3 Commonwealth expenditure on Aboriginal and Torres Strait Islander health services

This chapter presents data in respect of Commonwealth expenditures for Aboriginal and Torres Strait Islander people and for non-Indigenous people.

Commonwealth funding of health care for Aboriginal and Torres Strait Islander people may be through Commonwealth-managed mainstream programs, such as Medicare, the Pharmaceutical Benefits Scheme (PBS) and public health programs, or through Indigenous-specific programs, such as Aboriginal Community Controlled Health Services (ACCHSs). The Commonwealth also funds private sector programs through initiatives such as private health insurance subsidies and provides funding to States and Territories by way of grants for State-managed programs such as hospitals and State community and public health programs.

The main focus of this chapter is Commonwealth funding of Commonwealth programs such as Medicare and the PBS, and various community and public health programs, including Indigenous-specific programs. Although Medicare and pharmaceutical services are delivered by private providers, they are considered to be Commonwealth programs because most of the expenditure is funded by the Commonwealth and it determines exactly what services are subsidised. Commonwealth funding of the private sector by way of private health insurance subsidies is also examined here. The Commonwealth funding of State and Territory programs, or grants to States, is described in Table 3.6 of this chapter. (Full details of State and Territory programs are given in Chapter 5.)

Patients also fund some components of health service costs for services delivered through Commonwealth programs—for example, patient payments for Medicare or PBS services. Total expenditures of $281 million through Commonwealth programs include patient funding.

Total Commonwealth funding of recurrent health services expenditure for Aboriginal and Torres Strait Islander people (excluding transfers to States) was estimated to be $267 million (Table 3.1). Of this, around a fifth was for Medicare services, 8% was for PBS benefits, and around 45% ($121.2 million) was for Indigenous-specific health services. The remaining 25% ($66.3 million) was for other health services including general administration.

Per person expenditure by the Commonwealth for Aboriginal and Torres Strait Islander people (excluding payments to States) was $658 compared with $786 for non-Indigenous persons. Of the $658 spent per Aboriginal and Torres Strait Islander person, the Commonwealth contributed $146 to Medicare, $50 to the PBS and $298 to Indigenous-specific programs. Combined, Commonwealth funding of these Commonwealth programs represented $495 per person, which is approximately 75% of total Commonwealth per person expenditure for Aboriginal and Torres Strait

Islander people (Figure 3.1). The remaining $163 was spent on high-care residential aged care ($54) the RFDS ($19) and other health services. Of the total $786 spent per non-Indigenous person, almost two-thirds (64%—$506) of health funding is through benefits paid for Medicare services and the PBS.

In regard to Medicare funding, the per person expenditure for Aboriginal and Torres Strait Islander people was estimated at $146 compared with $356 for non-Indigenous people, a ratio of 0.41:1. For PBS expenditure the Indigenous to non-Indigenous ratio was 0.33:1.

Patient and other privately sourced payments through Commonwealth programs, for example medical, pharmaceutical and aged care co-payments, is estimated at $40 per person for Aboriginal and Torres Strait Islander people and $141 per person for non-Indigenous people, a ratio of 0.29:1.

Table 3.1: Commonwealth recurrent health services expenditure for and by Aboriginal and Torres Strait Islander people (excluding payments to States and Territories), 1998–99

	Total expenditure for and by Indigenous persons ($m)	Per Indigenous person ($)	Per non-Indigenous person ($)	Indigenous/ non-Indigenous per person ratio
Medicare[(a)]	59.4	146.11	355.53	0.41
Pharmaceutical Benefits Scheme	20.4	50.25	150.59	0.33
Indigenous-specific health services	121.2	298.22	0.57	. .
Other health services including general administration[(b)]	66.3	163.24	279.29	0.58
Commonwealth funding of health expenditure (excl. payments to States)[(b)]	*267.3*	*657.82*	*785.97*	*0.84*
Commonwealth funding of private sector programs[(b)]	2.7	6.73	76.61	0.09
Commonwealth funding of Commonwealth programs[(c)]	*264.5*	*651.08*	*796.11*	*0.82*
Patient and other private funding[(d)] of Commonwealth programs	16.4	40.34	141.34	0.29
Total expenditure through Commonwealth programs[(e)]	**280.9**	**691.42**	**937.44**	**0.74**

(a) Includes Medicare payments for optometrical and dental services.

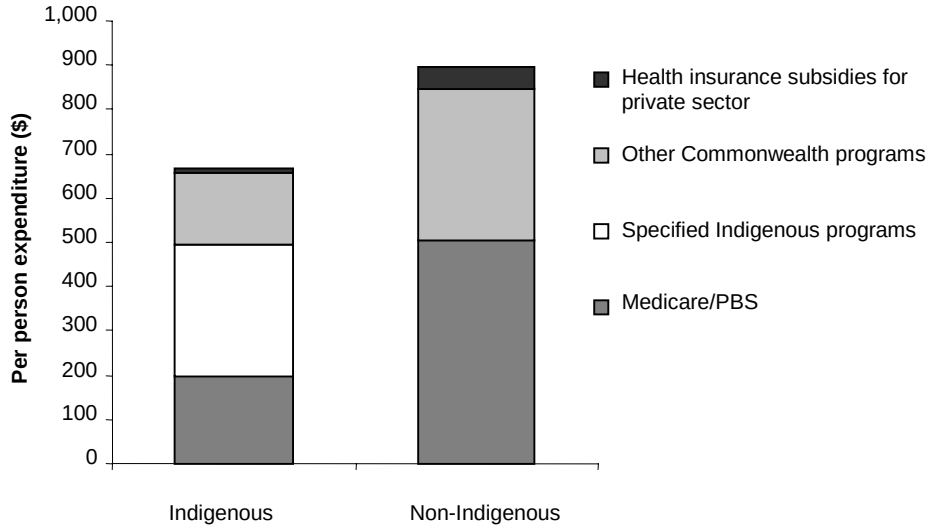
(b) Most of this expenditure is private health insurance subsidies. For the non-Indigenous population it also includes $27.32 per person of Department of Veterans' Affairs' expenditure.

(c) Commonwealth funding of health expenditure for Aboriginal and Torres Strait Islander people ($267.3m) includes some funding of private sector programs through private health insurance subsidies ($2.7m). This funding is deducted in order to arrive at Commonwealth funding of **Commonwealth** programs ($264.5m).

(d) 'Private funding' includes funding from out-of-pocket payments by patients and other funding sources such as donations.

(e) Expenditure through Commonwealth programs includes the Commonwealth subsidy of Commonwealth programs as well as the patient contribution to these programs—for example, Medicare co-payments.

Source: AIHW Health Expenditure Database.



Note: Excludes Commonwealth grants to States and Territories.

Source: AIHW Health Expenditure Database.

Figure 3.1: Composition of Commonwealth funding of health services expenditure, per person, Aboriginal and Torres Strait Islander people and non-Indigenous people, 1998–99

Data sources

Apart from the Medicare and PBS estimates, which were based on the Bettering the Evaluation and Care of Health (BEACH) survey (AIHW: Britt et al. 1999 & AIHW: Britt et al. 2000), the data on expenditures for Aboriginal and Torres Strait Islander people and for the population as a whole were obtained from two sources, namely information from survey returns provided by the various divisions of the Department of Health and Aged Care (DHAC), and its 1998–99 annual report.

It should be noted that:

(a) Commonwealth data is reported on a cash basis, not accrual; and

(b) Details of the derivation of expenditures for Medicare and the PBS are included in Appendix 3.

Commonwealth programs with an Aboriginal and Torres Strait Islander element, whether mainstream or specific to Aboriginal and Torres Strait Islander people, were coded by area of expenditure. The areas of expenditure of relevance are: acute-care institutions, aged care, medical services, community health services (including community mental health), public health, research and administration.

The bulk of Commonwealth expenditure for Aboriginal and Torres Strait Islander persons is directed to programs specifically for them, administered by the Department's Office for Aboriginal and Torres Strait Islander Health (OATSIH).

Commonwealth programs

Aboriginal community-controlled health services

The bulk of OATSIH funding is directed towards ACCHSs (previously known as Aboriginal Medical Services), which are health services that are planned and governed by local Aboriginal communities. The services deliver holistic and culturally appropriate health and health-related services (DHAC 2000a) to Aboriginal and Torres Strait Islander people, with funding provided by State/Territory and Commonwealth Governments.

ACCHSs across the country offer a wide range of services, including general and specialist health services, eye health services, hearing services, substance use services, mental health services, remote health services, sexual health services, services fostering emotional and social well-being and transport. Furthermore they often fulfil a social role—for example, by acting as a community centre (Keys Young 1997). Many of these functions are important social determinants of health, but some of these functions are considered to be primarily serving 'welfare', 'community development' or other objectives. For the purposes of this report on health services, these 'non-health service functions' are excluded. Appendix 1 considers this issue in more detail.

The 1995–96 report estimated that health services accounted for about 75–80% of total outputs of ACCHSs, with the remainder being services mostly of a welfare nature.

It was estimated that $77 million (77%) of the $100 million Commonwealth funding for ACCHSs in 1998–99 were spent on health services for Aboriginal and Torres Strait Islander people. Non-Indigenous use of ACCHSs has been estimated to be 9.7% of total episodes of care. In the absence of other information, this proportion is assumed to apply to contacts as well, and so 9.7% of all contacts has been deducted from contacts provided by all health workers to arrive at an estimate of Indigenous use and expenditure.

In line with our discussion of the meaning of 'health' in Appendix 1, the non-health component has been estimated by assuming that contacts delivered by counsellors or social workers and 'other staff' are of a non-health services nature. In addition, it is considered that one-quarter of the contacts delivered by Aboriginal Health Workers are of a non-health services nature. Contacts by doctors, nurses, dentists and other medical practitioners are assumed to be of a health nature. Of course, this neat division does not occur in practice. Some contacts by doctors and nurses are of a welfare nature and some contacts by counsellors or social workers are of a health nature. However, until better data is collected regarding the nature of the service, the only alternative is to use the profession of the worker as a proxy for the nature of the service.

Other specific Aboriginal and Torres Strait Islander health programs

In addition to the grants to ACCHSs and other health services, there are a number of other OATSIH programs, such as the program to combat infectious diseases of Aboriginal and Torres Strait Islander people and the substance misuse services program. There are also a number of smaller programs specific to Aboriginal and Torres Strait Islander people that are administered by Divisions of the Commonwealth Department of Health and Aged Care other than OATSIH.

A sum of $121.2 million was spent through programs targeted to Aboriginal and Torres Strait Islander persons, including Indigenous flexible service models for high-care residential aged care ($3.721 million), the Indigenous portion of the OATSIH health services program ($77.4 million), combating infectious diseases of Indigenous people ($4.83 million), substance misuse programs ($17.22 million), coordinated care trials (CCTs) for Aboriginal communities ($8.81 million), public health ($0.995 million) and OATSIH administration for Indigenous health services ($8.207 million) (Tables 3.8 and A3.19).

Mainstream health programs

A significant proportion of Commonwealth expenditure on health services for Aboriginal and Torres Strait Islander people goes through mainstream programs. In this report the method of estimating the proportion of mainstream funding that flows to Aboriginal and Torres Strait Islander people varies. In some cases it is based on a measure of utilisation. In other cases, the proportion of the population who are Aboriginal and/or Torres Strait Islander is used.

Expenditure through Medicare and the PBS is estimated mostly using BEACH data (see below). The methodologies used to apportion other mainstream expenditure to Aboriginal and Torres Strait Islander people and the expenditures in each area are described in the section titled ‘Other mainstream health programs’.

Benefits under Medicare and the Pharmaceutical Benefits Scheme

None of the Medicare or PBS data record Aboriginality. For the 1995–96 report, therefore, there were two specific-purpose surveys of general practitioners (GPs) and pharmacies in those Divisions of General Practice where the proportion of Aboriginal and Torres Strait Islander people in the population served was above the national average in the 1991 Census (1.7%). One in three full-time GPs were surveyed and one in two pharmacies. The results were expanded to provide national estimates of services or medications provided and benefits paid.

For this report alternatives were available, namely the results of the first two years of survey data from the BEACH study of general practice activity. BEACH is a joint undertaking of the Australian Institute of Health and Welfare and the University of Sydney's Family Medicine Research Centre. The study has been undertaken annually since April 1998. The survey comprises about 100,000 doctor–patient encounters provided by random samples of approximately 1,000 GPs throughout the country

each year. The results for 1998–99 were published in 1999 and those for 1999–2000 were published in 2000.

Aboriginal and Torres Strait Islander status was amongst the patient details collected for each encounter—identified, in principle, by the GPs asking a specific question rather than by their impressions or beliefs. In general the data from BEACH were more detailed than that collected in the 1995–96 study. However, there were also disadvantages; for instance, the BEACH collections were primarily designed to examine GP activities, not Aboriginal and Torres Strait Islander health care or the operations of Medicare and the PBS.

Results

Table 3.2 summarises the results for both services and medications provided and Medicare and PBS outlays. In all cases the methodology was to expand the BEACH data according to the proportion of all Medicare-paid GP services covered by BEACH. Resulting estimates of average benefits and total outlays were then standardised, for all GP-generated outlays, to the national figures for those services published by the Commonwealth Department of Health and Aged Care in May 2000 (DHAC 2000b).

There was also some independent information about services provided to patients of those ACCHSs and State Aboriginal and Torres Strait Islander services which participate in Medicare. The only services for which no benchmarks were available were those provided and generated by private specialists post-referral. These contribute comparatively little to Aboriginal and Torres Strait Islander outlays and, in any case, the standardisation process applies only to the valuation of services, not to their use. The utilisation data come from BEACH, which is the most reliable source.

Table 3.3 shows benefit outlays per person for Aboriginal and Torres Strait Islander and non-Indigenous people and the Indigenous or non-Indigenous ratio for each broad type of service. Table 3.4 compares the outlays per person and expenditure ratios in 1998–99 with those in the 1995–96 report.

Table 3.2: Estimated services provided and Medicare and PBS benefits paid for Aboriginal and Torres Strait Islander people, 1998–99

	Services/items (m)	Average benefit ($)	Total ($m)	% all benefits
Medicare[(a)]				
Primary				
GP	1.236	23.2	28.7	1.22
Pathology	0.380	24.7	9.4	1.37
Imaging	0.090	79.4	7.1	1.16
Specialist				
Consultations	0.090	49.8	4.5	0.48
Procedures	0.065	78.0	5.1	0.46
Pathology	0.043	34.2	1.5	0.46
Imaging	0.017	123.5	2.1	0.46
Total Medicare[(a)]	*. .*	*. .*	*58.3*	*0.87*
Pharmaceutical benefits				
GP	0.850	21.4	18.2	0.78
Specialist	n.a.	n.a.	2.1	0.46
Doctor's bag	0.007	23.3	0.2	1.22
Total PBS	*. .*	*. .*	*20.4*	*0.73*
Total benefits	**. .**	**. .**	**78.7**	**0.81**

(a) Medicare estimates do not include benefits paid for optometry and dental services.

Sources: AIHW – GPSCU BEACH data, 1998 and 1999; DHAC, *Medicare Statistics,* various; Deeble et al. 1998; Health Insurance Commission, *Annual Report 1998–99.*

Table 3.3: Estimated Medicare and pharmaceutical benefits paid per person, by type of service, for Aboriginal and Torres Strait Islander and non-Indigenous people, 1998–99

	Indigenous ($)	Non-Indigenous ($)	Ratio: Indigenous/ non-Indigenous
Medicare[(a)]			
GP	70.5	126.1	0.56
Pathology	26.7	54.1	0.49
Imaging	22.6	57.3	0.39
Specialist	23.5	113.3	0.21
Total Medicare	*143.4*	*350.8*	*0.41*
Pharmaceutical benefits			
GP	44.8	125.4	0.36
Specialist	5.1	24.5	0.21
Doctor's bag	0.4	0.7	0.56
Total PBS	*50.3*	*150.6*	*0.33*
All benefits	**193.6**	**501.4**	**0.39**

(a) Medicare estimates do not include benefits paid for optometry and dental services.

Sources: AIHW – GPSCU BEACH data 1998 and 1999; DHAC, *Medicare Statistics*, various; Deeble et al. 1998; Health Insurance Commission, *Annual Report 1998–99.*

Table 3.4: Estimated Aboriginal and Torres Strait Islander and non-Indigenous Medicare and PBS benefits per person, 1995–96 and 1998–99

	1995–96			1998–99		
	Indigenous ($)	Non-Indigenous ($)	Ratio	Indigenous ($)	Non-Indigenous ($)	Ratio
Medicare[(a)]						
GP	44	130	0.34	71	126	0.56
Pathology	15	48	0.31	27	54	0.49
Imaging	16	49	0.33	23	57	0.39
Specialist	13	104	0.13	24	113	0.21
Total	88	331	0.27	143	351	0.41
PBS	27	123	0.22	50	151	0.33
All benefits	**115**	**454**	**0.25**	**194**	**501**	**0.39**

(a) Medicare estimates do not include benefits paid for optometry and dental services.

Sources: AIHW – GPSCU BEACH data 1998 and 1999; DHAC, *Medicare Statistics*, various; Deeble et al. 1998; Health Insurance Commission, *Annual Report 1998–99*.

As can be seen, all of the estimated Indigenous to non-Indigenous expenditure ratios were higher in 1998–99 than in 1995–96. Some of this reflected improvements in identifying and quantifying use specific to Aboriginal and Torres Strait Islander people. Specialist-prescribed drugs were not included in the 1995–96 estimates, and the data for pathology and imaging services were better in the more recent surveys. However, the effects of this were relatively small. There were also very few changes in the way in which services were delivered. Per GP consultation, the rate of prescribing actually fell a little and, taken together, the rates of GP referral to specialists and hospitals were almost the same.

Almost all of the difference thus appears to have come from the higher rate of reported GP use by Aboriginal and Torres Strait Islander people recorded in the BEACH surveys—three contacts per person per year in 1998–99, compared with 1.95 per year in the 1995–96 estimates. Because all of the specialist services and prescribed drugs were generated by these GP contacts, they are the key statistic. Some of the increase may have been due to a better recording of non-surgery contacts in the later survey, particularly those in institutions. However, the numbers in this category were small.

Interpretation

If these data had come from either full population surveys or comprehensive Medicare/PBS records, their interpretation would be clear: the Aboriginal and Torres Strait Islander use of Medicare-paid services and drugs would have increased significantly over the three years. The only issue would then be the extent to which the difference represented a 'real' increase in service use or simply changes in entitlement rules and practices which transferred some of the costs from block grants to the mainstream benefit schemes.

That is not a simple question. There were certainly changes in law and practice over these years. The practice of ACCHSs (or their doctors) claiming Medicare benefits for their clients was facilitated from 1997 onwards. By 1998–99, 83% of the ACCHSs

which employed doctors claimed Medicare benefits of $7.6 million for 194,000 GP services and 78,000 other services provided or ordered by their doctors. Also, from 1997 State-salaried doctors in 51 locations in Queensland and Western Australia became entitled to bill Medicare, covering 84,400 GP consultations and 18,000 other services, for benefit payments of nearly $2.7 million in 1998–99. All told, ACCHSs and State Aboriginal and Torres Strait Islander services claimed for 278,000 GP services and 96,000 other medical services in 1998–99. Benefits of $10.3 million were paid.

The difficulty was in determining how many of these Medicare-paid services were 'new' or simply the result of shifts in funding. The State-provided services were clearly new, because the relevant Commonwealth/State agreements required new doctor appointments with no reduction in existing service volumes. However, the ACCHSs' position was unclear. Their total medical service volumes in 1995–96 were unknown. Some Medicare billing certainly occurred in 1995–96 and there are estimates from Commonwealth sources of benefit payments of between $2 million and $3 million in that year, covering between 80,000 and 100,000 GP visits. The maximum figure of new ACCHS service provision would then be between 94,000 and 114,000. However, that had to be reconciled with other Commonwealth data which indicated that the number of full-time-equivalent doctors employed by Aboriginal-controlled health organisations rose by 28% over the three-year period. Applying all of this information we estimate that:

(a) In total, ACCHSs provided about 234,000 GP services in 1998–99 (194,000/0.83). Of these, 194,000 were billed to Medicare and an estimated 40,000 were funded by Commonwealth block grants to ACCHSs; and

(b) In 1995–96, the corresponding figures were about 183,000 GP services in total, of which between 85,000 and 100,000 were billed to Medicare. Because the higher figure is the more probable, a figure of 95,000 has been assumed. Therefore, by subtraction, 88,000 were funded from block grants.

The estimated composition of the ACCHSs' 234,000 GP services in 1998–99 is shown in Table 3.5.

Table 3.5: Estimated composition of GP services provided by Aboriginal Community-Controlled Health Services, 1998–99

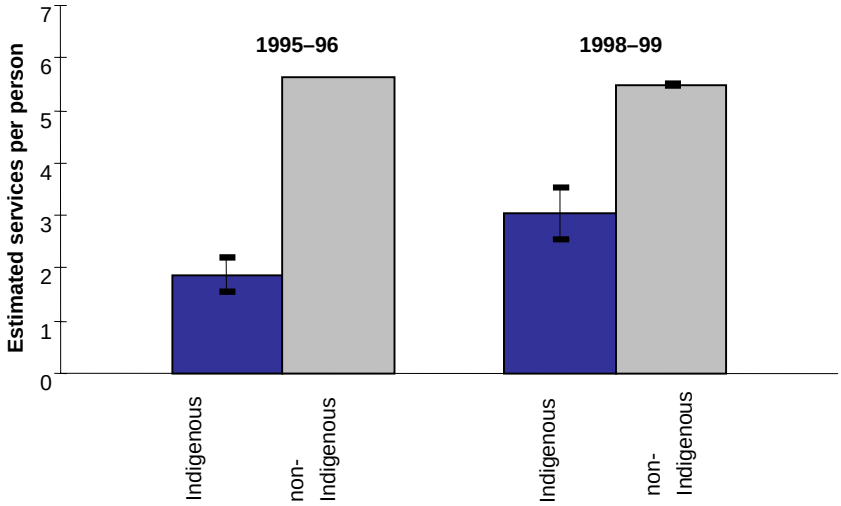
	'000
Currently funded through grants	40
Currently Medicare-funded	194
Total	**234**
Of the 194,000 Medicare-funded GP services	
–Medicare-funded in 1995–96	95
–Formerly funded from grants	48
–New services (calculated by subtraction)	51

Half of the increase in Medicare billing by ACCHSs of 99,000 GP services could thus be attributed to 'new' services (51,000). Adding the 84,400 additional GP visits provided by State organisations then raised the total to about 135,000 new services

since 1995–96, or about 75% of all the additional Medicare billing by organisations for Aboriginal and Torres Strait Islander people.

However, services specific to Aboriginal and Torres Strait Islander people are a relatively small component of those ultimately paid by Medicare. In 1998–99, they represented 278,000 (22%) of the 1.236 million Medicare-paid GP services estimated to have been used by Aboriginal and Torres Strait Islander people nationally. Nearly one million were attributed to privately practising GPs—about 336,000 visits more than in the 1995–96 report—and the interpretation of that apparent increase is more difficult. In both years, all of the information came from surveys in which the numbers of Aboriginal and Torres Strait Islander patients were quite small. They were therefore open to potential sampling error.

Figure 3.2 shows the 95% confidence limits to the estimated GP use per Aboriginal and Torres Strait Islander person in the BEACH surveys, together with an approximation to the same error estimation for 1995–96. As can be seen the ranges almost overlap. The lower level of the 1998–99 estimate is only 0.2 services per person more than the highest likely figure for 1995–96. However, these figures almost certainly understate the possible range of error. The methodology of the first survey limited it to doctors and pharmacists in areas with an Aboriginal and Torres Strait Islander population share at or above the national average, which gave a much smaller sampling of metropolitan regions than country areas. Totals could be estimated by differential expansion factors but the potential error could not be. In the 1998–99 case, standardisation to overall Medicare data was based on GP attendances only, which is an appropriate procedure for estimating totals but not for calculating likely sampling error where the variation in every generated good or service becomes a separate factor. Under these circumstances both of the estimates of sample variation must be conservative.



Source: AIHW–GPSCU BEACH data; Deeble et al. 1998.

Figure 3.2: Estimated GP use by Aboriginal and Torres Strait Islander and non-Indigenous Australians with confidence intervals, 1995–96 and 1998–99

But sampling error was not the major issue. There were systematic, non-sampling improvements in reporting and content in the later surveys. More importantly, the BEACH studies addressed the Aboriginal and Torres Strait Islander identification problem directly, by asking patients to identify themselves, whereas the 1995–96 estimates incorporated an assumed under-identification factor of 20%, the same as the national average assumed for public hospital admissions in that year. There was indirect support for that figure but no external evidence by which it could be checked. This combination of systematic differences in content and a potentially large but unknown error in estimating under-identification initially means that the differences between the two surveys (which were undertaken within two years of each other) cannot be disaggregated by cause or, indeed, statistically confirmed as 'real'. All that can be said is that the BEACH data—which appear to be reliable for the whole population—provide the best current evidence of Medicare and PBS use by Aboriginal and Torres Strait Islander people. However, they are still subject to survey error.

It is probable that the administrative efforts of the Health Insurance Commission (HIC) and an increasing awareness of Indigenous health issues led to both higher Aboriginal and Torres Strait Islander enrolments and a higher service use under Medicare generally, but the extent of the increase is not known.

Summary

Given all of the possible errors in the survey used for the 1995–96 report and in those conducted under BEACH, it is hard to test the above results. Nor is it easy to identify what, if any, additional services (not necessarily medical) might have been provided as a result of administrative and other changes affecting Medicare/PBS use. However, it would appear that:

(a) There have been some real increases in the volume of Medicare-funded services provided by ACCHSs and State health authorities. Our best estimate is that these amounted to about 135,000 GP services and 55,500 other services for which benefits of about $5.3 million were paid in 1998–99.

(b) In 1998–99, a further $3.0 million in Medicare benefits were paid for medical services provided by ACCHSs which had previously been paid from the Services' grant funds. This was effectively new money available for health services provided by these organisations.

For privately provided Medicare and PBS services, estimated benefit payments for Aboriginal and Torres Strait Islander people were about $29 million higher in 1998–99 than in 1995–96. While the balance of probabilities is that this represents some real increase in use, the available evidence does not allow this to be separated from statistical error and other variations in the surveys on which the estimates were based.

Other mainstream health programs

Private health insurance subsidy schemes

In 1998–99 $1,057 million was allocated to the Private Health Insurance Incentives Scheme, which operated to 31 December 1998, and to the Private Health Insurance 30% rebate, which has operated since then. Of this $1,057 million, $783 million was allocated as a direct subsidy through the health insurance funds, and $274 million was a subsidy through the tax system. Based on results from the 1995 Australian Bureau of Statistics National Health Survey, which found that 0.3% of Australians with private health insurance were Aboriginal and/or Torres Strait Islander, it is estimated that $3 million of the $1,057 million was of benefit to Aboriginal and Torres Strait Islander people. Those subsidies are allocated across all areas of expenditure according to the proportions in Table 5.12 of *Australia's Health 2000* (p.253) and are included in Table 3.8 under 'other' for each relevant program and in Table A3.19.

Blood fractionation products

The federal funding of blood products was allocated to Aboriginal and Torres Strait Islander people according to their proportion of public and private hospital admitted patient expenditure.

Residential aged care (health component)

In general, the health component includes only those aged care services where residents require a high level of care. Other services, where lower levels of care are required (formerly hostel-type care), and the Home and Community Care Program are regarded as welfare services.

Commonwealth funding for high-care residential aged care in 1998–99 totalled $2.4 billion, of which $25.7 million or 1.1% was for Aboriginal and Torres Strait Islander people. In addition there was $3.7 million of subsidy for high-care in Indigenous

flexible care services. Details of these expenditures are in Appendix 4. Only the Commonwealth funding for non-State Government high-care residential aged care is included in the tables in this chapter, as the funding for State Government high-care residential aged care is included in Chapter 5.

Medical services

Of the $64.5 million expenditure for medical services for Aboriginal and Torres Strait Islander people, $58.3 million was incurred under the Medicare Benefits Schedule (MBS) (see section on Medicare and the PBS above for details). Some medical services expenditure occurs through other programs, such as alternative GP funding arrangements and the mainstream CCTs. These expenditures are allocated according to the proportion of GP Medicare benefits that Aboriginal and Torres Strait Islander people receive. (Note that the health services provided through the Indigenous CCTs and ACCHS funding are classified as community health). Expenditure through programs to support medical services in areas with a shortage of doctors is allocated according to the proportion of MBS benefits that are used by Aboriginal and Torres Strait Islander people in remote and moderately accessible areas.

Health program grants for pathology

These figures are based on utilisation data. Total health program grants for Western Australia's private pathology providers in 1998–99 amounted to $16,502,395, of which $1,954,868 related to services provided to Northern Territory residents. Of these services for Northern Territory residents, it was estimated that 99%, or $1,935,319, was for Aboriginal and Torres Strait Islander people.

Health program grants for medical practitioner services

Total health program grants for a Northern Territory Government organisation providing medical practitioner services amounted to $1,133,860 in 1998–99, of which 90% or $1,020,474 was the estimated Aboriginal and Torres Strait Islander component.

Other health professionals

The proportion of expenditure on optometry services for Aboriginal and Torres Strait Islander people is assumed to be the same as that for pharmaceutical benefits. Use of these services is thought to be low for Aboriginal and Torres Strait Islander people, given the costs associated with optometrical devices.

Community health

Per person Commonwealth expenditure on community health programs for Aboriginal and Torres Strait Islander people was significantly greater than expenditure for non-Indigenous community health programs. This difference is largely attributable to the inclusion of Aboriginal and Torres Strait Islander Health Service Programs and the Aboriginal Coordinated Care Trials in this section. Both these programs include medical services. Domiciliary nursing care benefit was

allocated to Aboriginal and Torres Strait Islander people in proportion to their use of mainstream high-care residential aged care.

Public health

Expenditure on Aboriginal and Torres Strait Islander people through public health programs was higher than expenditure per person on non-Indigenous people. Commonwealth contributions to a number of Aboriginal and Torres Strait Islander-specific programs explain this difference. Mainstream public health programs such as the National Mental Health Program and the Australian Radiation Protection and Nuclear Safety Authority cannot identify recipients of expenditure in the same way as other programs. Expenditure through these programs has been distributed according to the Aboriginal and Torres Strait Islander population proportion.

Patient transport

The Commonwealth contribution to patient transport is mostly through support of the Royal Flying Doctor Service (RFDS). It is estimated that 46.5% of use of the RFDS is by Aboriginal and Torres Strait Islander people.

Health research

National Health and Medical Research Council grants for Aboriginal and Torres Strait Islander health research were $2.7 million.

Department of Veterans' Affairs

Expenditures by the Department of Veterans' Affairs (DVA) on health services for returned servicemen and women have not been allocated to Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander veterans are thought to comprise a very small proportion of Australia's surviving veterans; however, there is no information from which to reliably estimate expenditures on Aboriginal and Torres Strait Islander people. There was also no allocation of DVA expenditures to the Aboriginal and Torres Strait Islander population in the 1995–96 report.

Administration

Administration costs for the Office of Aboriginal and Torres Strait Islander Health in 1998–99 were $10.4 million. It was estimated that $2.2 million of the $10.4 million was used for administering the welfare services component and the non-Indigenous component of OATSIH expenditures, so this $2.2 million was not counted as Indigenous health expenditure. The non-OATSIH administration was assumed to be in proportion to the Aboriginal and Torres Strait Islander proportion of non-OATSIH program expenditure—that is, 1.0% of non-OATSIH administration.

Grants to States and Territories

Data presented in the State and Territory health services expenditure chapter (Chapter 5) include Commonwealth payments to the States and Territories. To avoid

double counting, these grants have not been included within other tables in this chapter. Table 3.6 provides information on the Indigenous portion of Commonwealth grants to State and Territory authorities, payments of Commonwealth subsidies to State Government residential aged care and payments by OATSIH to State Governments for health programs specific to Aboriginal and Torres Strait Islander people ($299 million). Acute-care institutions receive the majority of such payments—87% or $260 million.

Table 3.6: Commonwealth payments to State and Territory authorities[(a)], by area of expenditure, total and per person, 1998–99

	Total ($m)		Per person ($)		Indigenous/ non-Indigenous
Area of expenditure	**Indigenous**	**Other**	**Indigenous**	**Other**	**ratio**
Acute–care institutions	*260*	*5,687*	*639*	*309*	*2.1*
Admitted patient services	195	4,265	479	231	2.1
Non-admitted patient services	65	1,422	160	77	2.1
Aged care homes	2	196	6	11	0.5
Community and public health	32	197	78	11	7.3
Administration	5	67	12	4	3.3
Total	**299**	**6,148**	**735**	**334**	**2.2**

(a) Includes specific purpose payments and grants to States and Territories ($6,232 million), subsidies for State Government high-care residential aged care ($198 million), and payments by OATSIH to States and Territories for Indigenous specific programs ($17 million).

Source: AIHW Health Expenditure Database.

Summary

Total Commonwealth funding of recurrent health services expenditure for Aboriginal and Torres Strait Islander people, including Medicare and PBS programs but excluding transfers to States, is estimated to be $267 million (Table 3.7). This represented 1.6% of the total Commonwealth recurrent funding of health services—$16,351 million in 1998–99 (excluding grants to the States). Per person expenditure for Aboriginal and Torres Strait Islander people was $658 compared with $873 for non-Indigenous persons.

Table 3.7: Commonwealth expenditures for Aboriginal and Torres Strait Islander people and non-Indigenous people, by type of service, 1998–99

Service	Total $m	Indigenous $m	Non-Indigenous $m	Per person ($) Indigenous	Per person ($) Non-Indigenous	Ratio: Indigenous/ Non-Indigenous
Benefits paid through Medicare[(a)]	6,611.6	59.4	6,552.2	146.11	355.53	0.41
Benefits paid through the PBS	2,795.6	20.4	2,775.2	50.25	150.59	0.33
Indigenous-specific health programs[(b)]	131.7	121.2	10.5	298.22	0.57	. .
Other Commonwealth programs	***6,812.1***	***66.3***	***6,745.8***	***163.24***	***366.04***	***0.48***
DHAC funding of other Commonwealth programs	4,487.3	59.4	4,427.8	146.21	240.26	0.61
DHAC general administration	726.2	6.9	719.3	17.03	39.03	0.44
DVA funding of private and Commonwealth programs	1,598.7	. .	1,598.7	. .	86.75	. .
Total Commonwealth funding (excluding payments to States)	***16,351.0***	***267.3***	***16,083.7***	***657.82***	***872.74***	***0.75***
Commonwealth (DHAC & DVA) funding of private sector programs	1,414.6	2.7	1,411.9	6.73	76.61	0.09
Total Commonwealth funding of Commonwealth programs[(c)]	***14,936.4***	***264.5***	***14,671.9***	***651.08***	***796.10***	***0.82***
Patient and other private payments for Commonwealth programs	***2,621.2***	***16.4***	***2,604.8***	***40.34***	***141.34***	***0.29***
Patient payments through Medicare	1,153.1	7.0	1,146.1	17.13	62.19	0.28
Patient payments through the PBS	601.3	4.4	597.0	10.71	32.39	0.33
Payments by residents of aged care facilities	747.7	5.1	742.6	12.49	40.29	0.31
Funding of research by private sector	119.1	0.0	119.1	0.00	6.46	. .
Total expenditures through Commonwealth programs[(d)]	**17,557.6**	**280.9**	**17,276.7**	**691.42**	**937.44**	**0.74**

(a) Includes benefits paid through Medicare for optometrical and dental services as well as medical services.

(b) Includes administration costs of OATSIH.

(c) Commonwealth funding of Commonwealth programs equals 'Total Commonwealth funding (excluding payments to States)' and subtracting 'Commonwealth funding of private sector programs'.

(d) Total expenditures through Commonwealth programs equals 'Commonwealth funding of Commonwealth programs' plus 'Patient and other private payments for Commonwealth programs'.

Source: AIHW Health Expenditure Database.

Of the $267 million, around 22% ($59.4 million) was for Medicare services, 8% ($20.4 million) for PBS benefits, around 45% ($121.2 million) for Aboriginal and

Torres Strait Islander health services and the remainder ($66.3 million) for other health services including administration (Table 3.7). In comparison, Medicare benefits of $6,552 million represented 41% and pharmaceutical benefits of $2,775 million represented 17% of the total Commonwealth funding of non-Indigenous health services.

Patient co-payments and other private payments through Commonwealth programs comprised 15% of total expenditures of $17,558 million through Commonwealth programs. However, these payments represented only 6% of the total Aboriginal and Torres Strait Islander expenditures of $281 million through Commonwealth programs.

Comparison of 1995–96 and 1998–99 Commonwealth expenditures

In the 1995–96 report, it was estimated that $178 million was spent through Commonwealth programs for health services for Aboriginal and Torres Strait Islander persons (excluding grants to the States). The estimate for expenditures through Commonwealth programs in 1998–99 was $281 million. Differences in estimation procedures and the effect of sample error mean that the difference between the two amounts cannot be interpreted as growth in expenditure.

There have undoubtedly been some increases in real expenditures over this period. However, the extent of these is unclear. Approximately half of the change is due to documented increases in service delivery to the value of $55.1 million. This is described below. The remaining half is due to method changes, survey error and some real increases that cannot be quantified. The documented increase in health services expenditure per Aboriginal and Torres Strait Islander person of 20% compares with a 10% increase in real per person expenditure for non-Indigenous people.

Documented increases in service delivery include:

- Medical services delivered by ACCHSs and State medical services increased by 135,000 GP services and 55,500 other medical services, for which Medicare benefits of about $5.3 million were paid in 1998–99.
- Health services expenditure through Indigenous-specific health programs, after adjustment for non-Indigenous use, increased by $35.5 million.

In addition to the above, OATSIH paid $14.3 million to States and Territories for Indigenous-specific health services in 1998–99, such as for sexual health, Remote Communities Initiatives, Coordinated Care Trials and for an ACCHS in the Australian Capital Territory. These payments were included in Commonwealth direct expenditure in the 1995–96 report (and so were double counted) but in 1998–99 are not double counted as they are counted only in State expenditure. Thus to measure the true increase in expenditure between the two years, this $14.3 million needs to be added to the $35.5 million and $5.3 million above to ascertain documented increases in services. This gives a total of documented increases in expenditure on services delivered of $55.1 million.

Table 3.8: Estimated Commonwealth funding (excluding payments to States) of health services for Aboriginal and Torres Strait Islander people and the total population, by type of service, 1995–96 report versus 1998–99 report, current prices

	1998–99 report			1995–96 report		
	Total	Indigenous		Total	Indigenous	
Service	$'000	$'000	Per cent Indigenous	$'000	$'000	Per cent Indigenous
Acute-care institutions						
Blood fractionation products	122,500	4,082	3.3	96,510	3,754	3.9
Other	613,000	1,839	0.3			
Aged care						
High-care residential aged care services[(a)]	2,445,397	25,744	1.1	2,001,732	4,276	0.2
Other	1,761	1,503	85.4			
Medical services						
Medicare benefits	6,459,314	58,253	0.9	5,894,321	32,400	0.5
Other	441,297	6,274	1.4	175,413	1,193	0.7
Dental services						
Medicare benefits	6,242	45	0.7	2,180	115	5.3
Other	131,000	393	0.3			
Other health professional						
Optometrical services	146,050	1,067	0.7	141,881	848	0.6
Other	51,135	156	0.3			
Community health services						
Office of Aboriginal and Torres Strait Islander Health[(b)]	111,694	103,413	92.6	114,843	89,662	78.1
Family planning	12,384	267	2.2	14,389	144	1.0
Hearing services	132,378	8,037	6.1	93,276	1,000	1.1
Other	148,941	1,447	1.0	119,821	230	0.2
Pharmaceuticals						
Pharmaceutical benefits	2,795,645	20,419	0.7	2,381,350	9,300	0.4
Other	9,000	27	0.3			
Aids and appliances						
Other	41,003	123	0.3			
Public health						
National public health	113,335	2,445	2.2			
Combating infectious diseases of Indigenous people (OATSIH)	4,832	4,832	100.0			
Other	10,948	1,210	11.1	79,868	4,142	5.2
Patient transport						
RFDS	16,560	7,700	46.5	16,469	6,588	40.0
Other	27,000	81	0.3			
Research	174,333	2,796	1.6	174,117	6,128	3.5

(continued)

Table 3.8 (continued): Estimated Commonwealth funding (excluding payments to States) of health services for Aboriginal and Torres Strait Islander people and the total population, by type of service, 1995–96 report vs 1998–99 report, current prices

	1998–99 report			1995–96 report		
	Total	Indigenous		Total	Indigenous	
Service	$'000	$'000	Per cent Indigenous	$'000	$'000	Per cent Indigenous
Administration						
OATSIH	10,410	8,207	78.8	4,560	4,560	100.0
General	726,176	6,918	1.0	481,440	3,392	0.7
Total expenditure through Medicare and the PBS	**9,407,252**	**79,783**	**0.8**	**8,417,552**	**42,548**	**0.5**
Indigenous specific health programs[(c)]	131,652	121,169	92.0	114,843	89,662	78.1
Other Commonwealth programs plus general administration	5,213,433	66,326	1.3	3,255,215	30,963	1.0
Total Commonwealth funding (excl. payments to States)	**14,752,337**	**267,278**	**1.8**	**11,787,610**	**163,173**	**1.4**
Total expenditures through Commonwealth programs (excl. payments to States)[(d)]	**16,462,435**	**280,931**	**1.7**	**15,980,241**	**178,105**	**1.1**

(a) Excludes Commonwealth subsidy for high care in State Government residential aged care homes.

(b) Total expenditures through the Office of Aboriginal and Torres Strait Islander Health are not comparable for the 1998–99 and the 1995–96 reports, as the 1995–96 number of $114.8m included OATSIH payments of $25.2m for services which were considered of a welfare nature, whereas the 1998–99 number of $111.7m excluded the payment for those services of $14.6m.

(c) Includes administration costs of OATSIH.

(d) The difference between total Commonwealth funding and total expenditures through Commonwealth programs is patient contributions and Commonwealth funding of non-Commonwealth programs.

Note: Table excludes DVA payments, therefore totals above do not correspond with Table 3.7.

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