UnitingCare NSW.ACT

Too poor to be sick
A reflection on health related issues before the federal election 2004

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Let's be realistic The title should be: Too poor to be sick: too poor to be well.

Health

We begin with some very basic ideas about health.

Theology

First, theology. Salvation is about health. Theologians used to talk about God's providence, by which they meant our belief that the good things of the earth to be shared by all – all people and all species - so that they might not merely survive, but flourish. God's grace is about healing, accepting human beings as they are. The Gospel is about restoring relationships – about justice and peace. A significant themes of the ministry of Jesus, in each of the gospels, is healing people who are sick or disabled. When we engage in healing or work for health, we share in the ministry of Christ. Which leads me to a more negative point. Destruction of health would seem to be rebellion against God

Health is more than health care

Health is more than health care. There are many aspects of human life that can contribute to health. Examples are

- Control, community, cooperation, autonomy
- Reconciliation with Australia's first peoples
- Peace
- Environment
- Adequate, secure income, housing, services
- Clean food and water, healthy environment
- Affordable energy and transport
- Occupational health and safety

Anti-health policies

We live in a world and at a time where there are many policies that harm people's health. These include: War, terrorism, detention, alarm through alert, the hysteria of the law and order debate, people lacking control over lives or lacking local community.

Then there are problem such as individualism, and loss of community support. Inequality is a health hazard, as are low wages, or depriving people of support by encouraging non-union labour. Other health hazards are inadequate pensions and benefits; punitive Centrelink policies; lack of secure housing and family-work tensions

Too poor to be well

Health is expensive

The basic requirements of good health are quite expensive. They are difficult for many people on low incomes to purchase. They include:

- Good diet
- Exercise and recreation
- Adequate housing
- Education
- Services: energy, water, communications
- Participation in community
- Medical, dental care and other treatment

Senate inquiry into poverty

The recent Senate inquiry into poverty has documented that poverty is a health hazard. Poverty means people lack the ability to satisfy fundamental needs.

Poverty in Australia

The poverty inquiry reports the following estimates of poverty in Australia.
Henderson poverty line (1999) 3.7 to 4.1 million (20.5 to 22.6% of population)
St Vincent de Paul Society - 3 million
ACOSS 2000 2.5 to 3.5 million 13.5 to 19%
Smith Family 2000 2.4 million 13 %
Brotherhood of St Laurence 2000 1.5 million
The Australia Institute - 5 to 10% of population
Centre for Independent Studies - 5% of population in 'chronic poverty'

Testimony - poverty harms health

The Senate Inquiry reports evidence that poverty harms health in a number of ways. Contributing factors include:

- Homelessness
- Poor diet
- Lack of heating, cooling, refrigeration
- Poor clothing
- School children without breakfast
- Poor dental health; Lack of dentures
- Social and political alienation, lack of control
- Lack of glasses

- Financial stress

There is also evidence that disadvantage tends to be concentrated in particular postcode areas, leading to severe disadvantage, illhealth and development problems among some people.

Anglicare study

The Senate Poverty Report also includes a summary of a study which Anglicare conducted with their clients. These are not average Australians, but people who use their service. Their families reported: Over 50% of families with children didn't have enough to eat. In 20% of families - this occurred 'often'. In 41.8% - their children went hungry some of the time. In 7.6 % of the families, their children had gone without food for a whole day in the last 12 months.53

Child malnutrition

The report noted that child malnutrition has a number of negative consequences on health. These include:

- Poor general health
- Higher levels of aggression, hyperactivity and anxiety as well as passivity
- Difficulty getting along with other children
- Increased need for mental health services
- Impaired cognitive functioning and diminished capacity to learn;
- Lower test scores and poorer overall school achievement;
- Repeating a grade in school; and
- Increased school absences, tardiness and school suspension.54

Too poor to be sick

Health care costs

The official Medicare figures show that there has been a 4.6% decline in bulkbilling from 2002 (72.3%) to 2003 (67.7%). This has led to the development of a three tiered system within Medicare - based on safety net for poor, private health insurance for the rest.

In recent years, there has been increased use of allied health professionals – but no rebate. Long waiting lists for hospitals disadvantage the poor more than the rich

Bulkbilling- WA 2002, 2003

I have listed the bulkbilling statistics for all WA electorates to show the overall situation, and the decline from 2002 to 2003. (Source: http://www.health.gov.au/haf/medstats/tablee1.xls 020404). I have also looked top fifteen electorates in the bulkbilling states. I think WA has some reason to be angry and disturbed, since all fifteen top bulkbilling electorates are in or near Sydney, and no WA electorate comes close to that level of bulkbilling.

Western Australia – all electorates

	2002	2003	Change
Brand	64.9	59.8%	-5.1
Canning	59.8%	54.2%	-5.6
Cowan	79.2%	73.2%	-6.0
Curtin	59.8%	55.6%	-4.2
Forrest	52.6%	53.6%	+1.0
Fremantle	71.5%	64.6%	-6.9
Hasluck	74.1%	69.2%	-4.9
Kalgoorlie	61.4%	61.3%	-0.1
Moore	71.2%	64.1%	-7.1
O'Conor	50.9%	50.1%	-0.8
Pearce	73.0%	70.4%	-2.6
Perth	79.6%	72.2%	-7.4
Stirling	79.3%	73.2%	-6.1
Swan	78.3%	72.4%	-5.9
Tangney	68.0%	61.4%	-6.6

Bulkbilling 2003 Highest rates in Australia, by electorate

	2002	2003	
Chifley	98.5%	98.3%	sydney
Fowler	98.2%	97.5%	sydney
Reid	98.0%	97.1%	sydney
Prospect	97.6%	96.9%	sydney
Blaxland	95.9%	95.5%	sydney
Watson	96.3%	95.5%	sydney
Werriwa	95.7%	95.3%	sydney
Greenway	94.9%	94.4%	sydney
Throsby	92.8%	94.2%	outer sydney
Lowe	92.4%	91.3%	sydney
Barton	92.1%	91.2%	sydney
Parramatta	92.4%	90.7%	sydney
Grayndler	92.5%	90.6%	sydney
Macarthur	90.3%	89.5%	sydney
KingsfordSmith	91.0%	88.1%	sydney
Lindsay	90.6%	87.1%	outersydney

The difference between availability of bulkbilling in WA and NSW seems quite unfair. I think the NSW rates are fine – the problem is the low rates in WA

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Changes in household health spending

The Senate Report reproduces a graph from St Vincent de Paul, showing that health costs have increased in the last ten years, but that the change in costs has affected the poorest families more than most families. (See graph in presentation)

Medicare

Medicare principles

Medicare was originally founded on a number of principles. These were:
Access to services
Equity in paying for healthcare
Universality – scheme applies to everyone
Simplicity – easy to know entitlements, claim
Efficiency – value for money

Medicare original had two components

(a) Access to public hospital treatment without charge, meaning that ther ewas no need for private health insurance.
(b) Rebates for doctors visits. The rebate could be provided either through bulkbilling – the doctor claimed directly from Medicare, so the visit was free at the point of service; OR upfront fee – often above scheduled fee – and rebate (85% of scheduled fee). There was a safety net that increased the rebate to 100% of the scheduled fee when payments reached a set amount.

Medicare – not free

We all pay for Medicare through at least three means: the Medicare levy, general taxation, and discounted wages. Ideally, we should only pay in these three ways. The weakness of Medicare is that it places high value on doctors being able to charge patients if they wish, rather than the needs of patients. If doctors charge the scheduled fee, but do not bulkbill, patients pay the gap between rebate and scheduled fee. If their doctor charges more than the scheduled fee, then the patient also pays the gap between the scheduled and actual fee. That means that we can pay in up to five different ways. The decline in bulkbilling means that more people are making more of these payments.

Increases in costs since 1989-1990

The Senate inquiry into poverty reports estimates from St Vincent de Paul about health cost increases. They report that overall, increases in health costs are 98% higher than the consumer price index (CPI, measure of inflation). Increases in hospital and medical expenses are 137% higher. Increases in dental are 113.5 % higher. *Source:* Submission 44, p.19 (SVDP National Council). Senate Poverty Inquiry Report 2004

Medicare Minus 1

A few years ago the Commonwealth decided to encourage us all into private health insurance by paying a 30% rebate for private health insurance for hospitals (PHI is 6th payment). Community health ratings to force people into PHI when they prefer to trust public hospitals. PHI has increased number of procedures, not reduced pressure on

public hospitals. The rebate drains money from the public health system into private organisations. To benefit from this rebate one has to pay out money both in insurance and in extra costs for private care (7th payment). But poor people cannot afford PHI or the extra costs involved in private hospitals.

Medicare Minus 2

Last year the government modified Medicare further. Their first attempt, the so-called "Fairer Medicare" was rejected by almost all stakeholders. The second attempt was Medicare Plus.

The problem with both these proposals is that they fail to address the problem of bulkbilling. The assumption is that most people don't really need bulkbilling. Indeed, the government has said publicly that Medicare was not about bulkbilling.

The point is that bulkbilling is the best way to ensure that Medicare works in accordance with the principles of access, universality, equity and simplicity.

The reason bulkbilling rates are falling seems to be that the rebate out of kilter with costs and workvalue. Doctors claim that they cannot afford to provide care for the current rebate.

Instead of improving the rebate for everyone, the revised Medicare provides a differential rebate. The increased rebate only applies to people with concession cards and children under 16. Doctors will only receive the old rebate for everyone else. So they are likely to charge us an upfront fee, above the scheduled fee.

The Government is dealing with this shift to increased up front fees by providing two new safety nets. For concession card holders, the safety net cuts in after $300 in out of pocket expenses. Patients then get 80% of what they pay. For everyone else, the threshold is $700.

Safety net dangers

St Vincent de Paul Society and some other NGOs have opposed safety net changes. They talk about the danger of the safety net myth – it appears to give help, but does not . The $300 threshhold is really a gaping hole that the poor will fall through as they cannot afford to pay up front doctors fees. When we tried to discuss this at the Medicare inquiry in January, there was clearly a clash of world views, with certain government senators unable to grasp how a safety net could be unsafe.

There other problems with safety nets. Health care costs are concentrated on some individuals and families. So only some families have to pay the safety net amounts, but others do not. It is inequitable. Also, complex systems make it harder to access entitlements. The third problem is the interaction with other health related safety nets.

The first safety net – Medicare safety net. The second is the pharmaceutical safety net – the provision of subsidized medicines. Concession card holders pay small fee for their

medicines, and that fee is now covered by pensions. Everyone else pays up to $23.70* for each script, until they have paid $708 of the cost of their medicines each year. The cost is higher if the doctor does not prescribe the cheapest brand. So people can end up either $300, or $300 plus $726 (that is, $1026) or $700 plus $726 (that is, $1426). After that, people still pay a small fee for medicines and 20% of the doctors fee.

Pick a box – the doctor or the medicine or…

This is not a well researched scenario, but is intended to raise the basic issue. After paying rent and bills, you have only $30 left this week. One child is sick, the other needs money for a school excursion. Will you

- Take the child to the doctor, who charges an upfront fee, and hope that you don't need medicine, and keep the other child at home while the excursion is on.
- Go to the chemist and hope an over the counter medicine will work and you have money left over for the excursion
- Send the child on the excursion, and take your sick child to the emergency department of the hospital instead of the local GP
- Or go back to bed and hope the whole problem goes away?

Private health insurance rebate

We have already touched on the issue of the private health insurance rebate. We need to think carefully about the use of this money. At the recent Medicare Inquiry, UnitingCare took the view, as did many other community service organisations, that this money would be better spent direct on the public hospital system.

Dental health

Philosophers talk about mind-body dualism. In health policy, we have mouth-body dualism. Medicare has not covered dental care.

The Constitution, section 51(xxiii) makes Commonwealth responsible for medical and dental services. Some years ago the Commonwealth instituted a Commonwealth funded dental program when states were not providing adequate dental care. The Howard government axed it.

Senator Susan Knowles made the point at the Medicare inquiry that the commonwealth scheme was only ever intended as a temporary measure. That avoids the basic question about constitutional responsibility, and the absurdity of the mouth-body dualism in health policy. The poor cannot afford dental care. Why is the mouth not part of the body?

Medicare plus dental

Commonwealth, from March 2004 will pay up to $220 per annum for dental care for patients whose severe chronic health problems are aggravated by dental problems – maximum of 3 visits

Medicines

The PBS

Under the Pharmaceutical Benefits Scheme, medicines are subsidised by government if on PBS list. The scheme is highly cost efficient, affordable to most consumers and to the government. The PBS makes use of reference pricing: to get a higher price than current treatments, new treatments have to be demonstrably better. PBS also only pays the lowest price for a particular medicine, rather than paying brand premiums. The government makes use of its power as a bulk purchaser to get low prices.

USA-Australia Free Trade Agreement

The USA-Australia free trade agreement requires that the committee gives detailed reasons for rejecting application to include a drug in PBS. It also requires independent review of decisions if they are appealed. The FTA also sets up a medicines working group, which works on principles based on commercial interests, not the right to affordable medicine. The FTA also includes a provision for extending patents. Patents protect the intellectual property of the company that originally did the research to discover the medicine. Patents allow them to manufacture it exclusively for some years, or to charge licence fees to other companies to make it. This allows them to recoup research costs. After a time, the patent lapses, there is more competition and prices become cheaper. The decision to extend the life of patents means that it takes longer before patients have access to the cheap versions of medicines. Patents are really anti-free trade, and it is somewhat absurd that an fta includes extensions on patents.

Allied health care

Medicare is largely basedon a myth that health depends on doctors. Until this year, Medicare paid only doctors, and a small rebate for the work of nurses in medical practices. Until March 2004, did not pay allied professions, ie physiotherapists, psychologists, dieticians, or podiatrists Now pays for 3-5 treatments by allied professions for people with chronic illnesses. While this is a step forward, is it adequate?

Indigenous health

Indigenous ill-health

Australia's failure to respect the right to health of Indigenous people is well documented. Some of the indicators are:

- Life expectancy 20 years less
- Median age of death is 24 years less
- Death from diabetes - 8 times higher
- Death from Respiratory conditions - 4 times higher
- Infant mortality 2.5 times higher
- Indigenous ill-health cont.
- Chronic heart diseases - 3 times higher
- Chronic respiratory conditions - 9 times higher
- Chronic kidney disease – 9 times higher

- Low birth weight twice as likely
- Hospitalisation twice as likely

Documents

The reasons for Indigenous health problems, and what is needed to improve their health has been well documented, much of it as early as the 1930s. Some of the key documents are:

Analysis

Social justice commissioners' reports (HREOC)
Royal Commission into Aboriginal deaths in custody
AMA report card 2002, 2003

Campaign kit

ANTaR– Indigenous health rights

Social determinants

The documented social determinants of Indigenous ill-health include incarceration, unemployment, inadequate income, inadequate housing, poor infrastructure such as water and sewerage, inappropriate education, violence, and the failure of "practical reconciliation".

What is needed?

There have been a plethora of reports since 1930s. They all describe problems in areas such as:

- Water, sewerage, housing.
- Affordable healthy food
- Education and employment
- Control - respect for culture, tradition
- Reconciliation
- Native title, access to land
- Appropriate health care

Funding

Commonwealth spends less on Indigenous health than on other Australians. Indigenous people make less use of Medicare and PBS. They make more use of hospitals (state funded). Overall, Australia spends slightly more on each Indigenous Australian than others. Professor John Deeble, a health policy academic, has estimated that Australia needs to spend an extra $245 million per year on Indigenous health for equity.

Improving Indigenous health

- Increase funding
- Aboriginal community controlled health services
- Early intervention and prevention programs
- Increase health workforce

- Deal with social determinants: education, employment, housing, infrastructure
- Reconciliation

Other health issues

Health in a war torn land

The wars in Iraq and Afghanistan are a health hazard to the people there. They live with chaos, violence and lack of control. Many of them lack water, sanitation, food, jobs, education. Rebuilding is too slow. There is unexploded ordinance and depleted uranium dust. We need to take responsibility, to pay for rebuilding, and to pay reparations.

Rural Australia

The health workforce inadequate in many parts of rural and remote Australia. They experience lower levels of bulkbilling, and the MBS benefits paid per capita lower than in city – about $20 lower in rural compared to city, about $60 less in remote. People in rural and remote areas can expeience high levels of disadvantage. This suggests the differential reflects injustice.

Mental illness and Disability

I have not been able to look at these issues specifically.

Refugees

The health of many people who come here as refugees is at risk. Detention is a health hazard. Some people in the community on bridging visas and other arrangements have no permission to work, no access to income support, and no acess to free health care. One must ask, in Australian policy, do they have the right to live?

Australian policy in this area should be based on the recognition that human rights apply to all people by virtue of being human – whatever the label. This means the right to asylm when persecuted, the right to work, the right to income support and a decent standard of living if there is no work, the right to health, and the right to family life.

Election 2004

So what should we say in the lead up to the next election?

First we might remember the Australian constitution. Section 51 (xxiiiA.) says that the Commonwealth has responsibility for:

> The provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances.

But we should also remember that the health issues we have raised cover a wide range of portfolios such as:

- Health
- Indigenous affairs

- Housing
- Education, employment and training
- Environment
- Tax and Social security
- Immigration
- Foreign affairs, defence

A health oriented pre-election strategy might include advocacy for the following:

- National coordinated poverty reduction strategy
- Adequate funding for Indigenous health strategy
- Medicare as universal health insurance system, not tiered safety nets
- Improved bulkbilling
- Provision of community health centres with salaried doctors and allied health professionals
- Oppose USA-Australia FTA on medicines
- Rights for asylum seekers
- Non-violent mechanisms to preserve international security
- Oppose USA undermining international treaties such as ABM (star wars)
- Economic justice so terrorism is not supported as a legitimate expression of grievance (fair trade, aid, cancel debt)
- Environmental responsibility