

3. Where does the money go? Funding for Indigenous health

People often ask why Aboriginal and Torres Strait Islander peoples' health is so bad when so much money seems to be spent on them. How much do we *really* spend? Is it too much? Is it well spent?

Who pays for health?

To a great extent, health costs for *all* Australians are paid for by governments¹.

- State governments provide public health services such as hospitals.
- The Commonwealth Government pays for nearly half the cost of public hospitals under Australian Health Care Agreements².
- The Commonwealth also heavily subsidises health costs through Medicare (the Medical Benefits Scheme, MBS) and the Pharmaceutical Benefits Scheme (PBS) and rebates for private health insurance. The Commonwealth health budget is more than \$31 billion per year³.
- Important public health costs – like ensuring a clean environment, clean food and water, sewerage, roads and so on – are also the responsibility of governments.

Good access to affordable primary health services (eg, doctors, pharmacies) is very important to good health and prevention of serious illness. It is also a much more cost effective way of providing health care (see information sheet no.7).

For most Australians, nearly all primary health costs are covered by Medicare and the PBS.

This is not the case for Indigenous people. Indigenous people have less access to GPs and instead usually go to community health services or public hospitals. Many Indigenous communities have established their own health services (ACCHSs⁴) which are directly funded by the Commonwealth or state governments. This network is not spread consistently across Australia however, and many Indigenous communities have very poor access to doctors or health clinics.

Doesn't the Commonwealth Government spend a lot more on Indigenous health than for mainstream Australia?

No! Indigenous specific health programs account for less than 1% of Commonwealth funding of Australian health services.

Indigenous Australians have less access to GPs, so they gain little benefit from the MBS and PBS funding system. In 1998-99 the Australian Institute of Health and Welfare calculated that for every \$1.00 spent per person for the general population on these schemes, only \$0.37 was spent per Indigenous person. In 2000, a Commonwealth Government inquiry found that, despite being much sicker than the non-Indigenous population, Commonwealth funding for Indigenous health care (through MBS, PBS *and* through community controlled health services) was around **\$100 per person per year less** than other Australians receive from the MBS and PBS alone⁵.

At present, Commonwealth spending on Indigenous people through programs it administers is about 18% less per person than for non-Indigenous people.

But doesn't ATSIC (ATSIS) have a lot of money for Indigenous health?

No! In fact ATSIC (ATSIS)⁶ does **not** have funding and does **not** have responsibility for Indigenous health. The Commonwealth Department of Health looks after Indigenous health through the Office of Aboriginal and Torres Strait Islander Health (OATSIH). ATSIC is usually not able to put extra funds into health because most of its budget is 'tied' and must be spent as the Commonwealth Government directs. Most

of ATSIC's budget is spent on 'work for the dole' schemes and developing community housing and infrastructure.

Who does have responsibility for Indigenous health?

Both the Commonwealth and state/territory governments have responsibility.

The total funding for Indigenous health is shared almost equally between these two levels of government, but state/territory government expenditure on Indigenous people is *twice* as high per person, mainly because of the high demand for hospital care by Aboriginal and Torres Strait Islander people.

This means that a large proportion of the total national funding for Aboriginal and Torres Strait Islander health is spent at the tertiary end of health care, that is at the high cost end. As a result, the *combined* expenditure of Commonwealth, state and territory governments on Indigenous health is higher for Indigenous than non-Indigenous Australians (22%)⁷ (see table).

This high hospital use reflects a failure to deliver adequate primary health care. More is spent on high cost hospital treatment because too little is being spent on more cost effective community health care services which can help prevent serious illnesses.

Paying for the past – prevention is better than cure

One of the reasons for the crisis in Indigenous health is the neglect of the past. Indigenous people as a group are much, much sicker than other Australians because so little money and so few resources have ever been put into this area. Many people are ill now because of the neglect of 10, 20 or 30 years ago. High expenditure on hospitals represents costly treatment for acute illness, and it shows a failure to provide primary health care.

For example, the cost of maintaining a person on renal dialysis in the last stage of life has been estimated at \$100,000 per year. The rate of kidney disease is much higher for Indigenous people (in some

regions an astonishing 60 times higher) because of a range of health issues that begin early in life, even before birth.

Only money spent **now** on primary health care and education to **prevent** illness will improve the health of Indigenous people in the long run and ultimately bring down the cost of health care.

Should governments be more accountable?

One of the biggest problems with funding for Indigenous health is that there is no overall system for delivering health care to Indigenous communities. There is no system to ensure that enough money is spent where it is most needed.

Our national expenditure on health is increasing, but Indigenous people have gained little benefit. In current prices, average health expenditures per person rose by nearly 15% from 1998-99 to 2000-2001 and the growth in 2001-2002 would have approximated 6% at least. But it occurred mainly in private hospital use, expensive PBS drugs and high level aged care, the three categories of service which Indigenous people use least⁹.

Many government inquiries have found that although all levels of government have responsibility for Indigenous health, none **takes** responsibility! A practice called 'cost shifting' (claiming another level of government, department or agency has responsibility) lets governments and departments 'off the hook'⁹.

The Commonwealth Government spends much less on Indigenous peoples' health than for the wider community. It provides funds to state and territory governments under Australian Health Care Agreements, but has no power to direct them to spend more on Indigenous health. The Agreements don't deal with Indigenous health, so additional Framework Agreements on Indigenous Health have been developed. Despite this, the effectiveness of these agreements is questionable¹⁰ because they don't commit the parties to any specific actions, such as a minimum level of funding. They do not make state and territory governments **accountable**.

Estimated government and private expenditure on health services, 1998-99

	Indigenous		Non-Indigenous		Ratio Indigenous/non-indigenous
	\$m	\$pc*	\$m	\$pc*	
Government services					
Public hospitals – admitted patients	457	1 125	10 278	558	2.02
Public hospitals – non-admitted patients	125	307	2 562	139	2.21
Mental institutions	26	64	465	25	2.53
Residential high level aged care	40	99	3 853	209	0.47
Community and public health	355	874	3 137	170	5.14
Patient transport	43	106	577	31	3.39
Medicare and other medical (a)					
PBS medicines	73	179	8 632	468	0.38
Administration and research	25	61	3 611	196	0.31
	41	101	1 324	72	1.40
Total government	1 185	2 917	34 439	1 868	1.56
Non-government services					
Private hospitals	10	25	4 092	222	0.11
Dental and other professional	17	42	3 928	213	0.20
Other	33	82	3 963	215	0.38
Total non-government	60	148	11 982	650	0.23
Total	1 245	3 065	46 421	2 518	1.22

(a) Optometrical and Medicare dental included

This table published in Commonwealth Grants Commission *Report on Indigenous Funding*, Vol 1, chapter 6, p.114, <http://www.cgc.gov.au/>

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

* per capita

How much should be spent?

Professor John Deeble has estimated for the Australian Medical Association that an additional \$300 million per year is needed to achieve an equitable allocation of health care resources and to train the additional health workforce required¹¹:

- \$250 million for primary health care, and
- \$50 million (just \$12 per Indigenous person) for public health and preventive programs such as health promotion, health education and screening.

This is a small amount compared with the total annual Commonwealth health budget of \$31 billion (less than 1%), an overall national expenditure of more than \$66 billion, and the terrible cost, financial and otherwise, of ongoing ill health.

References

1. Australian Institute of Health and Welfare (AIHW) 2003, *Health expenditure Australia 2001-02* (AIHW cat. no. HWE24, Carb. p.5. Governments funded nearly 70% of health expenditure in Australia in 2001-02)
2. Senator the Hon Kay Patterson, Minister for Health and Ageing, *Australian Health Care Agreements 2003-2008*, press release, 13 May 2003
3. The Hon Peter Costello, Treasurer, Budget Speech 2003-04, 13 May 2003
4. Aboriginal community controlled health services (ACCHSs)
5. *Health is Life - Report on the Inquiry into Indigenous Health*, House of Representatives Standing Committee on Family and Community Affairs, Canberra, May 2000, p.20
6. Aboriginal and Torres Strait Islander Commission / Aboriginal and Torres Strait Islander Services
7. Prof John Deeble, *Expenditures on Aboriginal and Torres Strait Islander Health*, AMA 2003, [http://www.ama.com.au/web.nsf/doc/WEEN-5N6285/\\$file/AMA_03Deeble.pdf](http://www.ama.com.au/web.nsf/doc/WEEN-5N6285/$file/AMA_03Deeble.pdf)
8. *Ibid*, p.1
9. Commonwealth Grants Commission, *Report on Indigenous Funding 2001*, p.27
10. *Health is Life*, p.57
11. Prof John Deeble, *op cit*

