1 Overview

This chapter summarises the main results of the 1998–99 study. Methodologies, sources of data and more detailed results are shown in the chapters which follow.

Funding and administration of health services in Australia is a shared responsibility, with Commonwealth, State and local governments, and individuals all contributing funding for the full mix of health services used by the community, and with differing administrative arrangements for different services. In this report expenditure is reported primarily by program. The term 'program' is used to group services of the same type—for example, medical, allied health or hospital services—that also have the same funding and administrative arrangements (Appendix 1).

These arrangements may be quite complex. For example, the Pharmaceutical Benefits Scheme (PBS) is administered by the Commonwealth, with pharmaceuticals being provided by private providers and paid for by a mix of Commonwealth funds and consumer co-payments. Public hospitals provide both public and private services. They are administered by State governments and jointly funded by the Commonwealth, the States and private patient payments. Private hospital services are administered and delivered by private organisations, regulated by Governments and funded through a mix of private payments from health funds and consumers and Commonwealth funding through the Department of Veterans' Affairs (DVA) and the 30% rebate for private health insurance.

The information on expenditure provided below is arranged to reflect this diversity and provides the same information from a number of different viewpoints. Expenditure is presented by area of administrative responsibility, by source of funds, by type of service and by jurisdiction. There is also an analysis of regional patterns of expenditure, an examination of the split between primary and secondary/tertiary care, and a comparison with the estimates for 1995–96 produced for the first expenditure report.

This information should be considered in the context of Aboriginal and Torres Strait Islander health status, income and demographics:

(a) Aboriginal and Torres Strait Islander people have the poorest health of any sub-population in Australia. Life expectancy at birth for Aboriginal and Torres Strait Islander people is estimated to be about 20 years lower than for all Australians (ABS & AIHW 1999).

(b) The incomes of Aboriginal and Torres Strait Islander people are much lower than those of the non-Indigenous population. The median weekly income for Aboriginal and Torres Strait Islander adult males was $189, less than half of the median for non-Indigenous males.

(c) Over a quarter of Aboriginal and Torres Strait Islander people (27.5%) reside in remote and very remote areas, compared with 2.6% of the total population.

Total expenditures

Total expenditures on health services for Aboriginal and Torres Strait Islander people are estimated at $1,245 million in 1998–99. That was equivalent to $3,065 per person, compared with the $2,518 per person estimated to have been spent for non-Indigenous people. The ratio of expenditures for Aboriginal and Torres Strait Islander people to those for non-Indigenous people was 1.22:1.

While the sections below examine expenditures for health services for Aboriginal and Torres Strait Islander people from a number of perspectives, in all cases the patterns of expenditure are different from those of non-Indigenous people, with higher use of hospital and community health services and lower use of the major Commonwealth programs and private services. In both aggregate expenditures and their composition, these patterns are consistent with a low-income population in which 27.5% of people live in areas classified as remote on the Accessibility/ Remoteness Index of Australia (ARIA) classification of access to service centres (compared with 2.0% of non-Indigenous people). Only 62% live in places where service centres are seen as accessible or highly accessible, as compared with 94% of other Australians. That is quite apart from questions about whether underlying health status was sufficiently reflected in service use or whether the services available were both medically and culturally appropriate.

Total expenditures, by administrative responsibility

Tables 1.1 and 1.2 and Figures 1.1 and 1.2 examine total expenditures and total expenditures per person, by area of administrative responsibility.

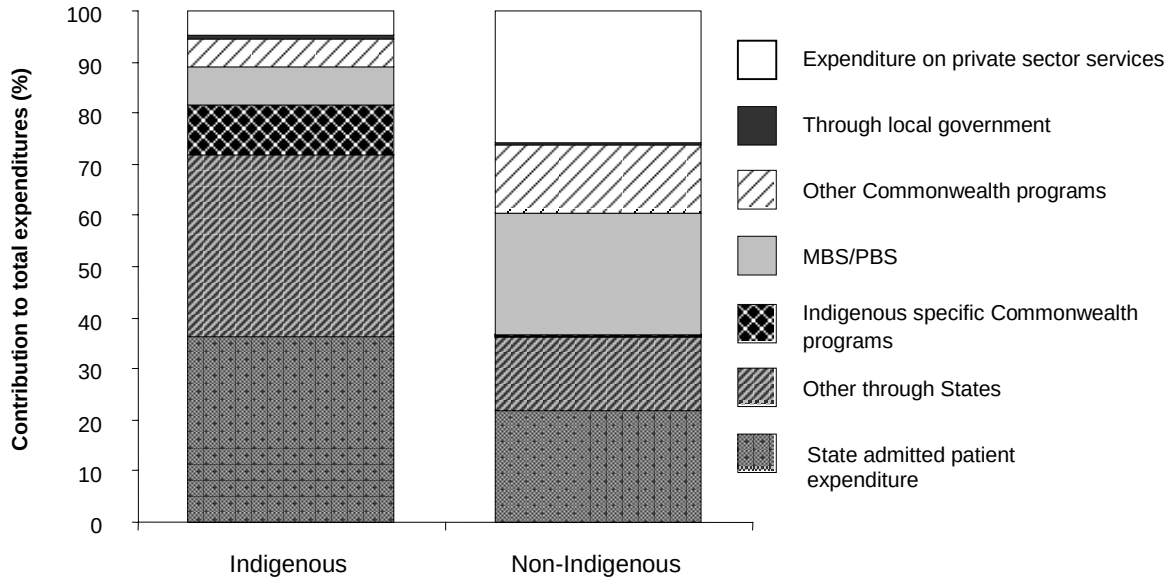
Table 1.1: Estimated health expenditures for Aboriginal and Torres Strait Islander people and non-Indigenous people, by program, 1998–99

			Contribution to total expenditures	
	Indigenous ($m)	Non-Indigenous ($m)	Indigenous (%)	Non-Indigenous (%)
Through State programs				
Admitted patient expenditure	453	10,096	36.4	21.8
Other through State program exp.	443	6,850	35.6	14.8
Total through State programs	**896**	**16,947**	**72.0**	**36.5**
Through Commonwealth programs				
Indigenous specific Cwlth programs	121	10	9.7	. .
Medicare/PBS	91	11,071	7.3	23.9
Other Commonwealth programs	69	6,196	5.5	13.3
Total through Cwlth programs	**281**	**17,277**	**22.6**	**37.2**
Through local government programs	**8**	**206**	**0.6**	**0.4**
Services through private sector programs	**60**	**11,982**	**4.8**	**25.8**
Total recurrent expenditure	**1,245**	**46,412**	**100.0**	**100.0**

Source: AIHW Health Expenditure Database.

These tables and figures cover all expenditures, including those by individuals. Administrative responsibility rests with the level of government where decisions are made as to financing arrangements, the range of services to be provided and eligibility criteria. This way of presenting expenditure does not examine the mix of funding sources for each program.

Figure 1.1 shows the difference in the composition of recurrent health expenditure for Aboriginal and Torres Strait Islander people as compared with that for non-Indigenous people.



Source: AIHW Health Expenditure Database.

Figure 1.1: Composition of total recurrent health expenditure for Aboriginal and Torres Strait Islander people and non-Indigenous people, 1998–99

The composition of expenditures through Commonwealth, State and privately administered programs was quite different for Aboriginal and Torres Strait Islander people from that for the rest of the population.

Of all expenditure on Aboriginal and Torres Strait Islander people, 72% was through programs administered by State or Territory Governments. That was almost twice the percentage for non-Indigenous people. Two-thirds of the State expenditure was for public hospital services, mostly for admitted patients.

Spending through Commonwealth programs accounted for 23% of expenditures on Aboriginal and Torres Strait Islander people. Almost half of this was for Indigenous-

specific services, mainly through grants to Aboriginal Community Controlled Health Services (ACCHSs). The remainder represents the estimated Aboriginal and Torres Strait Islander share of outlays for nationwide health services. The differences between Commonwealth and State expenditure patterns are due to the different roles of the two levels of government. The Commonwealth's largest programs are community-wide and fund services to the whole population, usually through private providers. The States and Territories are major service providers to people who are disadvantaged by socioeconomic status or location. All of those people, including many Aboriginal and Torres Strait Islander people, rely heavily on public hospitals and state-run community health services.

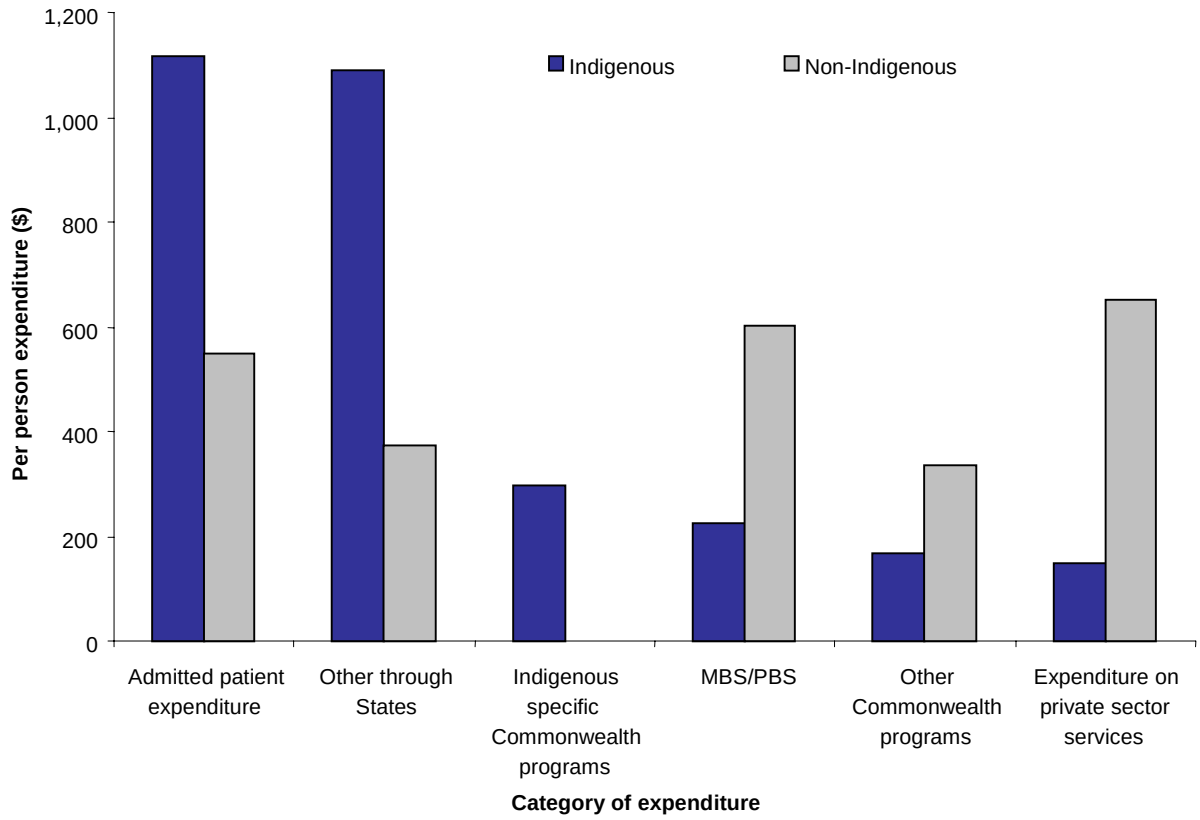
For Aboriginal and Torres Strait Islander people, the proportion of outlays on private sector services such as private hospitals, private dentists and allied health professionals was very low. At 5%, it was one-fifth of the percentage for other Australians and reflects the lower socioeconomic status of Aboriginal and Torres Strait Islander people.

Table 1.2 and Figure 1.2 present the same information, but on a per person basis. Expenditure per person through State programs for Aboriginal and Torres Strait Islander people is $2,205 per person out of total health expenditure of $3,065 per person. This is 140% higher than for non-Indigenous persons—a ratio of 2.4:1. For Commonwealth programs the Aboriginal and Torres Strait Islander/non-Indigenous per person ratio is lower at 0.74:1. These differences reflect the different roles of the two levels of government discussed above.

Table 1.2: Estimated health expenditures per person for Aboriginal and Torres Strait Islander people and non-Indigenous people, by program, 1998–99

	Per person Indigenous ($)	Per person non-Indigenous ($)	Ratio Indigenous/ non-Indigenous
Through State programs			
Admitted patient expenditure	1,115	548	2.04
Other through State program expenditure	1,090	372	2.93
Total through State programs	**2,205**	**920**	**2.40**
Through Commonwealth programs			
Indigenous specific Commonwealth programs	298	1	. .
Medicare/PBS	224	601	0.37
Other Commonwealth programs	169	336	0.50
Total through Commonwealth programs	**691**	**937**	**0.74**
Through local government programs	**20**	**11**	**1.78**
Services through private sector programs	**148**	**650**	**0.23**
Total recurrent expenditure	**3,065**	**2,518**	**1.22**

Source: AIHW Health Expenditure Database



Source: AIHW Health Expenditure Database.

Figure 1.2: Estimated total expenditures through government and private sector programs for Aboriginal and Torres Strait Islander people and non-Indigenous people, per person, 1998–99

Sources of funds

Table 1.3 looks at financing rather than administration. For non-Indigenous Australians, governments met about 68% of recurrent health care costs, with the remainder being privately financed. For Aboriginal and Torres Strait Islander people the proportions were quite different. Governments funded just over 90% of their health care costs and, as might be expected from their economic situation, private payments, whether through various types of insurance or out-of-pocket, met less than 10% of total expenditures. Governments meet a similar proportion of health care costs for non-Indigenous people in low socioeconomic groups (Deeble et al. 1998). Overall, the ratio of Indigenous to non-Indigenous expenditures per person was 1.64:1 for public funding alone, slightly higher than in the 1995–96 figures of 1.52:1. The difference between the Indigenous to non-Indigenous expenditure ratio for government expenditures and the ratio for all health expenditures is explained by the much lower use of private services by Aboriginal and Torres Strait Islander people.

All of the State and Territory outlays were direct; that is, their outlays went through programs and/or authorities which they themselves administered. However, over

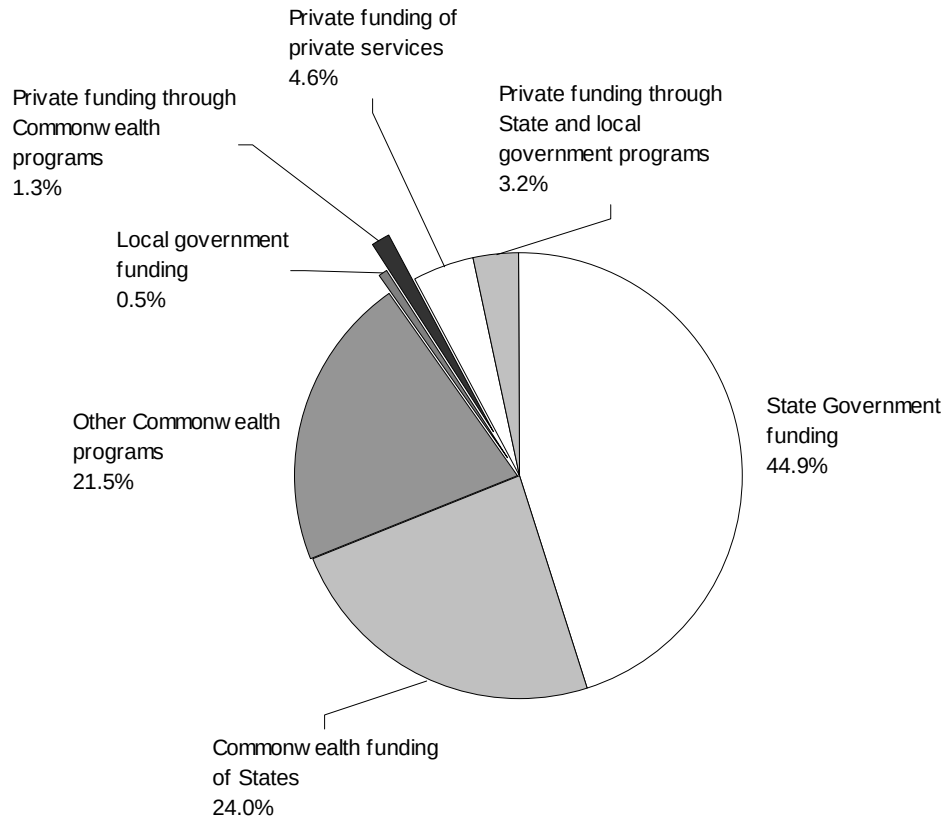
50% of the Commonwealth's overall contribution was indirect, through its sharing of the cost of public hospitals and some other services under the Australian Health Care Agreements, public health funding agreements and other payment arrangements. When these payments by the Commonwealth to the States are included, the two levels of government contributed very similar amounts to funding expenditure on services for Aboriginal and Torres Strait Islander people.

Table 1.3: Estimated expenditures per person, by source of funds, Aboriginal and Torres Strait Islander people and non-Indigenous people, 1998–99 ($)

Source of funds	Indigenous	%	Non-Indigenous	%	Ratio Indigenous/ other
State government funding (of State government programs*)*	1,376	44.9	484	19.2	2.84
Commonwealth Government funding					
Indigenous specific programs	298	9.7	1	—	. .
Medicare/PBS	196	6.4	506	20.1	0.39
Other Commonwealth programs	163	5.3	366	14.5	0.45
Payments to States	735	24.0	334	13.2	2.20
Total Commonwealth funding	***1,393***	***45.5***	***1,206***	***47.9***	***1.15***
Local government funding	**15**	**0.5**	**9**	**0.4**	**1.67**
Total government funding	***2,783***	***90.8***	***1,700***	***67.5***	***1.64***
Patient and other private payments					
State Government programs	94	3.1	101	4.0	0.93
Commonwealth Government programs	40	1.3	141	5.6	0.29
Local government programs	5	0.2	2	0.1	2.21
Private sector programs	141	4.6	574	22.8	0.25
Total private funding[(a)]	***281***	***9.2***	***819***	***32.5***	***0.34***
Total health funding	**3,065**	**100.0**	**2,518**	**100.0**	**1.22**

(a) 'Private funding' includes funding from out-of-pocket payments by patients, health insurance funding and other funding sources such as workers' compensation.

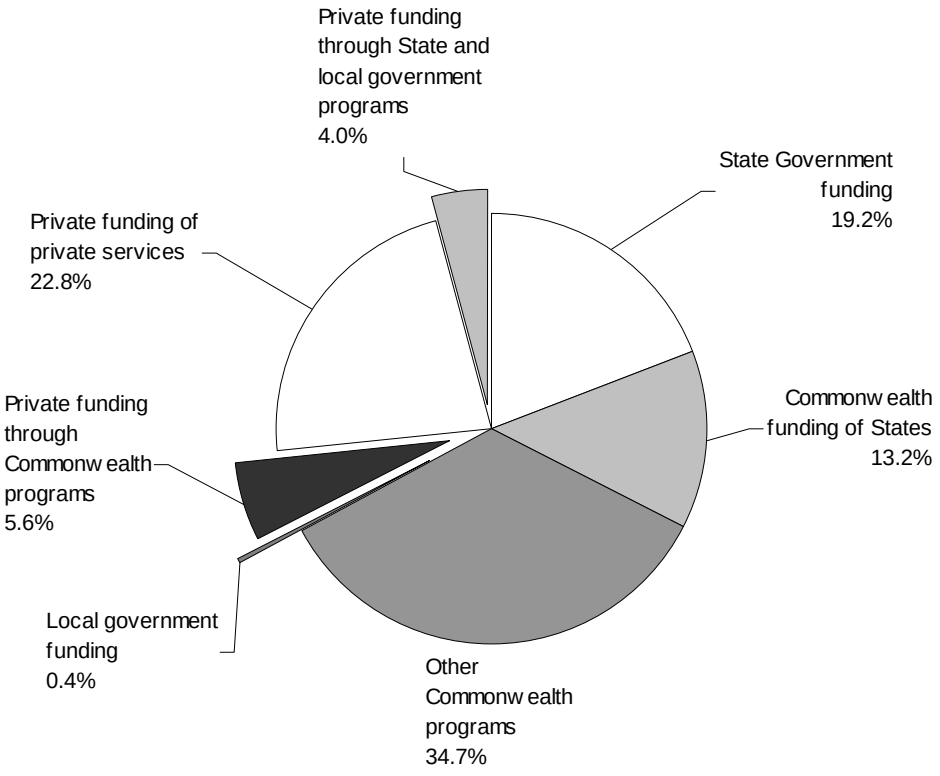
Source: AIHW Health Expenditure Database.



Note: 'Private funding' includes funding from out-of-pocket payments by patients, health insurance funding and other funding sources such as workers' compensation.

Source: AIHW Health Expenditure Database.

Figure 1.3: Funding of recurrent health expenditure for Aboriginal and Torres Strait Islander people, 1998–99



Note: 'Private funding' includes funding from out-of-pocket payments by patients, health insurance funding and other funding sources such as workers' compensation.

Source: AIHW Health Expenditure Database.

Figure 1.4: Funding of recurrent health expenditure for non-Indigenous people, 1998–99

Expenditures, by type of service

Table 1.4 and Figure 1.5 show per person expenditure by type of service, for Aboriginal and Torres Strait Islander people, together with similar data for non-Indigenous people. More detail on expenditures under State and Commonwealth Government programs are provided in Chapters 3 and 5.

Table 1.4: Estimated expenditures, by program, for Aboriginal and Torres Strait Islander people and non-Indigenous people, per person, 1998–99

	Per person Indigenous	Per person non-Indigenous	Ratio Indigenous/ non-Indigenous
Expenditures through government programs			
Acute-care institutions			
Admitted patient services	1,125	558	2.02
Non-admitted patient services	307	139	2.21
Mental health institutions	64	25	2.53
Public hospitals	*1,496*	*722*	*2.07*
High-care residential aged care	99	209	0.47
Community and public health	874	170	5.14
Patient transport	106	31	3.39
Medicare[(a)] and other medical	179	468	0.38
PBS medicines	61	195	0.31
Administration & research	101	72	1.40
Total government program expenditure	**2,917**	**1,868**	**1.56**
Expenditures on private sector services			
Private hospitals	25	222	0.11
Dental & other professional	42	213	0.20
Non-PBS medicines & appliances	66	144	0.46
Medical (compensable, etc.)	11	37	0.30
Administration	5	34	0.14
Total private sector services expenditure	**148**	**650**	**0.23**
Total	**3,065**	**2,518**	**1.22**

(a) Includes Medicare optometrical and dental as well as medical services.

Source: AIHW Health Expenditure Database.

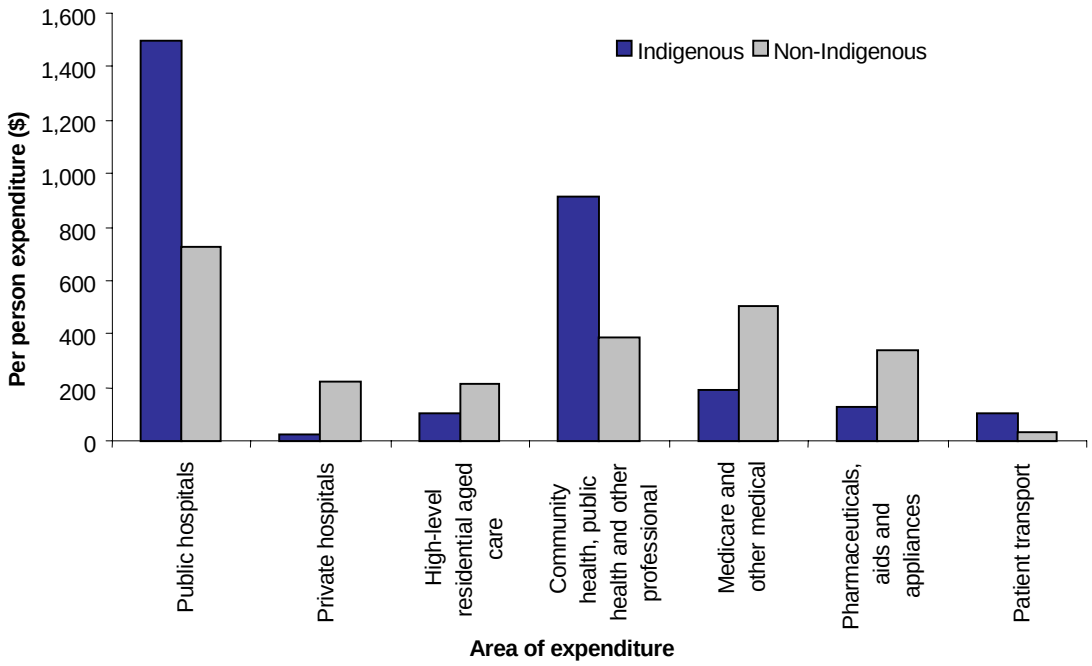
As in the 1995–96 data, the pattern is one where Aboriginal and Torres Strait Islander people were much more dependent on public hospital care than non-Indigenous people, although the difference in expenditures on admitted patient services was smaller when all hospital treatment (public and private) was considered. In 1998–99, over one-third of all admissions were to private hospitals, and very few of these were for Aboriginal and Torres Strait Islander people. For all public and private hospitals,

the Indigenous to non-Indigenous expenditure ratio was 1.61:1, compared with a ratio of 2.07:1 when only public hospital expenditures are considered.

Aboriginal and Torres Strait Islander people were higher users of community health services such as State Government community services, ACCHSs and the Aboriginal Coordinated Care Trials (CCTs). These programs deliver services in an integrated way, rather than having separate provision for medical and dental services and other health professional services, as is frequently the case in the general community. This results in a high Indigenous to non-Indigenous ratio of 5.14:1 for community and public health. This ratio should be interpreted in the context of the low ratio for private medical, dental and other health professional services.

When private dental and other health professional health care is combined with government-provided community and public health care, the ratio decreases from 5.14 to 2.39:1 (Figure 1.5).

Aboriginal and Torres Strait Islander people also used patient transport much more, particularly the Royal Flying Doctor Service (RFDS) in remote areas.



Source: AIHW Health Expenditure Database.

Figure 1.5: Estimated total expenditures for Aboriginal and Torres Strait Islander people and non-Indigenous people, by area of expenditure, per person, 1998–99

Selected expenditures, by jurisdiction

Table 1.5 shows expenditures per person, by jurisdiction and type of service, for the 80% of expenditures on Aboriginal and Torres Strait Islander people which flow through State and Territory programs and the ACCHSs.

Table 1.5: Estimated government expenditures for Aboriginal and Torres Strait Islander people, by jurisdiction, per person, 1998–99 ($)

State/Territory	State Government admitted patient care	State Government other health services	ACCHSs (Commonwealth Government)	Total Commonwealth and local government	Total expenditure through government programs
New South Wales	945	884	151[a]	n.a.	n.a.
Victoria	793	650	392[b]	n.a.	n.a.
Queensland	1,068	946	157	n.a.	n.a.
Western Australia	1,516	1,257	439	n.a.	n.a.
South Australia	1,434	916	700	n.a.	n.a.
Tasmania	836	809	(b)	n.a.	n.a.
Aust. Capital Territory	1,206	1,226	(a)	n.a.	n.a.
Northern Territory	1,219	1,989	432	n.a.	n.a.
Total	**1,115**	**1,090**	**287**	**711**	**2,917**

(a) Australian Capital Territory ACCHS funding is included with New South Wales.

(b) Tasmanian ACCHS funding is included with Victoria.

Regional variation

Expenditures on admitted patient hospital services, Medicare/PBS benefits and Commonwealth expenditure on high-care residential aged care (nursing homes) were able to be analysed by region according to the Accessibility/Remoteness Index of Australia (ARIA). Together they account for about 50% of all expenditures for Aboriginal and Torres Strait Islander people. Other Commonwealth health services and State Government community and public health services were not able to be allocated by region. Had it been possible to include a greater proportion of total expenditures in the analysis (such as State-funded community health services) then the overall pattern of expenditure distribution shown here may have been somewhat different.

ARIA is a system which classifies localities according to an indicator of the accessibility of services (distance from service centres) into the five categories of 'highly accessible', 'accessible', 'moderately accessible', 'remote' and 'very remote'. The distribution of Aboriginal and Torres Strait Islander people across these regions is quite different from that of non-Indigenous people. In particular, the proportion living in remote and very remote regions is more than ten times that for other Australians. Given the accessibility criteria for ARIA classification, there should be

an association between residence and service use. It would be expected to be both lower in total and different in composition in the remote and very remote areas as compared with better served regions. This would clearly lead to spending on Aboriginal and Torres Strait Islander people being lower, given more of this population live in remote areas. However, if their health status differed across the regions or the mix of services they used was more or less expensive than the average, this relationship might not hold.

Table 1.6 summarises the analysis in Chapter 7 on regional differences.

- For Medicare and the PBS, outlays were lower in remote and very remote areas than in the more 'accessible' ones. This was also the case for non-Indigenous people but for this group there are age structure differences which partially explain the differences (Phillips (in press)). Aboriginal and Torres Strait Islander people's access to these selected programs was generally less than half that of other people in each region.
- Expenditure on ACCHSs was highest in the remote regions. In the absence of information about the full range of services in each region it is difficult to draw conclusions about the reason for this distribution. It may reflect higher costs in remote regions, poor access to other services or historical factors.
- Aboriginal and Torres Strait Islander people in the remote regions have rates of separation from hospitals, and associated expenditure, more than twice that of Aboriginal and Torres Strait Islander people in the highly accessible region.
- Expenditure on aged care facilities for Aboriginal and Torres Strait Islander people in the remote regions is higher than in the more accessible regions.

Further analysis is required to understand the reasons for the difference in hospital separations and expenditure. Such analysis would separately identify the impact of the higher cost of delivering hospital services to the very remote regions.

With Medicare data, the uniform payment schedule does not allow examination of the relative costs of delivering medical services in remote areas relative to more accessible areas.

Overall for these selected health services, there is approximately twice the expenditure per person for Aboriginal and Torres Strait Islander people living in the remote and very remote areas compared with those living in the highly accessible areas. Of expenditures on Aboriginal and Torres Strait Islander people in remote areas, 75% is on hospital services compared with 58% in highly accessible areas.

In contrast to remote areas, and to the estimates of total expenditure, expenditures on Aboriginal and Torres Strait Islander people in the highly accessible areas are less than those for non-Indigenous people in the same area. This is significant in view of their poorer health status.

Table 1.6: Health expenditures per person on selected health services, Aboriginal and Torres Strait Islander people and non-Indigenous people, by ARIA region, 1998–99 ($)

Area of expenditure		Highly accessible	Accessible	Moderately accessible	Remote and very remote
Public acute-care institutions and private hospitals[a]	Indigenous	660	953	1,185	1,690
	Non-Indigenous	704	794	879	709
High-care residential aged care (Commonwealth contribution only)	Indigenous	61	55	21	76
	Non-Indigenous	150	123	86	43
Medicare (medical only)[b]	Indigenous	157	156	143	84
	Non-Indigenous	367	289	275	197
PBS[c]	Indigenous	55	58	51	23
	Non-Indigenous	152	117	112	89
OATSIH	Indigenous	212	227	98	386
Total	**Indigenous**	**1,145**	**1,449**	**1,498**	**2,259**
	Non-Indigenous	**1,373**	**1,323**	**1,352**	**1,038**

(a) Excludes Queensland acute-care institutions.

(b) Excludes Medicare benefits for optometry and dental services.

(c) Excludes the Repatriation Pharmaceutical Benefits Scheme (RPBS).

Expenditures on primary and secondary/tertiary services

Primary health services are those provided to whole populations (community and public health services) and those provided in, or flowing from, a patient-initiated contact with a health service. Secondary services are those generated within the system by referral, hospital admission, etc.

For Aboriginal and Torres Strait Islander people, expenditure on primary health services comprised:

- allocated expenditures on community and public health services;
- all expenditures by ACCHSs;
- estimates of all Medicare-paid general practitioner (GP) services to Indigenous people (and the diagnostic services ordered by them);
- estimates of all GP-ordered PBS drugs;
- 50% of the estimated cost of hospital outpatient services; and
- half of the cost of transport for Aboriginal and Torres Strait Islander patients.

The remainder was classified as secondary/tertiary.

For non-Indigenous people, the same basic divisions were applied, although some of the proportions were naturally different. Administration and research were not divided for either group.

As in the first report (but contrary, perhaps, to some expectations) the overall ratio of Indigenous to non-Indigenous expenditures per person was somewhat higher for primary care services than for secondary/tertiary ones—1.27:1 compared with 1.19:1—and much higher for government programs—(1.74:1 and 1.44:1 respectively (Table 1.7). This was despite the relatively high hospital admission rate for Aboriginal and Torres Strait Islander people.

There were (at least) three factors of significance here. The first was the very much higher use of both hospital outpatient and community health services by Aboriginal and Torres Strait Islander people. This is a category where non-Indigenous population use is largely limited to low-income groups.

Second, as might be expected, the use of transport services was high. Aboriginal and Torres Strait Islander patients accounted for nearly half the cost of the RFDS and the need for local transport was also high.

The third factor was the very low Aboriginal and Torres Strait Islander use of private dentistry, drugs and Medicare-paid medical services, particularly those of private specialists with all of their flow-on effects in terms of private hospitalisation and relatively high-cost, high-technology treatment. Low spending in these areas almost offset any pro-primary bias in government-run services for Aboriginal and Torres Strait Islander people.

These data do not give any indication as to the appropriate distribution between primary health care and secondary/tertiary health care services for Aboriginal and Torres Strait Islander people. The balance between primary and secondary/tertiary health care services required by, and culturally appropriate for a young, low-income population may well be different from the balance that is required by, and is appropriate for the general population. There is evidence that much Aboriginal and Torres Strait Islander mortality and morbidity is preventable and 'that further consideration is needed to service delivery reform at all levels (i.e. primary, secondary and tertiary) in the health system and the distributions of funding' (Stamp, Duckett & Fisher 1998).

Comparisons with the first report

The structure embodied in these estimates is very similar to that in the first report. All of the numbers are of course higher because of inflation (health care costs rose by 7% over the three years) and the share of Aboriginal and Torres Strait Islander people would have increased a little because the estimated Aboriginal and Torres Strait Islander population was 7% larger than the estimated population in 1995–96. (The population used in the 1995–96 report was 4% lower than the latest ABS estimates of the Aboriginal and Torres Strait Islander population in 1995–96. The calculations in this section use the latest estimates. See also Appendix 7). However, these factors can be removed by expressing all results on a per person basis at 1997–98 prices (see Chapter 6). On that basis, the 1998–99 expenditures for Aboriginal and Torres Strait Islander people were 29% higher than in the earlier survey and those for the non-Indigenous population were 10% higher.

Table 1.7: Direct expenditures[(a)] on primary and secondary/tertiary health services through Commonwealth, State and local government programs and the private sector, 1998–99

	Primary				Secondary/Tertiary			
	Total ($m)		Per person ($)		Total ($m)		Per person ($)	
Source	**Indigenous**	**Other**	**Indigenous**	**Other**	**Indigenous**	**Other**	**Indigenous**	**Other**
Expenditures through government programs								
Acute-care institutions								
Admitted patient services	. .	. .	. .	. .	457	10,278	1,125	558
Non-admitted patient services	62	1,281	154	70	62	1,281	154	70
Mental health institutions	. .	. .	. .	. .	26	465	64	25
High-care residential aged care	. .	. .	. .	. .	40	3,853	99	209
Community and public health	355	3,137	874	170	. .	. .	. .	. .
Patient transport	22	115	53	6	22	461	53	25
Medicare and other medical	59	5,773	146	313	13	2,859	32	155
PBS drugs & appliances	22	3,242	55	176	2	360	6	20
Total government programs	**521**	**13,549**	**1,282**	**735**	**623**	**19,557**	**1,533**	**1,061**
Ratio: Indigenous/other per person			***1.74***				***1.44***	
Expenditure on private sector services								
Private hospitals	. .	. .	. .	. .	10	4,092	25	222
Dental & other professional	17	3,928	42	213	. .	. .	. .	. .
Medical (compensable etc.), non-PBS medicines & appliances	26	2,731	66	149	5	609	13	33
Total private sector	**43**	**6,659**	**107**	**361**	**15**	**4,701**	**37**	**255**
Ratio: Indigenous/other per person			0.30				0.14	
Total govt & private	**564**	**20,208**	**1,389**	**1,096**	**638**	**24,258**	**1,570**	**1,316**
Ratio: Indigenous/other per person			***1.27***				***1.19***	

(a) Administration and research not included.

Source: AIHW Health Expenditure Database.

It is tempting to interpret this as a real change in both relative spending and service use. However, the results should not be read that way. The two reports, though conceptually similar, were in many ways quite separate attempts to estimate the same thing. First, very few data sources reflected a consistent collection. The only information which is, in principle, recorded consistently is that in the hospital morbidity collection for admitted patients. It was the base for much of the State and Territory estimates, but it is subject to problems of under-identification which make it difficult to separate real changes from statistical artefacts with any certainty (see Chapter 4). In other services, the databases were different. The most recent estimates of Medicare and PBS outlays, for example, used a national survey of GP practice in lieu of the more limited, though more directed, surveys used in the 1995–96 report. Had that been available for the first report some figures would have been different.

Second, some of the methods of estimation and costing changed. Public hospital outlays were one such case. The first study adjusted Aboriginal and Torres Strait Islander costs only for differences in length of stay, whereas the calculations for 1998–99 added factors relating to higher cost intensity for Indigenous separations, and differentials in costs of hospitals within States. Finally, the range of services for which there was some basis for estimating Aboriginal and Torres Strait Islander use widened. All of these changes make comparisons hazardous.

Table 1.8 separates, by program, changes in those expenditures where the indicators gave documented support for some 'real' differences (column 2) from those where different methodologies and different data sources make it impossible to separate real increases from changes in the estimation process (column 3). The two were of broadly similar importance. However, there were elements of 'real' increase in the second category, so that the true difference between 1995–96 and 1998–99, while clearly less then 29%, was somewhat more than 15%. That was significantly more than the 10% per person increase in non-Indigenous spending.

Overall the aggregate effect was small. The proportion of all Australian health expenditures going to Aboriginal and Torres Strait Islander people would have increased from 2.2% of recurrent expenditure in 1995–96 to 2.6% of recurrent expenditure in 1998–99.

Table 1.8: Changes in health services expenditure per Aboriginal and Torres Strait Islander person from 1995–96 to 1998–99, 1997–98 prices (per cent)

Type of program	Documented (real) change %	Additional changes: changes in methods, new data sources and real change %	Total %	Percentage of total expenditure
State & Territory programs	12	9	22	72.0
Commonwealth programs	20	19	42	22.6
Other sectors	30	38	79	5.5
All programs	**15**	**12**	**29**	**100.0**

Note: Numbers in this table must be combined geometrically not added arithmetically—e.g. 15 + 12 does not equal 29, but 1.15 * 1.12 =1.29