

Notes

1. The health–social status correlation is hypothesised to occur because: (1) social position impacts health through access to health care, nutrition, working conditions etc; (2) health determines social status (the health selection hypothesis); or (3) common factors determine both social position and health (a variation of the health selection hypothesis)—that is, the social epidemiology literature tends to discount the health selection hypothesis.
2. Sparsely settled areas are defined as statistical local areas (SLAs) where the dwelling density for the SLA as a whole is less than 57 dwellings per 100 square kilometres.
3. The standardised morbidity ratio is equal to hospital separations identified as Indigenous divided by expected separations based on all-Australia rates.
4. The rationale behind the use of equivalence scales is based on the simple fact that, for example, a six-person family can usually live more cheaply than six single people can. As a result of economies of scale, a six-person family does not need six times the resources of one person to reach the same welfare. That is, an additional family member does not cause a proportionate increase in expenditure on, say, heating or housing.
5. Sensitivity testing to a variety of equivalence scales is a common practice in research (Burniaux et al. 1998). For example, Atkinson (1995) considered income inequality using raw family/household income (that is, no adjustment for family size—an ‘equivalence scale elasticity’ of zero) and per capita income (‘equivalence scale elasticity’ of one). They found that the level of income inequality was higher with these assumptions than when measured using the square root of the number of people in the family (‘equivalence scale elasticity’ of 0.5). The equivalence scale elasticities between zero and one cover the majority of possible assumptions about household costs, from there being no extra cost to additional persons living in the household to there being no economies of scale in people living in a household.
6. To facilitate the exposition, this paper equates ‘family’ with ‘income unit’ as defined by the ABS. Income unit is the social grouping across which the ABS assesses that aggregate income is effectively shared.
7. The 1995 NHS data provides income data adjusted using a version of the simplified Henderson equivalence scales.
8. See Buhman et al. (1988) for a single parameter estimate of ‘equivalence elasticities’. These elasticities provide a rough guide to what we have called economies of scale.
9. In an analysis of Indigenous housing disadvantage, Neutze, Sanders and Jones (1999: 45) found that high rates of home ownership in low-income groups were driven by the disproportionate numbers of retired persons in such groups.

10. 'Jackknifing' is a method used for estimating the standard errors of estimates obtained from complex sample surveys. The jackknife method involves repeated sampling from subsets of the sample data. The characteristics of the repeated sub-samples are used to estimate the variance over the entire data set – that is, the method calculates the effect of each unit on the estimate. If there are n units in the sample, then n estimates are calculated from the sample where a single different unit is removed each time from the total sample (Levy & Lemeshow 1999: 378).
11. Deeble et al. (1998) include the following medical services in their estimates of health expenditure by income group for the total Australian population: inpatient and outpatient hospital services; out-of-hospital GP and specialist medical services; allied health services; and prescribed drugs.
12. However, it was possible to present some statistics for Indigenous people from each quintile where the estimates were reasonably reliable. See Appendix B.
13. The cost per GP and specialist visit is estimated using data from the Bettering the Evaluation and Care of Health (BEACH) survey. The BEACH survey collects information from about 100 GPs a year and asks them about the details of the patients they treat (results in data on about 100 000 patient encounters per year). Information about the presenting problems of patients, diagnosis, and treatments prescribed and given is available. In addition sociodemographic characteristics of the patients, including whether patients are Aborigines or Torres Strait Islanders, are recorded.
14. For prescription medications which are listed on the PBS schedule, the share of the costs borne privately versus publicly depends upon the amount of the subsidy, whether or not the individual has a health care card, their income and the amount they have spent on prescription medications in the current year.
15. The estimate of the average per capita health expenditure for the non-Indigenous population implied by Table 2 differs to the overall estimate reported in a previous paragraph due to the omission of several individuals with very high levels of health expenditure which happen to have missing values for the income variables. This is also true for the estimates of expenditure by income reported in Tables 4.3 and 4.4.
16. The hospital services data excluded from the estimates are: number of visits to a hospital; number of visits to casualty/emergency; number of visits to outpatients; and number of visits to day clinic. As indicated above, these are low frequency events which are unlikely to have occurred in the previous two weeks and hence their exclusion should enhance the reliability of the estimates.
17. That is, health expenditure is highly skewed. A recent US study shows that, in a year, 27% of the expenditure is by 1% of users, and 97% by 50% of users (Berk & Monheit 2001). Of that top 1%, 46% are elderly.
18. In addition approximately half of the original sample were asked to complete a written supplement comprising the Short Form-36 (SF-36) health status questionnaire. The SF-36 is a well-known measure of general health and well-being; it produces scores

for eight dimensions of health. Selection into this 'treatment' group was based on the random assignment of blocks within census districts. Approximately 30% of the Indigenous sample was administered the SF-36. Given the small Indigenous sample, it is not possible to make use of the SF-36 in a comparison of the health status of the Indigenous and non-Indigenous population.

19. The SF-36 is a well-known measure of general health and well-being which produces scores for eight dimensions of health in the reporting of long-term health questions. It has been extensively validated for many samples from many countries (Ware, Snow & Gandek 1993).
20. In economic terms, poverty is a static concept defined by whether an individual, family or household has sufficient income at a particular point of time.
21. Social, economic and political factors have an important influence on health and longevity, but the social position and lifestyle patterns of individuals only partially explain ill health. Psychosocial factors, such as a sense of isolation, deprivation or loss of control, are also important (Marmot 2000). Another factor is that relatively high income may be a relatively recent phenomenon for Indigenous people and, consequently, it may be difficult for these newly wealthy people to adjust to their changing circumstances. For example, compared with those experiencing no significant organisational change, men exposed to major changes in their workplace demonstrated increases in all self-reported morbidity measures, including health ratings of average or worse, adverse sleep patterns, long-standing illness, mean number of symptoms in the previous fortnight, blood pressure, and body mass index (Ferrie et al. 1998). In the Indigenous context, the pressure of frequently being the first Indigenous person in an organisation adds extra stress into the working environment.