13	37	509	582
No access	1	7	16	92	473	589
Total collected	10	21	29	131[(b)]	987[(c)]	1178[(d)]

(a) Includes communities with a population of less than 50 and communities with a population of 50 or more located 10 kilometres or more from the nearest hospital.
(b) Includes 2 not stated.
(c) Includes 5 not stated.
(d) Includes 7 not stated.
Source: Derived from the *Community Housing and Infrastructure Needs Survey*, produced by ABS on behalf of ATSIC, Canberra, 1999.

5 National Aboriginal Community Controlled Health Organisation, initial submission, May 2000, p8.
6 *Community Housing and Infrastructure Needs Survey*, produced by ABS on behalf of ATSIC, Canberra, 1999.

16. ***Measures taken to make hospitals more culturally accessible.*** Indigenous membership of hospital boards is reported on as part of the National Aboriginal and Torres Strait Islander health performance indicators[7]. Table 4-5 shows the results by State.

Table 4-5 HOSPITALS WITH INDIGENOUS MEMBERS, 1998

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Number of boards with Indigenous representation[(a)]	20(20)	3(213)	Not given — poor quality	5(48)	Data not available	0(1)	0(1)	4(6)

(a) The numbers of relevant boards on which Indigenous people could be represented in each jurisdiction are shown in parentheses.

Source: AIHW, *National Summary of the 1998 Jurisdictional Reports Against the Aboriginal and Torres Strait Islander Health Performance Indicators*, The National Health Information Management Group for the Australian Health Minister's Advisory Council, AIHW cat. no. IHW 5, p27, Table 3.7.

17. The cross-cultural training of acute care staff is another strategy to improve the cultural appropriateness of acute care. While most jurisdictions have Indigenous cross-cultural programs to educate hospital staff, these programs are not linked to hospital accreditation. In New South Wales, the establishment of Indigenous cross-cultural awareness programs is part of agreements with its health services. Fifteen out of 20 health services have implemented cultural awareness training.

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7 AIHW, *National Summary of the 1998 Jurisdictional Reports Against the Aboriginal and Torres Strait Islander Health Performance Indicators*, The National Health Information Management Group for the Australian Health Minister's Advisory Council, AIHW cat. no. IHW 5, p27, Table 3.7.