# Finding directions for health policy

**A Discussion Paper**

**Ann Wansbrough**

5 November 2001

UnitingCare NSW.ACT
PO Box A 2178
Sydney South NSW 1235
Australia
Phone 02 8267 4276
Fax 02 9267 4842
Email bsr@nsw.uca.org.au
Website: nsw.uca.org.au/bsr

This paper has been authorised by the Board of UnitingCare NSW.ACT for distribution to stimulate discussion and feedback. The section "Proposed Principles – Health" was adopted as Interim Principles by the Board at its September meeting. An earlier draft was distributed in August and a number of suggestions have been incorporated into this paper as a result. A short version is also available.

## *Posing the dilemma*

In Australia we have an excellent medical and hospital system. Australia also does well on international comparisons of levels of population health. We provide a high level of care for people whether people have acute, chronic or terminal illness. But our system is under increasing pressure. We expect it to deliver more and more. We expect the most up to date treatments, and high technology treatments. There is often an assumption that a nation should meet all the demands put on the health care system, no matter what the costs. International statistics suggest that this is not appropriate. Once a certain level of expenditure is reached, increases do not always lead to improved health. the richest nation in the world, the nation that spends the highest proportion of its GDP on health care, the USA, has only mediocre population health, and has 40 million people without any health insurance (private or public). A number of nations with much lower expenditure on treatment have much better population health.

In media stories, we see symptoms of problems, most of which seem to call for more money to be spent - waiting lists for elective surgery, rationing of some types of operations, shortages of nurses and doctors in public hospitals, and so on. But will more money really solve the problem? Or is it time that we reconsidered what we mean by health, and what treatments are worth having at what stages of life?

Too often we assume that what is needed is more money. We certainly need an adequately funded health system. But we need to be very wary of the idea that more expensive treatments are always better, or that more treatment will improve situations. We need to consider : how much should Australia spend on its health care system?

This question is fraught with difficulty. The most basic danger is that once one starts questioning the concept of every sort of treatment being available at every stage of life, one introduces discrimination. That is a serious problem. But so is the situation where treatment becomes a means of avoiding the fact that human life involves vulnerability and death. We need to take seriously the fact that medicine is an inexact science, that can deliver only limited outcomes.[1]

In Australia, high proportions of the treatment budget are spent on the earliest years of life, the last years of life, and people with multiple and chronic conditions. The rest goes on the moderate needs of the rest of the population - children and adults who are more or less healthy most of the time, and need only relatively minor or moderately expensive treatments on a one-off basis. The problem is that in spite of general good health of the population, we are becoming greater consumers of treatment.

There seems to be an assumption that patients always benefit from more treatment or more expensive treatment, and that the health care budget needs to expand constantly to meet human need. This is not necessarily true. There comes a time in every life when the question has to be asked whether treatment offers improved life, damages life or prolongs dying. Is the treatment for the sake of the patient, or for the sake of the family, the doctor, or the corporations who provide the drugs, prostheses and so on?

Three examples.

1. Nurses have expressed concerns about whether medical intervention with very premature babies is in the best interest of the child, when those interventions involve enormous pain for the child. This has both short term and long term dimensions. Distress in early life can have life-long repercussions. Giving a premature baby an experience of extreme pain may be too high a price for life. But there are emotional pressures on parents, doctors and government to do "everything" to keep such babies alive. This is not solved simply by determining a minimum birth weight below which intervention will not take place. At some point it has to be recognised that not everything that is possible is necessarily worth doing.

2. The high level of intervention in the last hours, days, weeks and months of life of elderly people raises serious questions about our ability to accept death and to allow people to die naturally at the appropriate time. There are doctors who are reluctant to accept that very elderly patients may not want to be treated for some conditions or resuscitated if they die in the course of an operation. Whether an elderly person in the last months of life will benefit from a pacemaker, for example, is not as self evident as some doctors and families seem to assume. It must be understood as not only a question of the condition of their heart, but their whole body and their life situation. For one person it is a gift, for another a burden. Huge amounts of money are spent on the last few days of life of elderly people in acute bed hospitals , although such intervention does not stop the dying process.

3. People with disabilities sometimes benefit from more expensive assistance such as more sophisticated wheelchairs or prostheses, but not always. Many arm amputees, for example, find a simple formed hand more useful than a more complex, mechanised hand. Too many technical gadgets in an artificial leg can make it heavy and unwieldly for some amputees, so they walk less well rather than better.

Treatment is paid for in at least five ways - public finance, private health insurance, personal payment, accident insurance, workers' compensation. However, these are somewhat confused, as public finance also subsidises private health insurance, and business costs are passed on to consumers.

How should resources be allocated? The simplistic answer is that everyone should get everything that is humanly possible. This ignores a number of serious questions:

- What level of treatment are we entitled to, in a nation with our level of affluence? That is, what level of treatment is within our resources?
- What level of treatment is optimal - when does more treatment become counterproductive because of its increased burdens? When is treatment pointless, in that it does not contribute to improved health or better quality of life?
- How do we answer this question, when different people have different types of needs, some people have much greater needs than others, some people are much wealthier than others and people perceive their needs differently?
- What is fair and reasonable, and how do we determine what is fair and reasonable, given that Australia a pluralist society where we have different attitudes to life, we are discriminatory towards people with disability and Indigenous people, and we rarely talk about dying and death?

**For reflection**

You may wish to return to these questions having read the Discussion Paper.

## *Christian perspectives on life and death, health and illness*

### The value of human beings

1. Christians believe that **all human beings are created by God and are intrinsically valuable** – not valuable only because of their particular characteristics or what they do. **Life is a gift from God.** People are not valuable because they participate in the economy or society; people have intrinsic value and their lives are inherently valuable. Having a disability or an illness is certainly an inconvenience, sometimes a painful one, but it does not make one less human, or one's life less valuable. Whether or not people express this in theological terms, the attitude of most people about their own lives reflects this understanding. Provided people receive adequate treatment, care and support, most people prefer to live out the full length of their lives even when they have painful terminal illnesses or serious disabilities.

### Death as part of life

2. The Biblical tradition recognises that **death is part of life.** As Ecclesiastes 3 puts it, there is a time to live, and a time to die. It recognises Christ as a healer and as having the power to bring life out of death. There are healing powers within the people of God when they act in loving openness to people and to God. Christ, however, is not the one who abolishes physical death but rather the fear of death. Death is not the end – there is a spiritual dimension of life that is not destroyed by death. Eternal life is not about avoiding physical death. Indeed, in the early church, many Christians looked forward to death. Health is not about defeating death, but about wellbeing during life and an ability to face death when it comes.

3. Christians also believe that **physical death is not the end of life, and the fact that we will undergo physical death does not deprive life of meaning.** Death is always a time to mourn, but when death comes at the end of a long and full life

sadness is to be tempered with thanksgiving and celebration. Death is not, in itself, an enemy. Death is a transition, the last rite of passage, the last task of human life. The modern idea of squeezing every last day from a body that has reached its time to die is alien to the Christian tradition.

4. In some eras, Christians welcomed death. They perhaps fell into the trap of valuing life after death more than life itself (in theology, preaching and liturgy, if not in practice). In times when human life was short, with high mortality rates at all ages and a limited life expectancy, this was a means of offering assurance and hope to people for whom life was a fearful and unpredictable event. But for most Australians, life expectancy is now long. Most people reach more than the "threescore years and ten" that in biblical times were seen as a sign of God's blessing. Death comes, for most people, when it should, in old age and not before.

5. The fact of long life expectancy makes infant mortality and terminal illness among working age adults more difficult**.** Death is not the norm, at these ages, but something only a minority experience. On the one hand, it is right to seek ways of extending the life of those who face premature death. On the other hand, we need to recognise that death continues to be part of life.

6. If we assume that for most of us death comes at the end of a long life, then the short life expectancy of Indigenous people is especially worrying and raises serious questions for the nation. Illness and death still rob them of years of life they should expect as Australians.

**For reflection**
1. How do you think about death and dying? Does this influence what you want or don't want from the health system?
2. What do you want from the health care system in your last months, weeks, days and hours of life?

## Illness and pain

7. The Christian tradition describes the Reign of God in inclusive terms. **Illness and disability are not signs of God's judgement on the individual or their families.** (See, for example, John 9). Sometimes they are the product of biological processes, and sometimes products of the "structures of sin", the social injustices that deprive people of those resources that they need in order to live.

8. The Biblical tradition recognises t**he painfulness of human life and especially of human illness** (eg Psalm 22 and the book of Job). Indeed, Romans 8 talks about the whole of creation groaning as it waits for salvation. A lesser quantity of life need not mean that life is without purpose or meaning. When this is ignored, people may have unrealistic expectations of doctors and the health system – as if they are entitled to every possible treatment no matter what the cost of doing so.

**For reflection**
What is your reaction to pain, illness and disability? How do you relate your Christian faith to these experiences?

## Spirituality, health and healing

9. **Christians do not see spiritual healing as an alternative to health services**.

Rather, Christ's acts of healing point to the appropriateness of human services that offer healing and ensure that physical, mental and emotions problems do not cut people off from the life of their family and community. Christ's acts of healing also point to the spiritual dimension of healing; true healing is never a mere physical action.

10. Christians understand spirituality as a crucial dimension to human life. Human beings exist for relationship with God, and with one another. "Abundant life" is life that involves God. It is difficult to talk about the connection between spirituality and health. The Bible recognises that life is highly ambiguous. Some people who defy God and deliberately embrace evil live long lives. Some people who are open to God and seek to live rightly and justly may be plagued by illness and injury, or live a shorter than normal lifespan. Openness to God is not a guarantee of health. That is, **spirituality does not wipe out problems of physical, emotional and mental health.** However, it is the testimony of many people, from Biblical times onwards, that **the spiritual dimension of life makes a fundamental difference to their health and the way they experience and handle the problems of physical, emotional and mental health.** One's spiritual life can affect the way one experiences and deals with injury, illness, and disability in oneself, one's children or others.

11. **The stories of healing in the Bible make it clear that it is God's will for human beings to enjoy a high quality of life**. This is not merely about healing physical disease or mental illness, but about people being part of community. The man born blind is not only given sight. He becomes part of the community of faith. The woman with a haemorrhage is once again able to take her place in the community. Lepers are restored both to the community of faith, and to society. While it may well be true that some Christians today have a spiritual gift of healing that performs miracles, the fact is that most Christians, most of the time, like the rest of society, rely on more mundane means of health and treatment.

12. The Methodist Church in England, in its publication *Limited Resources: Unlimited Demand* make the point that "Wholeness is possible, even in the presence of illness or infirmity…Such a state of wholeness is something which many people without any physical or mental illness lack." (page 9).

**For reflection**

1. What influence does your faith have on your health?
2. What is your understanding of the stories of healing in the Bible?

## The quest for long, healthy life

13. **There is no simple way of dealing theologically with issues of health and ill-health.** Christ's acts of healing clearly indicate that where healing is possible, it is God's will that people be healed. What that means varies from age to age and culture to culture, depending on a wide range of factors and issues. Once the idea of "threescore years and ten" was an ideal. Now that age is less than the life expectancy of Australians and most people in industrialised nations. It is more like a benchmark for measuring "premature death". However, the industrialised nations support their long lives with a level of consumption and resource use that cannot be sustained for the world as a whole. The question becomes whether we demand too much of life, and whether people in other parts of the world (and Indigenous people in Australia) pay the price for our long lives.

**For reflection**

1 What can we reasonably and responsibly expect of our health services, and when do our demands become unjust?
2 See section 14.

14. This leads to the question of whether the technologists have usurped God's role in determining the length of life and the time at which we die. Are there limits to what we should expect in the way of medical treatment? What values drive the medical agenda for research, development of new technology (including new drugs) and service delivery? Is it always appropriate to assume that medical intervention is about "healing"? How can we go about answering this set of questions?

## Being human and the nature of health

15. Christians understand **human beings in a holistic way**. Human beings are body, mind, emotions and spirit. Human beings are created for community, not to live in isolation. Health is about wellbeing in each of these aspects of their lives. However, it is possible and necessary to explore the various implications of these different dimensions of being human.

16. **Our bodies are biological organisms. They depend on the operation of human society for food, housing, sanitation, clothing, access to heating and cooling when necessary, and so on.** Unborn babies, infants and children depend on families to meet their physical needs. Human health depends therefore on adequate wages and income support and on effective public policies regarding housing, physical infrastructure such as water and energy supplies and appropriate processes for dealing with sewerage and garbage. That is, health depends on social and economic systems, and on the public policy that provides and maintains these. Issues such as welfare reform, workplace relations changes and the level of unemployment have significant implications for health. Appropriate policies can reduce, and inappropriate policies can create enormous health costs.

17. **Human bodies include mouths and teeth.** Dental (oral health) services are as important as any other health services, yet are not included in Medicare or integrated into health policy. People who cannot afford private dental services are severely disadvantaged with regard to oral health in most parts of Australia. This can harm their general health.

18. **As bodies, human beings are part of and dependent upon the web of life and the physical environment around us.** We depend on a vast array of organisms. While only some plants produce food, all plants contribute to the oxygen supply that allows us to make use of the food we eat. Plants, animals, and other organisms (such as fungi, bacteria, and even viruses) are part of the cyclic process of life and death, growth and decay, by which the health of the biosphere is maintained. Biological organisms are essential to the health of the soil in which we grow our food, and contribute to the breakdown of human waste. Health depends on environmental responsibility, not only by individuals, but also by corporations and nations. Health depends on public policy requiring that development be ecologically sustainable.

19. **Human bodies function less well when people's minds, emotions and spirit are ignored, stressed or abused**. It is crucial that human bodies receive

effective treatment for injury, disease and other forms of physical illness. But such treatment needs to take account of the whole nature of human beings and the context that contributes to both the genesis and continuation of ill-health. Health policy, to effectively address disease, must recognise all the dimensions of life that influence bodily function.

20. **The health of human beings as minds and emotions depends on many factors, especially education and social networks.** Human well-being requires that people feel a sense of identity, dignity and worth. It requires that people are part of families whose members are capable of relating to one another. It requires a strong civil society in which people are able to participate and contribute to their local community and their nation. It requires education that enables children to acquire the basic knowledge essential to controlling their lives, participating in social, economic, cultural and political life, and developing their creativity and capacity to think and communicate. Human well-being requires that people have emotional and social support when they go through crises, bereavement and trauma. Health policy, to minimise ill-health, must be coupled with policies that support family life (in the ways outlined in the NSW Synod family ministry policy), and that promote and invest in education, culture and civil society. .

21. The health of human beings as minds and emotions sometimes depends also on their receiving counselling for traumatic events and treatment for mental illness. **Health policy, to effectively address mental illness, must recognise both the biological and the social factors that contribute to ill-health.**

22. **Human beings are spiritual beings**. In every culture and every age, people have felt the need for spirituality. Religions vary greatly in the stories they tell about God and their "comprehensive theories" about human beings and their relationship to one another, the world around them, and the spiritual dimensions of existence. But all major religions recognise that human beings need openness to some sense of the transcendent. That is, they agree that there is more to life than is provided for by modern secular society with its emphasis on individualism, materialism, consumerism and scientific reductionism. They all recognise that reducing human beings to biological organisms is not enough. Human health requires that we recognise that there is more to life than we can see, taste, hear, touch, smell or measure. Knowledge requires intuition and creativity as well as research and logic.

23. The above comments suggest that **human beings need a holistic approach to health**, **and to treatment**. Within health system itself there is much discussion of "holistic care" and the need to see people as whole human beings. However, payment to hospitals on the basis of "diagnostic related groups", that is, payment for procedures done, without regard to the particular needs of individual patients. This means that the focus is on giving the least amount of staff time while still achieving clinical outcomes. There is need to develop a viable alternative to the "factory health care" approach.

**For reflection**

1. In your experience, how well does the "health system" deal with the various facets of who you are as a person? (You may think about your local GP, specialists, hospitals, nurses, physiotherapists and so on).
2. What influences your health or ill-health?
3. In your opinion, does health policy pay enough attention to the aspects of life that affect health?

## Christian perspectives on public policy and the provision of health services

24. An important role of the church and other community agencies is to offer **alternative discourse**. This looks at policy not from the viewpoint of those in power, but of those without power, those whose voice is not adequately heard by government. In the context of health policy, it means that the issues need to be addressed from the viewpoint of those who need treatment or whose health is at risk, rather than from the viewpoint of doctors. In particular, it means that policy must be rigorously evaluated for its impact on people who are poor, disadvantaged and marginalised. This is the **prophetic role of the church as the representative of the God who takes the side of the poor against those in power.** This section therefore offers an outline of those aspects of the Christian tradition that differ from the assumptions that underlie much of the contemporary discussion of health policy and other relevant areas of public policy.

25. **The Uniting Church in Australia has expressed its world view in number of documents**, such as the *Basis of Union*, the *Statement to the Nation 1977, Statement to the Nation 1988*, and *Invitation to the Nation* 1997. They can also be found in other documentation published by the church, such as the 1985 Assembly *statement on poor people and the gospel* , 1988 Assembly report *Economic Justice – the equitable distribution of genuine wealth* and the 1994 Assembly resolution on unemployment. The NSW Synod 1988 resolution on social justice and *Family Ministry Policy* 1997 also articulate relevant principles. These statements are developed by bringing the historic biblical and theological tradition of Christianity into dialogue with contemporary questions and issues.

26. Christians have a **vision of the Reign of God** (Kingdom of God) in which all humankind are in community, all feel equally included, all are respected, all are equally valued, all are equally able to participate, and all equally enjoy the fruits of their labours. We talk about this as eschatology, as part of the "**end things" or the "end time", ie the eschaton,** because it is a vision which only God can bring about. It is a future hope, not to be confused with any present political, social or economic agenda. However, God also invites humankind to work with God towards that end, by letting that vision shape the way we live now as individuals, as local communities and as a nation.

27. **Christians have a sense of justice. But what does justice mean in the allocation of health resources?** Does it mean allocation on the basis of need, to the extent that there is no limit on what we offer the most premature babies, the most badly injured, the most chronically ill or the oldest members of our community? Or does it mean that everyone gets a "fair share" as if there were a voucher system – we all have the entitlement to a particular dollar value of health care no matter what our individual need, and if we don't use it early in life we can use it late in life? Or does it mean that we all have access to the same types of health care and treatment, and the same support services, on the basis of need, so that if we need them, we get them, and if we don't, we should be grateful we are healthy rather than resentful that we have missed out on a using a public resource? In Oregon, USA, for example, people indicated by referendum what services they wanted funded. The problem is that such a system may disadvantage the minority who have greater needs. What seems extraordinary when one is young and healthy may seem reasonable when one is sick, injured or has a seriously ill child or aged parent. How do we decide what is

"extraordinary" care?

28. Christians recognise both the **goodness and the sinfulness of humankind.** All human beings are sinners, and **all are capable of loving God and their neighbour**. We all sin, both as individuals, and through our social and economic arrangements – the "**structures of sin**". (This term refers to the fact that the harm caused by society through its structures is more than, and sometimes different from, the harm caused by individuals.) We are all God's children, and so we are all capable of doing good, of being responsible, and of contributing to the lives of others. Most Australians recognise that health care is a human right and support Medicare as a universal, comprehensive system of health care. This is in spite of attempts of some parts of the medical profession, and some governments, to undermine this approach. It is an expression of human sinfulness to want the best possible medical treatment to be available for oneself, but not to be willing to pay the cost of ensuring that everyone has access to that same level of care. Money and effort spent on driving people into private health insurance that they do not want would be more appropriately, more ethically, spent on directly improving the public health care system.

29. **All human beings live by the grace of God**. There are no deserving and undeserving poor, or rich. Human beings are all sinners, dependent on God's grace for their right to live. We cannot and do not earn our right to live. People with disabilities, for example, raise serious questions about society's assumptions as to what constitutes a "healthy" child. They question the assumption that a child with a diagnosable physical or intellectual disability is less worthy of life than other children. Value does not depend on age – the frail aged are also valuable. **How do we responsibly relate this sense of grace and intrinsic human value to the question of our entitlement to resources of health care?**

30. Because this earth comes from God, and because all human beings are equally valuable, **everyone has the right to the basic necessities of life.** In the Bible, this concept is expressed in many laws, such as the right to glean in the field, and the prohibition on creditors taking away someone's millstone or keeping the cloak of the poor at night. These laws show that the basic right to the necessities of life takes precedence over others' right to private property. The international human rights instruments rightly recognise that people have a right to live as a family and a right to housing, paid employment, fair wages and conditions for employment, education, and health care. Neglect or violation of these rights is a significant contributor to illness and disease. But all those rights are about access to a level of services commensurate with the resources of the nation. They do not assume access without limit.

31. Having wealth, success and power is not a sign of moral worth, and being poor or disadvantaged or sick or disabled is not a sign of lack of moral worth. **The innocent often suffer**, and the unrighteous often prosper in this life. A person's illness does not mean that they are less morally responsible than other people. In some cases, ill health is the direct result of injustice, exploitation or human rights violations. The solution to innocent suffering is to deal with the causes, and to place the responsibility on those who have caused the innocent to suffer. Improving the health of disadvantaged groups often requires social change as much as it requires health services for individuals.

32. **Community** is about **interdependence**. It involves reciprocal relationships which are based on **respect and equality of power.** Provision of a universal health care system, accessible to all on the basis of need, and paid for by everyone on

the basis of capacity to pay (ie income and assets), is an expression of interdependence and the proper, ethical sense of “mutual obligation”. A two tier system which offers one standard of medical treatment to the rich, and a different standard to the poor, is not.

33. **A great deal of human ill-health is caused by human beings and is preventable** by appropriate actions such as better delivery of essential services, and better education about and enforcement of regulations and laws (eg occupational health and safety, road safety). The short life span of Indigenous Australians is a result of the sinful structures of society – structures that can be changed. Disabilities and ill-health that result from traffic or work accidents are also often the result of the structures of sin, which create avoidable hazards.

34. **Human beings also have moral autonomy**. We are moral agents who have some level of control over our lives. While some aspects of health depend on society, other aspects are within the control of individuals. It is not only stupid to neglect or damage one’s own body or emotional health by one’s life style, but also unreasonable to expect the health system to solve all the problems people create for themselves. This creates at least two problems for thinking about health policy. First, how do we distinguish between what is the legitimate responsibility of the individual , what is the responsibility of society and what is a genuine medical condition? Obesity is an example of a condition where this dilemma occurs. Obesity reflects different problems for the poor and the rich. The poor cannot afford a good diet. The rich may spend too much on food. Some people are more prone to obesity than others, whatever they do. Sometimes obesity reflects other health problems such as stress. Second, if something is at least partially under the control of the individual (eg smoking, drinking, obesity), what are the appropriate implications of this for health policy and health funding? Some writers suggest, for example, that in terms of human rights it is appropriate to provide disincentives to smoking, alcohol and use of other drugs, but inappropriate to penalise people at the point where they need medical treatment. At the very least, the implications of moral autonomy are that

    (a) part of health policy should be health education that enables people to work out how, within their resources and circumstances, they can look after their health and avoid health problems, and encourages them to do this and

    (b) patients should consider the appropriateness of proposed treatments - will the benefit be worth the cost?

35. **Governments have an important and positive role to play in human life, but governments are also part of the structures of sin (as is the church itself as a human institution)**. That is why human rights are so important. It is why governments need to be very careful of paternalistic and coercive policies. It is intrinsic to the role of being in government that one has power, and is “successful”. Governments need therefore to be wary of their use of power over those who have little or no political or economic power, and who are marginalised and disadvantaged. We understand that a nation will only function well when it is based on both **human rights**. Everyone has a responsibility to respect those human rights. The international human rights instruments are not perfect, but they are closest thing the world has to natural law, ie an understanding that is common to people regardless of nation, race, culture or religion. Human rights are the minimum standards a nation is entitled to expect of its government.

36. **An Uniting Church policy on health cannot be about Australia alone**. Globalisation means that the way one nation acts affects many others. To be faithful to its commitments to human rights, development, partner churches in other nations and ecumenical links around the world, the Uniting Church must set health policy for Australia in a global context and take account of the most crucial ways in which international relationships enhance or damage health of the poorest people and poorest nations in the world.

The theology outlined above helped shape the principles outlined towards the end of this paper – the understanding of health, of death and dying, the identification of groups who experience violation of their human right to health and advocacy on their behalf, and the principles of the health care system.

**For reflection**

1. What are some of the government policies that might damage people's health?
2. What are some of the ways the church or the local community might contribute to people's good health?
3. What more could be done to prevent ill-health?
4. What are the most important forms of health care that everyone should have access to?
5. If Australia can only afford some sorts of treatment, what types of treatment should have priority?

The theology outlined above helped shape the principles outlined towards the end of this paper – the understanding of health, of death and dying, the identification of groups who experience violation of their human right to health and advocacy on their behalf, and the principles of the health care system.

## *Issues facing health policy in Australia*

It will already be clear that we need to face some questions about the way health policy and treatments are developing. We need to reconsider our uses of technology and our assumptions about what it can deliver. Have we lost the plot? We need a first rate health system, but what is a first rate health system? Can a health system function effectively in isolation, or do other systems also matter? Are we turning to technology to avoid facing the human issues of life and death? Given the limits of the world's resources, what level of health care are we entitled to and what responsibility do we have for the health of others?

Health policy cannot begin with treatment policy or health industry policy. It needs to go back to fundamental concerns.

### 1 Indigenous health

The health statistics show that the health of Indigenous Australians is far below that of the general population. Their life expectancy is about 18 years less. Whereas the health of Indigenous peoples in the USA, Canada and New Zealand has improved in the last 20 years, this has not been the case in Australia. Infant mortality is higher than for other Australians, as is the incidence of preventable ear and eye infections and resultant deafness and blindness. Much of the work of Fred Hollows would have been unnecessary if Aboriginal Australians in remote communities had had access to clean water.

In 2000-2001, we have the situation where the federal Minister for Health will support nearly $2 billion a year for subsidies for health insurance to pay for treatments, but is on record as saying the government cannot afford to pay $3 billion to bring infrastructure up to scratch for Indigenous communities. (See the Discussion Paper from the House of Representatives Standing Committee on Family and Community Affairs inquiry into Indigenous Health, 1999). Yet there is a pile of reports, dating back to 1932 if not further back, that say that the most important thing to do to improve Indigenous health is provide infrastructure, such as reliable reticulated water. (See Aboriginal and Torres Strait Islander Social Justice Commissioner *Second Report 1994* Human Rights and Equal Opportunity Commission/AGPS Sydney). Those reports also draw attention to the importance of land rights, recognition of Indigenous culture, appropriate education, enjoyment of human rights, and reconciliation. Yet there is still a struggle in Australia about these matters.

*Principle 6 summarises some of the essential directions that have been recognised in a number of reports on Indigenous health.*

## 2 Universal health care or a two-tiered system

A second concern is the attacks being made on Medicare as a universal system of health care – the increasing pressure to rely on private health insurance and private hospitals. This is both a trend within Australia, and a trend being encouraged through the World Trade Organisation. Australia has always had a “mixed” health care system, that is a system which includes both private and public health care provision. Recently, there has been a shift in the balance so that more hospital care is now provided through private, for profit, hospitals, with government subsiding private health insurance to make this possible.

As Christians we need to question the view that care is a commodity to be sold like any other commodity and care is a legitimate source of profit for shareholders.

This needs to be considered in relation to health care, child care, aged care and care of people with disabilities. From a Christian viewpoint, care is an expression of community and compassion. It is not a tradeable commodity. Care is about serving the agenda of the person being cared for. Once one serves other agenda, such as corporate strategic plans and shareholders profits, one is no longer offering care.

We also need to question whether diversion of money to subsidise health insurance is the best value for money, or whether the $2 billion or more per year would be better spend directly on public hospitals.

*Principle 9 affirms the principles on which Medicare is based.*

## 3 Social policy and health

The third main concern is the way some directions of change in public policy are undermining the very basis of health. In the first instance, health does not depend on medical or surgical treatment. The biggest gains in health have been made through:

- peace – the absence of war, the control of violence within societies, action against domestic violence
- water, sewerage and drainage infrastructure (important in eliminating diseases such as typhoid, typhus, cholera, and hepatitis)

- town planning eg ensures adequate standards of housing and separation of housing from incompatible activities
- infrastructure such as transport, communications etc
- living wages and income support that allow families to provide themselves with adequate food, clothes, heating and shelter
- education
- affordable food, housing, and utilities (energy, water)
- respect for human rights, and development of democracy and civil society (It is no mere coincidence that the Australians whose human rights are most ignored and violated, Indigenous Australians, are those who have the worst health status in Australia)
- public health programs (immunisation, or screening and treatment) to get rid of communicable diseases such as measles, mumps, whooping cough, diphtheria, polio, TB and small pox)
- public health programs to encourage healthy behaviour and discourage unhealthy behaviour – high excise and other taxes on tobacco and alcohol, education programs about drugs and alcohol, encouraging exercise, healthy diet, reduced fat intake etc.
- occupational health and safety, and legislated limits on matters such as the number of hours of work

Baum[2] suggests that respect for culture is also important in health, a view supported by numerous reports on Aboriginal and Torres Strait Islander issues in Australia. All of these advances are under threat in the trend to globalised markets and to market based Australian society. At the same time, we have experienced degradation of the environment, and increasing illness due to chemical pollution of soil and air and new hazards such as electromagnetic radiation. For example, the incidence of various respiratory illnesses is highest in the western suburbs of Sydney, where air pollution is highest.

The World Health Organisation is helpful here. The WHO defines a healthy city as one which

- has a clean safe physical environment
- meets the basic needs of all its inhabitants
- has a strong, mutually supportive, non-exploitative community
- involves the community in local government
- offers inhabitants access to a wide variety of experiences, interactions, and communication
- promotes and celebrates its historical and cultural heritage
- provides easily accessible health services

- has a diverse, innovative economy
- rests on a sustainable ecosystem

WHO 1996 *Creating healthy cities in the 21st Century* Geneva: World Health Organisation, page 15

*Principle 4 affirms the role that good social policy, investment in infrastructure, and the environment play in ensuring the health of the population*

## 4 Health as a human right

At this point it is worth noting that the international human rights covenants talk about the right to health, not merely about the right to treatment. The International Covenant On Economic, Social And Cultural Rights says in "Article 12"

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

   (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

   (b) The improvement of all aspects of environmental and industrial hygiene;

   (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

   (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

This must be read alongside Article 2.2, which says that

> ..the rights enunciated in the present covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

*Principle 3 notes the health is an internationally recognised human right.*

There are a number of benchmarks that follow from this principle.

*General benchmarks related to the human right to health*

- High life expectancy
- High disability free life expectancy
- Low potential years of life lost
- Low levels of preventable diseases
- Low levels of suicide
- Low levels of violence

- Low level of illicit drug use, and low level of mortality from illicit drugs
- Low levels of road, industrial and domestic accidents
- Effective treatment of injuries and curable diseases
- Quality palliative care for people with incurable illness
- Care and support for people with special needs – the very young, the frail aged, and people with physical, mental or emotional disabilities
- Low levels of mental illness, such as depression, bipolar disorder and schizophrenia.

Provision for the reduction of stillbirth-rate and of infant mortality, and for the healthy development of the child (article 12.2 (a) would imply the following benchmarks (based on international comparisons with other OECD nations)

*Appropriate indicators for part 2 (a) of Article 12, the human right to health*

Indicators that show that Australians are enjoying this part of the human right to health would include

- Maternal death rate (low)
- Infant death rate (low) (Low for Australia but higher for Indigenous mothers in all states, very high in SA and NT)
- Low proportion of low birthweight babies for all groups in the population (eg While there is generally a low proportion of low birthweight babies in Australia, a high proportion of Indigenous babies have low birthweight).
- Low levels of SIDS (Sudden Infant Death Syndrome)
- Low levels of congenital malformations -also (b) below.

Healthy development of the child implies such things as:

- Low level of incidence of infectious diseases among children
- Low level of injury due to accidents among children
- Low levels of child neglect, child abuse and child sexual abuse – ie effective intervention programs to reduce these problems
- Children with disability complete schooling with same achievements as rest of population

- People with disability match rest of population on indicators such as effective transition from school to work.

(In 1996, 43% of deaths among children 1-14 years of age were from accidents, poisoning and violence – Australian Institute for Health and Welfare 1998)

*Indicators related to Article 12, 2 (b)" Improvement of all aspects of environmental and industrial hygiene".*

Indicators here would include:

- Low levels of diseases caused by environmental factors eg respiratory disorders => effective control of hazard wastes; air, water and soil pollution; radiation.
- Low levels of industrial accidents (High standards of Occupational Health and Safety)
- Low levels of congenital malformations - also (a)

*Indicators related to Article 12, Part 2 ( c) "Prevention and control of epidemic, endemic, occupational and other diseases"*

Indicators here would include:

- Effective public health programs to prevent and control epidemic, endemic, occupational and other preventable diseases
- Infectious diseases eliminated or effectively controlled to reduce incidence to zero or close to zero (there are a number of diseases which no longer occur in Australia; ie they have been eliminated as health threats in Australia although they still occur in other parts of the world)
- Effective quarantine mechanisms
- High levels of immunisation
- Low levels of ill-health caused by occupational diseases, which implies high standards of OHS, which implies effective regulation and training, and good government, business, union and worker cooperation on OHS issues.
- Low levels of incidence of preventable forms of diseases such as cardio-vascular diseases, diabetes, respiratory illnesses, cancers – eg low levels of obesity, smoking, alcohol abuse – good quality infrastructure (water, sewage, housing, fuel for all), good diet (education, income) – minimal levels of skin cancer
- Effective programs to prevent drug and other addictions
- There is already data for most of these.
- Effective, accessible programs to help people recover from obesity, drug abuse, gambling addiction etc
- Low levels of dental caries and other oral hygiene problems.

Many of these are already established "indicators", for which the data is collected and published. On most of them, Australia does very well by international standards, and much better than the USA, which spends a much higher percentage of GDP on medical and hospital treatment. See Australian Institute of Health and Welfare *Australia's health 1998* Canberra: AIWH, and Michael de Looper and Kuldeep Bhatia *International Health: how Australia compares* Canberra: Australian Institute of Health and Welfare 1998 for reports of the indicators. Colin Mathers "Well-being and quality of life" in Richard Eckersley *Measuring progress* Collingwood: CSIRO Publishing 1998 explains the significance of various types of health indicators. Some are not yet published as health indicators. The data on helping people with obesity, drug abuse, gambling addiction etc is less comprehensive, but it seems fairly clear that there is need for more services to deal with these problems.

## 5 Mental health and mental illness

The material in this section is taken directly from the Human Rights and Equal Opportunity Commission website.

*The Report of the National Inquiry into the Human Rights of People with Mental Illness was tabled in Parliament and publicly released on 20 October, 1993*

*The Inquiry played an important role in raising awareness about the human rights of Australians affected by mental illness. The Inquiry highlighted the extent of mental illness in the community and the need for more concerted government action in this area.*

*Findings of the Inquiry included:*

*People affected by mental illness are among the most vulnerable and disadvantaged in our community. They suffer from widespread systemic discrimination and are consistently denied the rights and services to which they are entitled.*

*Individuals with special needs - children and adolescents, the elderly, the homeless, women, Aboriginal and Torres Strait Islander people, people from non-English speaking backgrounds, those with dual or multiple disabilities, people in rural and isolated areas and prisoners - bear the burden of double disadvantage and seriously inadequate specialist services.*

*The level of ignorance and discrimination still associated with mental illness and psychiatric disability in the 1990s is unacceptable and must be addressed.*

*In general, the savings resulting from de-institutionalisation have not been redirected to mental health services in the community. These remain seriously underfunded, as do the non-government services which struggle to support the mentally ill and their carers. While the movement towards mainstreaming mental health services may alleviate the stigma associated with psychiatric care, there is a serious risk it will not receive the resources it so desperately needs.*

*Poor inter-sectoral links, the ambivalent stance of the private sector and a reluctance on the part of government agencies to cooperate in the delivery of services to people with mental illness have contributed significantly to the human rights violations they experience.*

*The recommendations of the Inquiry covered a wide range of areas including in-patient and community treatment and care of people affected by mental illness, the rights of carers, the special needs of particularly disadvantaged groups, accommodation, employment, professional training and education, community education, research, prevention and early intervention, and the reform of mental health and related legislation.*

*The recommendations have helped bring about major improvements in laws, policies, programs and funding to meet the needs of Australians affected by mental illness. However, many of our mentally ill and their carers have not yet felt the full benefit of these reforms. In particular, many people with mental illness are still homeless and many more still live in sub-standard accommodation. Many do not receive the medical care to which they are entitled. Much work remains to be done to fully implement the recommendations of the inquiry and ensure respect for the rights of those affected by mental illness.*

There is a national mental health strategy, but these problems persist. See principle 7

## 6 Rural health

The Human Rights and Equal Opportunity Commission summarises the situation regarding rural health as follows (see the Rural Health Project at http://www.hreoc.gov.au/human_rights/rural_health/

> *The State of Rural Health*
>
> *Many country towns are witnessing cutbacks and are finding it difficult to attract health professionals. This is troubling considering that the health of rural and remote Australians continues to be significantly wors*e than their urban counterparts
>
> *The health of populations living in rural and remote areas of Australia is worse than of those living in capital cities and other metropolitan areas. Mortality and illness levels increase as the distance from metropolitan centres increases. Relatively poor access to health services, lower socioeconomic status and employment levels, exposure to comparatively harsher environments and occupational hazards contribute to and may explain most of these inequalities. Also, a large proportion of the population in the more remote parts of Australia are Aboriginal and Torres Strait Islander peoples, who generally have poorer health status (Australian Institute of Health and Welfare, Australia's Health 2000, 2000, page 223).*

Bush Talks – a HREOC inquiry into the situation of rural people has identified a number of issues including:

- Inadequate, inaccessible and diminishing health services
- Children having to leave rural towns to complete their education
- Rural communities feeling under siege –declining populations, declining incomes, declining services and a declining quality of life
- Lack of opportunities for young people
- Intolerance in rural towns and disadvantage for people who are young, gay or lesbian, or Aboriginal

The Uniting Church material for Social Justice Sunday in 2000 was *Hear the pain; celebrate the gifts; stand together in hope*. It focused on the life, struggles and justice issues affecting rural and remote communities, and included the statement adopted by the Assembly in 2000. Most of these issues in some way affect health – the health of individuals, and the health of towns. In addition to the issues mentioned above, the church identified issues related to

- Employment
- Globalisation
- Powerlessness for some primary producers in dealing with large corporations

- A desire to shape their own futures

## 7 Who drives the health agenda?

The way resources are allocated for health depends on who is driving the debate. Many writers argue that health policy in Australia is currently driven by people with particular interests that distort policy. These people have a legitimate interest, but their special interest may prevent them from seeing the whole picture. Their information and ideas are important, but not sufficient. In some cases, their personal interest will be in conflict with the public interest. These people include:

- "Health professionals", people concerned mainly with delivering treatment once there is illness or injury, rather than people concerned about health.
- Bureaucrats who are responsible for delivering treatment, not for the health of the nation in its wider sense
- Biomedical and pharmaceutical companies which develop and market drugs and technology to make a profit
- Health insurance organisations
- People driven by political agenda and ideology, especially the concepts of private enterprise, personal provision, and user pays.

When the debate is driven by these groups, there are at least two main problems. The first problem is that those driving the debate tend to be those who deliver services, rather than the "consumers", the patients and the general population who are all affected by health policy. The second problem follows from this : in the public policy debate, the title "health policy" is largely a misnomer – on the whole, it is about the treatment industry and how to fund it. A genuine "health policy" would be something quite different, and much more broadly based, than the current treatment policy.

In the last few years there have been some moves to involve consumers in decisions about health policy. For example, the New South Wales Council of Social Service has held some workshops to develop consumer input into health policy discussions.

## 8 What can health care reasonably offer?

People have become unrealistic about what treatment can offer. They often have the false impression that doctors can and should fix anything and everything that goes wrong with us. It has been said that today, people trust in surgeons rather than God – churches are becoming smaller, but hospitals are becoming larger. People go to their doctor, instead of minister, in times of trouble.

Australia seems to do relatively little to encourage people to take responsibility for their own health. As a population we don't exercise enough, we eat badly (in spite of access to excellent food), we drink too much, and so on. We rely on doctors to fix us up. People seem to take for granted that they should have access to any form of treatment they need, regardless of how expensive it is and regardless of how they acquired there condition.

Again, this is a dangerous thing to say – because we can fall into the trap of blaming people for their illness. We need to be encouraging awareness and prevention, not

blame. It is about encouraging a realistic approach to health, instead of seeing treatment as a magical fix.

It is also a dangerous point because many people are affected by circumstances beyond their control. For example, poor people find it much harder to have a healthy diet. Many occupations seem to involve long working hours and high levels of stress. However, this only reinforces the point – it is inappropriate to expect medical treatment to be a solution to these social issues.

It is right and appropriate that doctors who are careless or negligent be held accountable through the courts and disciplinary tribunals. However, some of the increase in people suing doctors reflects unrealistic expectations about what doctors can do and a denial of the risks inherent in life.

## 9 What does health care cost?

Patients have very little awareness of what their treatment actually costs. This is not to agree with the economists who think user-pays and co-payments are better than bulkbilling. For families on low income, bulk billing is about access and equity. It is about getting treatment when it is needed, rather than postponing treatment because one is scared of the costs.

But most of us have no idea at all of the cost of any of the procedures we have done, or the prescribed drugs we take. We do what our doctor advises us to do, with little thought of the cost. We tend to assume that every cost incurred is appropriate. Treatment has ceased to be an area where we act as moral agents, making moral choices about what is and is not appropriate. It is assumed that if a treatment is available, it should be used.

Because the resources available for treatment are finite, moral choices are being made somewhere, by some people – doctors, public servants, area health boards. Someone decides who gets what. But the moral choices have become hidden, partly because of the way power is used, and partly because asking the questions creates problems – we all want this illusion that all treatment is available to everyone all the time. And also because the talk-back radio people can turn such questions into an emotional furnace and political nightmare. It is easier to pretend that choices are not being made.

Stephen Leeder (Professor of Public Health and Community Medicine, and Dean of Medicine at the University of Sydney) suggests that it would be helpful if Australians were at least more aware of the overall cost of health care. At the moment the Medicare Levy covers only a small part of the cost, with the rest paid for from consolidated revenue. The Medicare Levy should be set at an amount that more accurately reflects the cost of health care. (This could be done either by increasing the levy while leaving other taxes the same – an increase in overall taxation – or by increasing the levy but decreasing general income tax – the proposal is about labels, not changes in revenue, which is a separate issue).

Alternatively, perhaps we should at least be told the full costs of tests and treatment we receive.

## 10 Population health

The media debate on health seems to largely about inputs –doctors, nurses, drugs, surgical procedures, etc, and the money to pay for them, or outputs – number of

operations, patients seen, drugs dispensed, length of waiting lists etc - and very little about outcomes – the state of health of the population. If we go back to the human rights covenants, they talk about the right to health – the right to be well. In Christian terms, the right to shalom. Health policy seems to have become focused on the means, and not even the primary means, rather than the end.

### 11 How much should Australia spend on health care?

As this paper has already pointed out, it is not necessarily true that greater spending on treatment is the path to health. As international comparisons show, any particular level of expenditure can lead to a wide range of outcomes, depending on circumstances and spending priorities. In the light of the other issues that have been raised, this should not seem surprising.[3]

## *Health and international issues*

The health of children around the world has recently been evaluated for the United Nations Special Session on Children (19-21 September 2001). Their situation highlights health as a global issue, and the international problems that lead to disability, illness and premature death. Among the statistics:

- Over 10 million children still die each year, often from readily preventable causes;
- An estimated 150 million suffer from malnutrition;
- Over 100 million children are still not in school, and 60 per cent of them are girls;
- Conflicts killed 2 million children in the past decade and left many other millions disabled and psychologically traumatised;
- Over 10,000 children are killed or maimed by mines every year;
- Of some 35 million internally displaced persons and refugees worldwide, about 80 per cent are children and women;
- Children are also the victims of abuse, neglect and exploitation in rising numbers. For example, the trafficking of children, as well as women, for sexual exploitation, has reached alarming levels. An estimated 30 million children are now victimised by traffickers, who almost invariably go unpunished;
- 250 million children between the ages of 5 and 14 are economically active, and some 50 to 60 million of them are engaged in intolerable forms of labour, according to the International Labour Organisation;
- And the scale of the HIV/AIDS epidemic - which exceeds the worst-case projections of 1990 - now threatens decades of gains in child survival and development, especially in sub-Saharan Africa. In the most affected countries, from half to more than two-thirds of the 15-years-olds alive today will eventually die of the disease. Already, AIDS has orphaned more than 13 million children, and that figure may reach 30 million before the end of the decade

On some of these matters, the Uniting Church in Australia has already taken appropriate action and reached useful outcomes. We were part of the campaign that lobbied for, and achieved, legislation to deal with Australians who engaged in sex tourism overseas. We were part of the campaign that advocated, and achieved,

Australia signing the treaty to ban land mines. Through UIM, the church is part of the campaign that now lobbies Burma and Sri Lanka to sign that treaty.

But there are key areas listed above where much more needs to be done if children and poor people around the world are to enjoy even the most basic level of health.

### a) Cancel debt

One of the greatest obstacles to human health in the Highly Indebted Poor Countries is the amount of economic production (GDP) and national budget that goes to pay international debt. According to Jubilee Australia Drop the Debt Campaign, 7 million children a year die because their nations have to put debt servicing ahead of dealing with preventable diseases. The Assembly's support for the Jubilee Drop the Debt campaign is consistent with concern for human rights and human health (Assembly Standing Committee November 1998 and July 2000). Most synods have also expressed support for this campaign.

### b) Development Aid

As the Assembly publication *Election 2001: a briefing paper* says

> Australia's contribution to international development aid has fallen to an abysmal 0.25% of GDP. Foreign aid helps real need in our world, shows our intention to be good international neighbours, creates stability and sows the seed for future prosperity. We call on our next government to commit to the UN aim of 0.7% of GDP to foreign aid, laying out clear and realistic targets of incremental increase over the next five years. Australia is a wealthy country and it behoves us to be generous and caring neighbours through our foreign aid budget.

(i) Government – foreign aid budget needs to be increased

(ii) Church – the need to support development through both Uniting Church Development agency, and the National Council of Churches Christian World Service (funded through Force Ten and the Christmas Bowl)

### c) Trade negotiations

Poor nations cannot afford to pay the high prices charged internationally for pharmaceuticals to treat HIV/AIDS and other illnesses. International agreements such as the World Trade Organisation TRIPS (agreement on Trade in Rights to Intellectual Property) prevent them manufacturing drugs locally, to meet the needs of their people, unless they pay royalties to the international corporation owning the patent. These royalties are simply unaffordable for poor nations. They protect monopoly rights.

According to the Australian Fair Trade and Investment Network, TRIPS was not intended to prevent poor nations having access to essential medicines, and richer nations are misusing the agreement to bring complaints. TRIPS need to be clarified to ensure that such complaints do not occur in future and that developing nations have the right to the cheapest versions of essential medicines.

## d) Food

Food is essential to health. But in many parts of the world, corporations are taking control of food production, through gene patenting. Once this happens, farmers cannot store seed, they have to buy new seed from corporations each season.

Only some nations are allow their corporations to patent life forms and genes, but corporations seeking such patents usually operate internationally and enforce their interests. In some countries this means that corporations have taken control of varieties that have been grown by farmers for thousands of years. AFTINet comments "There have been huge protests in India because traditional farmers refused to recognise patent rights over plant varieties which they had developed over thousands of years."

The WTO TRIPS agreement seems to be inconsistent when, on the one hand, it requires that, in order to qualify for a patent, an invention needs to be "new, involve an inventive step and are capable of industrial application" but on the other hand seems to assume that plants and animals varieties can and should be patented (since it includes explicit permission for nations to exclude them from patentability, as if this was not automatic).

The WTO TRIPS also seems to be inconsistent with the United Nations Convention on Biodiversity, Article 15 which states "Recognising the sovereign rights of States over their natural resources, the authority to determine access to genetic resources rests with the national governments and is subject to national legislation".

In the interests of justice, including the right to health, the TRIPS agreement must be changed.

## e) Refugees, asylum seekers and multiculturalism

Violation of human rights is destructive of human health. People flee as refugees, seeking asylum, because the situation in which they are living destroys their health and identity. They can only survive if the nations to which they flee recognise their situation and respond to them, and their situation, appropriately. Racism is itself a violation of human rights, and traumatises people. As the Assembly *Election 2001 – briefing paper* comments, the church seeks in this area four policy directions:

- Humane and just treatment of refugees and asylum seekers
- Affirmation of cultural diversity in community life
- A comprehensive community education program aimed at counteracting xenophobia and nurturing respect for ethnic diversity and
- An end to mandatory detention of asylum seekers and refugees. Our next government should initiate compassionate and humanitarian community based alternatives to detention for the Australian context.

## Policy for health

A parallel can be drawn between health policy reform and constitutional reform:

> A policy deriving from such a process might begin with a negotiated preamble that states the values on which it is built. It would then go on to say what the Australian health care system plans to achieve, what health gain Australians could expect. It would set limits as well as create a positive vision of health for the future. It would tell us how the needs of the chronically ill and of older people will be met. It would contain a strong statement about goals and targets to be achieved. It would commit the health care system to efficient preventive strategies for problems we cannot cure and can only prevent" (eg severe brain damage from trauma and HIV infection). (Stephen Leeder " A comprehensive health policy for Australia – challenge or oxymoron?" in *Journal of Australian Political Economy No 45* June 2000, page 127)

### (a) Seeking health

The Uniting Church can make a number of general contributions to the debate about health and health policy in Australia. These include:

- Providing reflective input into the health debate
- Resisting medical consumerism. Encourage thinking about what are the legitimate limits to treatment consumption.
- Advocating movement from a health industry policy or treatment policy to a health policy, ie a policy focused on the outcome, health.
- Advocating on behalf of those people who are disadvantaged by current health approaches and who do not experience their human right to health, especially Indigenous Australians and people with mental illness.
- Advocating on behalf of people whose right to health is damaged by international arrangements to which Australia is a party (such as the World Trade Organisation TRIPS agreement, or the nations bombing Afghanistan with cluster bombs)
- Promoting health policy based on an understanding of what people need to flourish at particular ages and in particular circumstances.
- Resisting attempts to turn "health care", "treatment" etc into a tradeable commodity, divorced from culture and ethics
- Helping people find ways of taking appropriate responsibility for their own bodies and their own health.
- Ensuring that biomedical ethics is recognised as involving issues of treatment, not only issues of research
- Helping health professionals recognise the non-physical dimensions of life and death
- Encouraging health professionals come to terms with the limits of medical treatment and human life.
- Helping people come to terms with the limits of life, including death.
- Encouraging people, especially older people, to take control of their final months

by having living wills etc so that families do not feel compelled to seek to extend the dying process. (A "living will" is a directive that sets out the limits to treatment you wish to have if certain conditions and situations develop. There are several versions people use, one of them being to sign an "enduring power of guardianship" which nominates a particular person to make decisions about health treatment and says that you do not wish to have certain nominated forms of treatment in particular circumstances).

## (b) Treatment

We also need treatment for the sick and the injured. There are no simple answers as to what is an appropriate level of resources for medical and surgical treatment. I have been suggesting in this paper that we operate under an illusion when we think if we put enough money in treatment, everyone will be healthy. That illusion makes health decisions amoral – we need to restore the moral dimensions to health debate.

Stephen Leeder has suggested that to continue and enhance Australia's health system, there is need to

- Relocate Medicare in the current consideration of Australia's tax system – increase the Medicare levy so it explicitly covers all Federal health expenditure (this could be compensated for by decrease in income tax)

- Increase the amount available for public hospitals by $2 billion annually – through an increase in Medicare levy (ie an increase in taxation, not merely a change in labelling)

- Tether this increase to "a contractual commitment to basing care on evidence that it represents value for money and is not end-of-life defensive or obsessive care, nor support for an evidence-free adventure playground for health professionals mesmerised by new technology". Australia should be reorganised to provide greater productive efficiency in line with international standards of management and delivery of treatment that actually produces results.

From a Christian point of view, some of the directions would seem to be:

- Resisting the idea that care is for sale, or care is for profit – resist privatisation of health care

- Preserving Medicare as a universal health care system, and adequately funding it

- Encouraging public debate about treatment options and priorities – what can we reasonably expect from a finite health care system?

- Calling for evidence- based medicine, not medicine based on corporation propaganda, or doctors' fear of being sued (requires both better research, and the development of data bases summarising credible research).

- Recognising that more expensive does not always mean better and that some improvements are not moral, given the cost involved

- Better funding of community based mental health services

- Including dental treatment as part of health treatment

- Supporting the principles of Medicare, and the principles proposed by the Consumers' Health Financing Workshop in June 1998, as set out below.

**Medicare is based on several key principles, including:**

*Universality*

- all people have the same rights and entitlements to good quality health care

*Access*

- access to care based on health needs rather than an individual's ability to pay

*Equity*

- Medicare is funded through general taxation and the Medicare Levy (this means those who earn the most, contribute the most)
- services should be low or no-cost to patients at point of use

*Efficiency*

- *administrative costs are kept low by collecting funds through the tax system rather than individual payments*
- *overheads are kept low through bulk billing and limited advertising*

*Simplicity*

- *claim forms are simple to complete and easy to understand*
- *there are no complicated insurance plans to choose between because everyone has the same entitlements.*

The Consumers' Health Financing Workshop in June 1998 proposed the following principles for assessing health-related policy, all of which would seem appropriate from a Christian viewpoint

1. *Universality – does the policy preserve the universal basis of Medicare and recognise health as a public good?*
2. *Equity – does the policy promote equitable access to health services, and recognise barriers raced by all population groups?*
3. *Quality – does the policy promote quality of care and focus on health outcomes as defined by consumers?*
4. *Transparency – does the policy provide for transparency and accountability to consumers and in terms of both cost and quality?*
5. *Affordability – Does the policy ensure the affordability of health services to consumers and minimise the incidence of uncapped consumer co-payments? Does the policy provide for informed financial consent?*
6. *Directness – does the policy maximise the funding which goes directly to health*

*service provision, and minimise the funding which is channelled through indirect sources such as public and private administration?*

7. *Value for money – does the policy enable set outcomes to be met in the most cost-effective way (technical efficiency)?*

8. *Best use of money – Does the policy encourage the allocation of resources to where they are needed and discourage waste or inappropriate services (allocative efficiency)?*

9. *Broader context – Does the policy consider the impact on other parts of the health system in terms of cost shifting, unintended consequences and flow on effects?*

## *Matters yet to be considered*

We would envisage in our final set of principles looking at a number of questions not covered in this paper or in the interim principles. These include involvement of "consumers" in developing health policy, culturally appropriate health care, the health needs of children (especially children and young people at risk), the ageing, and people with disabilities, and the role of not for profit organisations in the provision of health care. We would also hope to make more precise comment on issues of resource allocation. This paper also has not looked at the questions related to current developments such as gene technology. UnitingCare held a seminar on genetic screening in March 2001.

## *Proposed principles - Health*

These principles were adopted by the Board of UnitingCare NSW.ACT at its meeting in September 2001 as Interim Principles for use while we develop a final proposal for the NSW Synod. We are seeking feedback on these principles. We would particularly appreciate comment on what principles should replace Principle 10 on Resource Allocation.

**For reflection**
1. Which of the following principles do you agree with? Why?
2. Which of the following principles do you disagree with? Why? How would you change these?
3. What other principles would you add?

### Principle 1: Health

Life is a gift from God. Health involves all dimensions of human life – physical, emotional, mental, cultural, social and spiritual. It is essential that those who seek to promote health, to prevent illness, to treat illness, or to ease death and dying recognise that health and healing require more than science and technology. Health depends on taking seriously all dimensions of an individual's life, their spirituality and on the way society functions and impacts on the individual.

### Principle 2 Health, ageing and death

The ability to cope with the stages of life, including ageing and death, is an aspect of health. The meaning of human life comes from the values and beliefs we live by. Life

cannot be deprived of meaning by illness, disability or death. Medical and surgical treatment are valuable means of enhancing our experience of life and reducing impairment due to illness and injury. They distort health, the human person and society when they become extraordinary measures used to deny the natural ageing process, prolong the dying process or to postpone death as the final stage of life.

## Principle 3 Health as a human right

Health is a human right. National health policies should protect and enhance the health of the whole population including children, the aged, people in rural and remote areas, Indigenous people, people with disabilities, and people who are poor (see principle 4, health and social policy and principle 5, health as a global issue). Priority in the allocation of resources for health care should be consistent with the matters set out in Article 12 of the International Covenant On Economic, Social And Cultural Rights, which says:

> The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
>
> The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:
>
> (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
>
> (b) The improvement of all aspects of environmental and industrial hygiene;
>
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
>
> (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

This must be read alongside Article 2.2, which says that

> ..the rights enunciated in the present covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

## Principle 4: Health and social policy

Health is, in the first instance, not dependant on health care systems or health professionals. A large proportion of illness and injury is preventable and should be prevented through appropriate social policy and public health measures.: The quality of health will decline, and the costs of health care increase, when public policy is inadequate in any of these areas.

- Peace, reduction of violence
- water, sewerage and drainage infrastructure
- living wages and adequate income support for those without paid employment

- education
- affordable food, housing, and utilities (energy, water)
- respect for human rights – civil and political, and economic, social and cultural rights
- public health programs to prevent infectious diseases, such as immunisation programs
- public health programs that facilitate healthy lifestyle choices
- occupational health and safety, and reasonable working conditions
- road safety
- healthy, unpolluted environment
- social capital, including family network and community organisations.

## Principle 5: Health as a global issue

For a large proportion of the human race, current international arrangements violate their human right to health. Among the crucial international issues that need to be tackled if people are to enjoy this human right are:

- Cancellation of unpayable national debt, and introduction of a mechanism for dealing with national insolvency
- Improving foreign aid and development assistance
- Banning land mines, removing the mines that exist, ending the arms race and the limiting trade in armaments
- Improving food security for less developed nations, and protecting their plant biodiversity and their intellectual property from foreign patents that deprive them of their rights
- Ensuring international trade arrangements do not give trade priority over human rights, labour rights, or environmental standards.
- Improving the situation of refugees and asylum seekers and Australia's response to them
- Revisions to the World Trade Organisation TRIPS agreement, to
    - Ensure access to essential medicines for use in treating epidemics in developing countries
    - Recognise the collective rights of indigenous peoples and traditional farmers to plants and cultural heritage

- Protect biodiversity and prevent the patenting of life forms, an approach consistent with the principles of the UN Convention on Biological Diversity.

### Principle 6: Indigenous health

In Australia, the single most important priority for health policy should be the improvement of Indigenous health. Recent reports on Aboriginal and Islander health show that sound health policy for Aboriginal and Islander Australians will need to pay attention to a range of factors. In summary, Aboriginal and Islander health policy will need to

- Be based on definitions of health agreed by communities, community controlled organisations and government institutions

- Be effectively coordinated by the Commonwealth, and involve the cooperation of state and local government.

- Be culturally appropriate and learn from Aboriginal and Islander communities and their own health workers and organisations.

- Be based on an effective partnership (equitable sharing of power and decision-making) between Aboriginal and Islander communities and the health system. This will involve adequate funding for relevant community organisations, appropriate training and employment of Indigenous health workers and health professionals, and an appropriate process for policy development, planning and delivery of services. It will also involve respect for varying patterns of organisation and planning.

- Focus on bringing Aboriginal and Islander health as measured by life expectancy and other agreed population health indicators to the level enjoyed by the Australian community generally, by a target date agreed with Aboriginal and Islander people themselves.

- Take seriously history, culture and identity of Aboriginal and Islander people, and provide for both symbolic and practical reconciliation

- Bring the infrastructure of Aboriginal and Islander communities to the level enjoyed by other Australians, with regard to standard of housing, education, water and sewerage, roads and transport, community services and communications, by a target date agreed with Aboriginal and Islander people themselves - and ensure that it can be maintained at that level (through adequate funding and training).

- Involve ensuring all Aboriginal and Islander communities, no matter how remote, have accessible to affordable, healthy food.

- Involve the strategy of improving Aboriginal and Islander access to paid employment

- Be funded at a level sufficient to redress past and present disadvantage that Aboriginal and Islander Australians suffer.

- Ensure that governments take account of the likely impact on Aboriginal and Islander health of policy initiatives in all portfolios.

### Principle 7 Mental health

The second highest priority in public policy for health should be improving mental health services. As the Human Rights and Equal Opportunity Commission has pointed out, much still remains to implement the recommendations of the Inquiry into the Human Rights of People with Mental Illness (1993). Actions required include

- Reducing discrimination against people with mental illness
- Providing better and more appropriate treatment services for individuals with special needs - children and adolescents, the elderly, the homeless, women, Aboriginal and Torres Strait Islander people, people from non-English speaking backgrounds, those with dual or multiple disabilities, people in rural and isolated areas and prisoners.
- Directing savings from de-institutionalisation into community mental health services and ensuring that these services are adequately funded to provide the necessary level of support and treatment
- Improving cooperation between government agencies in the delivery of services to people with mental illness (that is, delivery of the range of services people with mental illness may require, including treatment, income support, housing, and job placement)
- Better funding for research into mental illness, its prevention and treatment
- Improved support for carers of people with mental illness
- Support for services and disciplines that promote social, emotional and spiritual, not only medical, approaches to interventions and management of mental illness.

### Principle 8 Disability

A person with an impairment can enjoy a high level of health. Often lower levels of health are a product of the stress and trauma of discrimination and uncoordinated services, rather than of the impairment itself. Health depends on:

(a) Access and equity such as:

- Non-discrimination in society eg wheelchair access, handrails on steps and stairs, guides for people with visual impairment, and regular use of sign language so those who are deaf know what is happening in meetings and events.
- Non-discrimination in the work place.
- A health care system that ensures everyone has access to the aids and prostheses they need.

(b) Appropriate treatment and services, such as:

- Coordinated health care, especially for people with several impairments or chronic conditions
- Coordinated provision of services, such as health, housing, income support,

home care.

## Principle 9: Essential characteristics of a health (treatment) system

In addition to public policies that prevent illness and injury, people need access to treatment. Both patients and health professionals need to work within a framework that recognises that health care is not a cure for the vulnerability of human existence or for human mortality. It cannot eliminate disability or death. But it can ensure that the whole population has access to basic levels of treatment for physical, mental, and dental health problems. The principles upon which Medicare is based remain appropriate for any health care system, namely

**Universality**

- all people have the same rights and entitlements to good quality health care

**Access**

- access to care based on health needs rather than an individual's ability to pay

**Equity**

- Medicare is funded through general taxation and the Medicare Levy (this means those who earn the most, contribute the most)
- services should be low or no-cost to patients at point of use

**Efficiency**

- administrative costs are kept low by collecting funds through the tax system rather than individual payments
- overheads are kept low through bulk billing and limited advertising

**Simplicity**

- claim forms are simple to complete and easy to understand
- there are no complicated insurance plans to choose between because everyone has the same entitlements.

### Principle 10: Resource allocation

The initial priorities for resource allocation should be based on improving the health of the population through prevention and primary health care. This is about helping a generally healthy population stay healthy, by providing treatment that prevents minor problems becoming major problems that would unnecessarily shorten a person's life or leave them with a preventable permanent disability. The first benchmark for a health care system is that it ensures that people who are born with the physical potential to do so live reach the benchmark years of life free of disability, and achieve their life expectancy. Physical potential needs to be differentiated from social potential.

For example, in Australia, Aboriginal people are born with a lower life expectancy not because they are physically inferior, but because of social injustice. Aboriginal and

Islander health should be an absolute priority on the health system. That is, it is inappropriate and unjust to provide further tertiary treatment options for the Australian population, until there has been sufficient investment in Indigenous health to bring their health status to that enjoyed by the rest of Australia.

## *Further Questions for Reflection*

There are many different ways to think about these issues. You may find one of the following sections is the most helpful approach to discussing these issues, or you may wish to try more than one approach. Or make up your own.

### General

What would you like to see in a health care policy? What values should inform it? What purposes should it aim to achieve? What should be its vision of health care? What limits What will it offer the chronically ill and older people? What basic targets and gaols would it include? And how will it deal with prevention?

OR

Answer the questions on page 3 of this paper.

### Thinking about the theology

Which parts of the theology section did you agree with? Which parts were new ideas to you? Which parts were most important?

### Reflecting on the issues

The most difficult questions about health policy are about what treatment should be available and how it should be paid for. The following questions might help you discuss this. By treatment we mean assessment, treatment and rehabilitation.

1. What do you think are the changes in public policy that have (a) enhanced people's health and (b) damaged peoples health?

2. What for you are the developments in treatment that you think have been valuable in improving human life?

3. What for you are the developments in treatment that seem pointless or harmful?

4. What do you want from a health system-now, and as you grow older:

(a) for your family – for children, aged parents etc

(b) for yourself

(c) for people with disabilities (if they are not mentioned in a or b)

(d) for people with chronic illnesses (if they are not mentioned in a or b or c)

5. How should the cost of what you asked for in 4 be paid?

6. How much do you think Australia should pay altogether for health care, and how

should we pay it? (Usually, health care spending is described in terms of the percentage of the nation's income or GDP. In Australia, we spend about 8% at the moment. The USA spends 14%). What is the basis for your proposal?

7. What do you NOT want from a health system? That is, are there things that doctors and other health professionals do that you think should not be done?

## A request for feedback

**UnitingCare NSW.ACT wishes to revise the draft principles in this paper, and to bring a set of principles to the Synod in 2002 for adoption, as the basis for ongoing comment on health policy. We want your ideas and feedback.**
Please send comments, together with the name of the person, congregation, agency or group making them, to
Rev. Dr. Ann Wansbrough
UnitingCare NSW.ACT
PO Box A 2178
Sydney South NSW 1235
Email: annw@nsw.uca.org.au
Fax 9267 4842 Phone 8267 4280
(Please head emails or written responses: Health principles feedback)

## Useful reading

Miles Little *Human medicine* Cambridge University Press 1995

Stephen Leeder *Healthy Medicine: challenges facing Australia's health services* St Leonards, NSW: Allen and Unwin 1999

## Websites

Rural Health Project at http://www.hreoc.gov.au/human_rights/rural_health/

## Bibliography

Aboriginal and Torres Strait Islander Social Justice Commissioner *Second Report 1994* Human Rights and Equal Opportunity Commission Sydney

Australian Institute of Health and Welfare *Australia's health 1998* Canberra: AIWH

ARBUCKLE Gerald *Health Care Ministry: refounding the mission in tumultuous times* Collegeville, Minnesota: The Liturgical Press 2000

BATES Erica and LINDER-PEREZ Susie *Health Care Issues* St Leonards: Allen and Unwin 1987

BAUM Fran *The New Public Health: an Australian Perspective* Melbourne: Oxford University Press 1998

BLOOM Abby *Health Reform in Australia and New Zealand* South Melbourne: Oxford University Press 2000

CHAPMAN Audrey (editor) *Health Care Reform: a human rights approach* Washington: Georgetown University Press 1994

DE LOOPER Michael and BHATIA Kuldeep *International Health: how Australia compares* Canberra: Australian Institute of Health and Welfare 1998

GEORGE Janet and DAVIS Alan *States of health: health and illness in Australia* French's Forest NSW: Adison Wesley Longman Australia 1998

GARDNER Heather (ed.) *The politics of Health: the Australian Experience* South Melbourne: Pearson Professional (Aust.) 1995

GARDNER Heather (ed.) *Health Policy: Development, Implementation and Evaluation in Australia* South Melbourne: Longman 1992

House of Representatives Standing Committee on Family and Community Affairs *Inquiry into Indigenous Health Discussion Paper* Canberra: Parliament of the Commonwealth of Australia 1999

House of Representatives Standing Committee on Family and Community Affairs *Health is Life: report of the inquiry into Indigenous Health* Canberra: Parliament of the Commonwealth of Australia 2000

LEEDER Stephen " A comprehensive health policy for Australia – challenge or oxymoron?" in *Journal of Australian Political Economy No 45* June 2000

MANN Jonathan, GRUSKIN Sofia, GRODIN Michael, and ANNAS George (editors) *Health and Human Rights* New York and London: Routledge 1999

MATHERS Colin "Well-being and quality of life" in Richard Eckersley *Measuring progress* Collingwood: CSIRO Publishing 1998

Methodist Church, England *Limited Resources: Unlimited Demand* London 1995

REGAN Hilary, HORSFIELD Rod and McMULLEN Gabrielle (editors) *Beyond mere health: theology and health care in a secular society* Melbourne: Australian Theological Forum 1996

State Based Health Financing Consultation Project *Health Financing: bringing consumers into the loop* Melbourne: Health Issues Centre 1999

WADDEL Charles and PETERSEN Alan *Just Health: inequality in illness, care and prevention*

World Health Organisation 1996 *Creating healthy cities in the 21st Century* Geneva: World Health Organisation

---

[1] Miles LITTLE *Humane Medicine* Cambridge University Press 1995
[2] Fran BAUM *The new public health: an Australian perspective* Melbourne: Oxford University Press 1998

[3] See, for example, Michael DE LOOPER and Kuldeep BHATIA *International Health – how Australia compares* Australian Institute of Health and Welfare Canberra PHE 8 1998 (http://www.aihw.gov.au/publications/health/ihhac/index.html)