Expenditures on health for Aboriginal and Torres Strait Islander peoples, 2001–02

The Australian Institute of Health and Welfare is Australia's national health and welfare statistics and information agency. The Institute's mission is *better health and wellbeing for Australians through better health and welfare statistics and information*.

Please note that as with all statistical reports there is the potential for minor revisions of data. For the most recent estimates, please refer to the online version at <www.aihw.gov.au>.

HEALTH AND WELFARE EXPENDITURE SERIES
Number 23

Expenditures on health for Aboriginal and Torres Strait Islander peoples, 2001–02

July 2005

Australian Institute of Health and Welfare
Canberra

AIHW cat. no. HWE 30

This publication is part of the Australian Institute of Health and Welfare's Expenditure Series No 23. A complete list of the Institute's publications is available from the Business Promotion and Media Unit, Australian Institute of Health and Welfare, GPO Box 570, Canberra ACT 2601, or via the Institute's website <www.aihw.gov.au>.

ISSN 1323–5850

ISBN 1 74024 478 8

Suggested citation

Australian Institute of Health and Welfare (AIHW) 2005. Expenditures on health for Aboriginal and Torres Strait Islander peoples, 2001–02. Health and Welfare's Expenditure Series no. 23 AIHW cat. no. HWE 30. Canberra: AIHW.

Any enquiries about or comments on this publication should be directed to:

Mr Tony Hynes
Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601

Phone: (02) 6244 1160

E-mail: expenditure@aihw.gov.au

Published by Australian Institute of Health and Welfare

Cover: Cynthia McMillan, Kwatye Ngentye, 2005, acrylic on canvas, 500 x 310 mm, Irrkerlantye Arts, © artist.

Printed by Pirion

Contents

List of tables

Additional tables in appendices

The following additional tables were used in the development of the estimates in this report and are available, in Excel format, on the Institute's website at <www.aihw.gov.au>.

Table A1.1: Government Purpose Classification (GPC) used in report

Table A1.2: Major areas of health expenditure used in report

Table A2.1: Population estimates for Aboriginal and Torres Strait Islander peoples and the total Australian population, 2001

Table A2.2: Population distribution in Australia by ASGC remoteness areas, Aboriginal and Torres Strait Islander peoples and total Australian population, 2001–02

Table A2.3: Estimated mean resident population, Indigenous Australians and non-Indigenous people, 1995–96, 1998–99 and 2001–02, Australia

Table A3.1: Expenditures incurred by the Australian Government on public (non psychiatric) hospitals, 2001–02

Table A3.2: Proportion of BEACH encounters with Aboriginal and/or Torres Strait Islander patients, 1998–2002

Table A3.3: Method 1, estimated Medicare-paid GP services, 2001–02

Table A3.4: Method 2, estimated Medicare-paid GP services, 2001–02

Table A3.5: Estimated medical services and benefits through MBS for Aboriginal and Torres Strait Islander peoples, 2001–02

Table A3.6: Estimated services and benefits through MBS for Aboriginal and Torres Strait Islander peoples, 2001–02

Table A3.7: Estimated MBS benefits for GP services, reported and revised results, 1998–99 and 2001–02

Table A3.8: Estimated health funding by the Australian Government for Indigenous Australians, through the private health insurance incentives payments, 1998–99 and 2001–02, constant prices, Australia

Table A3.9: Estimated Indigenous share of Australian Government specific purpose payments to states and territories, by state and territory, 2001–02

Table A4.1: Australians Government recurrent health funding for high care in residential aged care homes, 2001–02

Table A4.2: Residents receiving high-level care in residential aged care facilities, by state, 2001–02

Table A4.3: Rates of usage of high-level residential aged care by Aboriginal and Torres Strait Islander people and non-Indigenous Australians, by age group, 2001–02

Table A4.4: Commonwealth recurrent health funding for high-level care in residential aged care facilities, per person 2001–02

Table A5.1: Reported Indigenous and non-Indigenous separations by hospital sector, states and territories, 2001–02

List of figures

List of appendices

Methodological issues related to the compilation of the estimates of expenditure and funding are discussed in the appendices to this report. The appendices to the report are quite extensive and have not been included in the printed version. They are available at the Institute's website <www.aihw.gov.au>. A list of the contents is provided here.

Abbreviations and symbols

Abbreviations

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
ACCMIS	Aged and Community Care Management Information System
AHCA	Australian Health Care Agreement
AHMAC	Australian Health Ministers Advisory Council
AHS	Aboriginal Health Service
AIHW	Australian Institute of Health and Welfare
ARIA	Accessibility/Remoteness Index of Australia
ASGC	Australian Standard Geographic Classification
BEACH	Bettering Evaluation and Care in Health
CACP	Community Aged Care Packages
COFOG	Classification of the Functions of Government
CSDA	Commonwealth/State Disability Agreement
CSTDA	Commonwealth State/Territory Disability Agreement
DHS	(Victorian) Department of Human Services
DRG	Diagnosis Related Groups
DVA	Department of Veterans' Affairs
GPC	Government Purpose Classification
HACC	Home and Community Care
HEAC	Health Expenditure Advisory Committee
MBS	Medical Benefits Scheme
NAHS	National Aboriginal Health Strategy
NAHSWP	National Aboriginal Health Strategy Working Party
NHS	National Health Survey
NPHEP	National Public Health Expenditure Project
OATSIH	Office for Aboriginal and Torres Strait Islander Health
PBS	Pharmaceutical Benefits Scheme
PHIIS	Private health insurance incentives subsidy
PHOFA	Public Health Outcomes Funding Agreement
RPBS	Repatriation Pharmaceutical Benefits Scheme
SAR	Service Activity Report
SIMC	Statistical Information Management Committee
SPP	Specific Purpose Payment

Symbols

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

The following symbols are used in tables:

n.a.	not available
. .	not applicable
nec	not elsewhere classified
—	nil or rounded to zero

Executive summary

The main conclusion from this third study into expenditure on health for Aboriginal and Torres Strait Islander peoples is that the relative position of Indigenous Australians compared with non-Indigenous people has changed little since the previous report for 1998–99. This finding relates to both their shares of national health spending and the structure of health expenditures. Indeed, there have been only small changes since the first report for 1995–96. However, health expenditure for both Indigenous and non-Indigenous people has risen substantially. In 2001–02:

- Aboriginal and Torres Strait Islander peoples comprised 2.4% of Australia's population. (Chapter 1)
- Total expenditures on health services for Aboriginal and Torres Strait Islander peoples were estimated at 2.8% of national health expenditures, having risen from 2.6% in 1998–99. Estimated expenditure on health for Indigenous people rose markedly, from $1,356.1 million in 1998–99 to $1,788.6 million in 2001–02. (Chapter 2)
- Average expenditures per Indigenous person were estimated at $3,901 in 2001–02. That was 18% more than the $3,308 per person spent on the non-Indigenous population. However, because Aboriginal and Torres Strait Islander peoples relied heavily on publicly funded health care providers, government expenditures were much higher for them than for other people—$3,614 per person compared with $2,225, or 62.4% more. The relatively small differential between average health expenditures on Indigenous and non-Indigenous people reflects both differences in the volume and mix of health goods and services provided to the two groups and differences in the average costs of providing those services. A greater proportion of the Indigenous population live in remote and very remote regions where service delivery costs are greater, but the types of services that they access, on average, involve lower costs. For example, while their average rate of separation from hospitals is about double that of non-Indigenous people, lower-cost interventions, such as dialysis, make up a larger proportion of those separations than in the case of non-Indigenous people.
- The Australian Government provided 43.1% of the total funding for Indigenous health expenditures, the state and territory governments provided 49.5%, and 7.3% came from non-government sources, including out-of-pocket payments. The corresponding figures for non-Indigenous people were 47.8% from the Australian Government, 19.5% from the states and territories and 32.7% from private sources.
- An estimated 70.5% of expenditures were through programs managed by the state and territory governments; 23.4% were through Australian Government programs; and the remaining 6.2% were for services that were essentially the responsibility of non-government providers.
- Hospital services, of all kinds, accounted for 47.5% of Indigenous health expenditures, compared with 34.2% of the spending on other people. Community health services and public health activities, including those through Aboriginal Community Controlled Health Services (ACCHSs), absorbed another 24.6% compared with 4.5% for non-Indigenous people.

- A number of factors should be noted when reviewing changes over time, including that the methodology for developing estimates has changed, the Australian average reflects variations in jurisdictional expenditure and the actual figures may be higher or lower than the estimates published in this report. Thus, caution should be exercised when interpreting changes in expenditures over time.
- Given these reservations, the ratio of Indigenous to non-Indigenous estimated expenditures per person in 2001–02 (1.18:1) was marginally lower than in 1998–99 (1.22:1). This reflects the faster expenditure growth in the types of health services of which Indigenous people use less (such as those funded through private health insurance).
- Estimates of average expenditures per person for Indigenous Australians increased in real terms by 16.9% between 1998–99 and 2001–02 (Chapter 3). This was lower than the increase for non-Indigenous people of 18.8% over the same period.
- Indigenous people were low users of mainstream medical and pharmaceutical services covered by Medicare and the Pharmaceutical Benefits Scheme. Per person, Medicare benefits for Indigenous people were 39% of the non-Indigenous average and PBS benefits were 33%. (Chapter 4)
- Expenditure on services provided to admitted patients in acute-care hospitals represented over half (52.5%) of state/territory expenditure for Indigenous Australians, lower than for the non-Indigenous population. (Chapter 5)
- Indigenous Australians were also low users of private dental and other professional services and of privately provided health aids and appliances. A possible contributor to the low rate of expenditure in these areas was the low rate of coverage by private health insurance—only about 15–20% of Indigenous people had private health insurance cover. (Chapter 6)
- Although the regional analysis was limited to a number of major programs, there was evidence that a combination of higher usage and costs resulted in much higher expenditures on Indigenous people in the outer-regional and remote/very remote areas than in the major cities. And the hospital use data accorded with it. At 489 per 1,000 population, the overall rate of acute hospital admissions/separations for Indigenous people was 45.0% higher than for non-Indigenous people. There was little difference between the two population groups in the cities, but in the outer-regional and remote areas Indigenous separation rates were between 87.7% and 165.2% higher. Hospitals played a much different role for Indigenous Australians in those areas. (Chapter 7)
- For the first time, this report includes some estimates of health-related welfare payments for Aboriginal and Torres Strait Islander peoples—specifically expenditures on welfare services for older people and for people with a disability. These expenditures are, however, outside the estimates of health expenditure as conventionally defined. At an estimated $151.8 million, these expenditures were equivalent to 8.5% of health expenditures. (Chapter 8)
- A number of recommendations to improve subsequent reports are provided, including recommendations for improving the quality of the data and the timeliness of reporting. (Chapter 9)