

# Executive summary

## Background

This report examines expenditures on the provision of health services to Aboriginal and Torres Strait Islander people by Australian governments and the private sector for the 1998–99 financial year. It follows on an earlier report covering similar expenditures for the 1995–96 financial year by Deeble et al. (1998).

As noted in that earlier report, the life circumstances of Aboriginal and Torres Strait Islander people differ from the general Australian population in a number of important respects which significantly affect their general health status and consequent health care needs. It is estimated that the total Aboriginal and Torres Strait Islander population in 1998–99 was 406,000 people. This represents 2.2% of Australia's total population. Of these, over a quarter (27.5%) reside in remote areas, compared with only 2.6% of the total Australian population. The age demographic for Aboriginal and Torres Strait Islander people is much younger than the Australian norm. The average annual income for Indigenous Australians is also much lower than for their non-Indigenous counterparts.

Related to these distinctive circumstances, Aboriginal and Torres Strait Islander people typically have the poorest health status of all Australians. Average life expectancy at birth is estimated to be 20 years lower than that of other Australians and the infant mortality rate in the Northern Territory, Western Australia and South Australia<sup>1</sup> for 1995–97 was over three times the rate for all Australian infants.

## Key results

Health expenditures by the categories of government and private sector, by region and by primary or secondary/tertiary health care are examined. The patterns of health expenditure in 1998–99 are compared with the findings of the first report on expenditures in 1995–96.

The task of measuring health resource allocation for Aboriginal and Torres Strait Islander people is a difficult one. This reflects the limitations of the data which are often difficult to obtain and/or incomplete in nature. Significantly, the vast majority of Indigenous health expenditure is allocated through mainstream health programs and such services generally do not, or only incompletely, document use specifically by Aboriginal and Torres Strait Islander people—Medicare data, for example, do not include an Indigenous identifier. Inadequate or incomplete data have required the

---

<sup>1</sup> The Northern Territory, Western Australia and South Australia are the only States with accurate Indigenous identification in death statistics in this period.

use of surveys and other estimation techniques. Even such crucial information as the number of Aboriginal and Torres Strait Islander people in Australia is uncertain. In this report the 'low' Australian Bureau of Statistics estimate of the Aboriginal and Torres Strait Islander population was used (see Appendix 2). Uncertainties with data have impact with regard to the estimates of hospital admission rates, expenditure and expenditure ratios. Thus interpretation of the numbers in this report should allow for these enumeration and statistical errors.

The findings of this report are very similar in nature to those of the first report on health expenditures for Aboriginal and Torres Strait Islander people in 1995–96.

Despite their much poorer health status—on average three times worse than other Australians'—total expenditures per person for health services for Aboriginal and Torres Strait Islander people are not much higher than for the rest of the population. Total expenditures were 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, a ratio of 1.22:1. (This ratio is subject to the data uncertainties discussed above. For example, the 'high' population estimate is 8½% higher than the 'low' population estimate. If the 'high' estimate was used, the Indigenous/non-Indigenous health expenditure and morbidity ratios would decrease proportionally).

There were significant differences in the patterns of expenditure. Aboriginal and Torres Strait Islander people were on average much higher users of publicly funded health services than non-Indigenous people. Reflecting their significantly lower income level, Indigenous people used fewer privately funded services such as doctors in private practice, private hospitals, dentists and other privately funded allied health professionals. When relative income position was taken into account, public expenditures on the health of Aboriginal and Torres Strait Islander people appear to have been similar to that for non-Indigenous people in low-income groups.

In common with other low-income groups Indigenous people have relatively poor health status; however, their health is worse. Because the health status of Indigenous people is so poor the opportunities to improve it are considerable. In this context it is noteworthy that the ratio of per person Indigenous to non-Indigenous expenditures on primary health care services, where much of the work to improve overall health status occurs, was 1.27:1.

Expenditures through the major Commonwealth-funded health programs, Medicare and the Pharmaceutical Benefits Scheme, were much lower for Aboriginal and Torres Strait Islander people than for other Australians. Together they contributed only 7.3% of total expenditures on health services for Indigenous people compared with 23.9% of total expenditures for non-Indigenous people. Per person expenditure on Aboriginal and Torres Strait Islander people through these two programs was 37% of that for non-Indigenous people.

Aboriginal and Torres Strait Islander people were much higher users of State-funded health services, in particular admitted patient services in hospitals and community health services.

The report also examined variations in the patterns of expenditure between highly accessible and more remote areas based on the Accessibility/Remoteness Index of Australia (ARIA) scale of remoteness. Due to the limitations of the data, only 50% of expenditures could be included in this analysis, and it is therefore difficult to determine any overall trends in expenditure between regions. The analysis did show decreasing levels of access to Medicare-funded services and pharmaceutical benefits as remoteness increased. In contrast, there was an increase in admitted patient expenditure with increasing remoteness. This was reflected in patterns of expenditure by State. States with a large proportion of Indigenous people living in remote regions generally had higher per person expenditures on hospital services. These higher hospital expenditures are partly due to the higher cost of providing services in remote regions. If the higher costs of providing services in remote areas could be factored in, the ratio of Aboriginal and Torres Strait Islander health service use to non-Indigenous services use would be lower than the expenditure ratio of 1.22:1. For example, the Commonwealth Grants Commission recognises the higher costs of service delivery in remote areas. Further research is needed in this area (McDermott 1995).

Overall, when sources of funds are examined, the Commonwealth and State Governments contributed very similar amounts to health services for Aboriginal and Torres Strait Islander people. Over 50% of the Commonwealth's contribution was indirect through its contribution to public hospital funding.

It is difficult to directly compare the figures in this report with those of the first report on 1995–96 expenditure as there have been changes in both methodology and data availability. Nonetheless, after controlling for population growth and inflation, there are areas where it is possible to say with some confidence that there have been increases in funding and service provision.

**A note on rounding: Figures in tables and the text have sometimes been rounded. Discrepancies between totals and sums of components are due to rounding.**