



Consumers Health
Forum **OF** Australia

SUBMISSION

Select Committee on Cost of Living

March 2023

Consumers Health Forum of Australia (2023)
Submission to the Select Committee on Cost
of Living

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*Consumers Health Forum of Australia is funded
by the Australian Government as the peak
healthcare consumer organisation under the
Health Peak and Advisory Bodies Program*

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Introduction

CHF is the peak body representing consumers of health services in Australia, regularly consulting with, and working with, consumers to develop and advocate for policies, programs and initiatives to improve practices and shape a consumer centred health system.

The Consumers Health Forum (CHF) thanks the Select Committee on Cost of Living for the opportunity to lodge this submission. This submission focuses on the cost of living pressures affect health outcomes, particularly for Australians with high health care needs. CHF is conscious that employment outcomes, income support and income security, housing security, educational attainment, and other demographic characteristics (including heritage, where people live, age, medical conditions and disability) are all interconnected physical and social determinants that contribute to cost of living pressures.

Australians with poor health, including from chronic conditions, age related illnesses, co-morbidities and disability are far more likely to live on low incomes, including income support payments, than others in the community. It is people on the lowest incomes experiencing the greatest cost of living pressures.

CHF has consulted consumer representatives and advocates with community networks throughout Australia. Their experiences are reflected in this submission.¹

When you have to choose between making sure you have enough to feed your kids and pay for your medication and theirs, and you have to keep going to the local services to get vouchers for your utility bills or for the grocery store. It's humiliating.

I've had them look at my budget over and over again. I don't smoke, I don't buy lotto tickets ... They said there's nothing I can do to improve on this.

So, how do you pay for your kids to go on a school trip and eat nutritious food and still pay for your medication? Medication for myself and my family are in the hundreds of dollars every month because we all have multiple health conditions and multiple medications and many of the conditions can only be prescribed medication that is not on the PBS. I'm paying between \$78 and \$120 a 'script because there's no other drug, or you're allergic to the other drugs, or whatever the reason. I ended up feeding my family on lettuce leaf soup most of the time because I just couldn't afford food and rent.

¹ Some of the direct quotes of consumers related in the boxes have been edited.

Cost of living pressures when in poor health

Cost of living pressure and chronic health conditions

Poverty is a strong risk indicator for chronic disease in the population. Increasing cost of living pressures, for direct health services and for the other goods and services that help keep people healthy – housing, nutritious food, energy – have only served to exacerbate the risk of, and from, chronic health conditions.

Many health conditions require specialised diets, where you have to cut out a whole lot of foods. How do you manage that? A dietician would be wonderful, but the gap that's charged is prohibitive.

Recent data compiled by the Grattan Institute shows that around 50 per cent of Australians in the lowest two socio-economic status (SES) quintiles have one or more chronic diseases, compared to around 41 per cent of Australians in the highest SES quintile. The most disadvantaged Australians have almost double the rate of co-morbidity than those in the highest SES, yet receive the same level of Medicare funded allied health services.²

CHF's own Australia's Health Panel survey data (January 2023) found that few than one in four health consumers thought that health services are affordable.

People unable to afford increased costs, are more likely to live in overcrowded, unhealthy and/or insecure housing or experience homelessness, and have limited access to healthy food, safe drinking water, and healthcare services. They are more likely to experience stress and trauma, which can affect their physical and mental health. Additionally, it means people may not be able to afford to take time off work or school, or to travel to seek medical attention, which can lead to delayed or inadequate treatment for illness and injuries.

Paying to see a doctor

ABS data indicates increasing rates of delays in visiting medical practitioners. People with long term health conditions were more likely to delay or not use a health service when needed, compared to people without a long term health condition.³

The Productivity Commission's latest Report on Government Services confirms the growing unaffordability of primary care, with number of people who could not afford to see a general practitioner (GP) in the last year increasing by almost 50 per cent, and nearly 25 per cent of people did not access mental health services due to the cost.⁴

² Peter Breadon, Danielle Romanes (2022) A new Medicare: Strengthening general practice, Grattan Institute <https://grattan.edu.au/report/a-new-medicare-strengthening-general-practice/>

³ ABS, (2022) Patient experiences 2020-21 <https://www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release>

⁴ Australian Government Productivity Commission (2023) Report on Government Services, E Health, 10 Primary and community health and 13 Services for mental health <https://www.pc.gov.au/ongoing/report-on-government-services/2023/health/primary-and-community-health>

Consumers confirm that some GPs do not want to take on new patients with high care needs. In many areas, there are no GPs who will bulk bill. That, in turn, limits access to specialist and allied health care. Recent research supports this, with indications that it is becoming increasingly difficult, except in Melbourne and Sydney, to access bulk billing. The out of pocket cost for patients who are not bulk billed now typically exceeds the Medicare rebate.⁵

People like me, living on the Disability Support Pension, cannot find a doctor. Before, I would go to the northside clinic because I could subscribe and they can understand trans health issues but now, because I cannot walk very far, I can't get there.

Most recently, a survey conducted using CHF's Australia's Health Panel indicated that only 53 per cent of health consumers were confident that they could afford the health care they needed if they became seriously ill. Further, many patients are constrained from consulting a GP or specialist when they are not bulk billed, because they must pay the full cost of the consultation before receiving their Medicare rebate. They cannot afford the up front payment, so they do not go to the doctor. Results from the Australia's Health Panel survey include that:

- 32 per cent of respondents had cancelled or not booked a health care appointment in the preceding twelve months because they could not pay
- 20 per cent had attended a hospital or an emergency department specifically because other options were too expensive
- only 42 per cent of respondents reported they were often or always bulk billed by their GP, with median out of pocket costs of \$85 (with a Medicare reimbursement of \$39.10)
- 60 per cent of respondents were never bulk billed by a specialist, experiencing median out of pocket costs of \$180 (with a median \$80 Medicare reimbursement)
- 33 per cent reported recent increases in out of pocket medical expenses.

Costs of medicines

People on low incomes simply cannot afford to include regular medications in their budgets. In quantitative research conducted by CHF in 2021, almost one quarter of respondents indicated that they did not fill a prescription or missed a dose of medicine in the last twelve months.⁶ While prescription costs may have eased for Health Care Card holders with a reduction in copayments, the pressure of increases to other costs, mean people are still choosing to forego medicine in favour of paying their rent and other bills.

⁵ <https://cleanbill.com.au/wp-content/uploads/2023/01/Cleanbill-Blue-Report-January-2023.pdf>

⁶ CHF (2021) The Voice of Australian Health Consumers: The Australian Health Consumer Sentiment Survey https://healthsystemsustainability.com.au/wp-content/uploads/2022/03/PCHSS_ConsumerSentimentSurveyReport_FINAL3.pdf

Further, many consumers need multiple medicines and/or have multiple family members with permanent conditions requiring medication. Even a \$6 co-payment can be unaffordable, let alone paying for medicines that are prescribed off label.

So, paying for medications, \$6 is a lot of money for some of us, you know. Last week, I couldn't afford to eat. Now, luckily, there's a space in Footscray and you can line up and get some food and, I'm not ashamed to say, I use that. But, where do we go? When we cannot afford the basic medication, I just leave it there.

Where people do fill their prescriptions, it can mean going without other necessities or juggling their medical expenses with emergency relief or other community supports. For example, by paying for medicines and seeking emergency relief vouchers for electricity or food.

Other costs

While telehealth services have improved equity for many health consumers, it does not entirely solve access issues.

- Many conditions need physical examination for a diagnosis.
- There is a poverty gap in digital access, including the cost of data, reliability of phone/computer and connections, and consumers' digital literacy
- People may not have a private space where they can have a confidential consultation with their health practitioner.

Even community transport in the region where I live has now added a \$20 a day booking fee to get me to the nearest town where the hospital is ... The buses run twice a day and there are only four taxis in the shire.

Telehealth means you have to have data; you have to have a device that's not being shared by everyone else in your family, and you have to have space for privacy.

There are also barriers to accessing face to face services. In many cases, people must travel some distance to receive GP, allied health, specialist and/or hospital care.

- Both access to transport and cost can be significant barriers. Transport can be a barrier not only in regional, rural and remote locations, but also in outer metropolitan areas of large cities.
- People who live in rural and remote areas may face extra expenses for accommodation.
- People with caring responsibilities may also need to arrange for family members to attend medical appointments.

The cost of mental health

Evidence from across high income countries suggests that income inequality and poverty increase mental health disorders. One recent study found that one in four Australians in the poorest SES quintile experience a high or very high level of psychological distress. This compares to one in twenty of people in the wealthiest quintile.⁷ Even worse, the most disadvantaged Australians, who experience more than double the rate of psychological distress, receive about half as much Medicare funded mental health care than those with the greatest resources.⁸

You have to pay upfront first before you get the money back. But, when I pay my rent, I can't do it. So I have to let go of the psychologist and psychiatrist, as I just can't afford it.

The cost of mental health can be prohibitive for people who need that support, with far too few bulk billing services. Psychiatrists' fees are especially problematic, with increasing out of pocket expenses pushing consultations out of reach for too many. Patients who can find a bulk billing psychologist or psychiatrist may have to travel some distance, and may then find that transport costs are unaffordable. On the other hand, not seeing a psychologist and psychiatrist when needed can increase disadvantage and further entrench poverty.

I know that it's very important that I maintain stability for son and my daughter, because my son's mental health and, well, his very survival actually, depends upon having a stable home to live in, where he can feel comfortable and secure. I do my best, but it's very, very, very difficult and if anything goes wrong, like your electricity goes, which mine has. I don't have lighting or much electricity, in much of my house. I do know that I'm in a better and a much more fortunate position than people who don't have a home at all..

People with mental health conditions have shorter life expectancy, losing 1.4 to 32 years of life, than for the general population.⁹ Those with severe mental illness are far more likely to die from heart attacks, strokes and pneumonia, and they are far more likely to die from unknown causes than people in the general population.¹⁰ Much of this difference can be associated with SES, including smoking, poor nutrition, less physical activity, difficulty in accessing quality healthcare, and lack of capacity in the healthcare system to deal with the intersectionality of physical health conditions, disability, and mental health conditions.¹¹

⁷ Anton N Isaacs, et al (2018) Lower Income Levels in Australia Are Strongly Associated With Elevated Psychological Distress: Implications for Healthcare and Other Policy Areas
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6213368/>

⁸ Peter Breadon, Danielle Romanes, op cit.

⁹ Australian Institute of Health and Welfare (2022) Physical health of people with mental illness
<https://www.aihw.gov.au/reports/mental-health-services/physical-health-of-people-with-mental-illness>

¹⁰ Ann John (2018) Having a severe mental illness means dying before your time, The Conversation
<https://theconversation.com/having-a-severe-mental-illness-often-means-dying-before-your-time-95529>

¹¹ AIHW, op cit.

Poor dental health

Delays to dental health care due to cost are increasing, with 16.4 per cent of people reporting cost as the reason for delaying or not visiting a dentist in 2021-22, compared to 14.8 per cent in 2020-21.¹²

While there are some public dental health services available to low income earners, the wait is long and the services are limited. Australian Institute of Health and Welfare (AIHW) data has waiting periods of up to 3.9 years¹³, while Freedom of Information data obtained by the Australian Dental Association Victoria shows an average waiting time of nearly 2.3 years in Victoria, with only 181,000 of 1.5 million eligible adults receiving the service in the 12 months to June 2022.¹⁴ AIHW data also indicates that fewer than half the Australian adult population visited a health professional in 2020-21, with about 67,000 hospitalisations (in 2019-20) that might have been avoided with earlier dental treatment.¹⁵

I'm very distressed about the level of attention to older people, whether they're in their own home receiving aged care services or in a residential facility. Their teeth are the most ignored part by the providers, which causes worse physical health and deterioration – and death.

Poor dental and oral health also exacerbate cost of living pressures. Poor teeth are a disadvantage in job interviews, and living with chronic pain – regardless of which part of the body is affected – creates and increases disadvantage. People who cannot access dental care often also suffer from poor nutrition, because they cannot chew food, or it causes them pain when they eat.

Costs exacerbating health conditions

Housing

There is clear evidence of a rental housing crisis in Australia, with sustained low vacancy rates since early 2022. It means accommodation is hard to find, and rents have been pushed up to the highest they have ever been (\$542 per week in November 2022).¹⁶

I can't afford the rent increase so I move house and that is further marginalising because you have to access cheaper and cheaper housing which is further and further from the services you require and the network you've created, so it increases isolation.

¹² ABS, op cit.

¹³ AIHW (2022) Oral health and dental care in Australia <https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/about>

¹⁴ <https://adavb.org/advocacy/campaigns/public-dental-waiting-times>

¹⁵ AIHW, op cit.

¹⁶ AHURI (2022) Why does Australia have a rental crisis, and what can be done about it?

<https://www.ahuri.edu.au/research/brief/why-does-australia-have-rental-crisis-and-what-can-be-done-about-it>

This situation is pushing low income households out of the private rental market, and increasing insecure housing and homelessness, exacerbating existing chronic physical and mental illness and disability, and contributing to new conditions developing. Many consumers report the difficulties, including long waiting lists, that they face trying to access government, social and emergency housing.

A friend of mine is trying to find a place because her building is being knocked down. She's applying for a 20 rent reduction ... I've looked at the application with her because she has ADHD ... It's very invasive and demeaning and, in terms of her mental health, it's paralyzing.

Nutrition

A preventive health survey about vegetable consumption, conducted by CHF for Nutrition Australia's Fruit and Vegetable Consortium in mid-2022, found that 78 per cent of respondents reduced their vegetable consumption because they had become too expensive to buy. They reported that the greatest factor that would motivate them to eat more vegetables was to make them more affordable.

I have had more home delivered food for convenience. When children arrive home with five to six extras, I find it cheaper to get a \$5 pizza than to make my own.

In complementary qualitative kitchen table/community conversations, almost all participants noticed recent increases in costs of vegetables and almost all had changed their purchasing habits and decisions because of those price increases, including by reducing either the quantity or variety of vegetables they bought and ate.

I still buy what I like to cook and live as healthy as I can, but the quality isn't as good. I shop once a week, but the food doesn't last more than a few days, even though I'm paying more.

Affordability in a disadvantaged community was raised as an issue in one community conversation. Many single (and sometimes only part time) income families, limited their diets to canned and frozen vegetables to save money, or ate cooked meals provided through a local food kitchen.

Decline in real income

Over the last ten years, real wages and salaries have been largely stagnant or in decline. Many households were not significantly affected because inflation and interest rates were also low. However, poorer households, particularly those relying on JobSeeker and related payments faced increasing inequality. They felt the effects of even small increases in their cost of living, as their real payments declined to a far greater extent than the rest of the community.

Prior to 1996, social security payments were aligned, with the same indexation applied to pensions and other payments, including JobSeeker. Since then, the divide has further and further widened, due to different indexation applications between the two classes of payments. It is now widely recognised that recipients cannot even subsist on JobSeeker and related payments.

Rather than put people on DSP who should be on DSP, they keep them on JobSeeker for years and years and years. Maybe [people with psychosocial conditions] should also access Age Pension earlier, as people with enduring and complex mental health issues have a much shorter lifespan?

Further, JobSeeker is no longer strictly a short term payment, as it is paid to many people who would once have received Disability Support Payment, Carer Payment or (no longer existing) Sole Parent Pension/Payment.

Improving cost, equity and accessibility

CHF has a vision for accessible and equitable care, that gives consumers choice, flexibility, and that is both affordable and available when they need it. Australia needs a system that delivers holistic care, where patients and their families/carers are equal members of their care teams, actively participating in their health care and choices. Consumers should be supported by GPs/practices that deliver consistent services to keep people healthy and well, regardless of a person's income, characteristics or where they live.

People in poverty may have access impediments to inclusion in consultation. Decisions about them are often made for them, by people of privilege.

A major issue in Australia's healthcare system is the "siloes" in delivery. These divisions between Commonwealth, state and territory and community service delivery can exacerbate disadvantage and inequality. For example, the lack of coordination in border areas, where there is often a lack of coordinated services, including end of life care, when a patient is discharged from a hospital in one state, to their home in another, exemplifies the need for a national approach.

Recommendations

Addressing the social determinants of health may seem like an overwhelming problem. Systemic improvements can, though, be incremental. CHF recommends taking some first steps to improve access to bulk billing, more integrated and person centred care, and access to dental health care.

When I got pregnant, there is a lot of financial burden on the family because, while you think the pregnancy is covered under Medicare, it is not the case because your ultrasound, your consultation and care after leaving hospital are not covered. There are a lot of out of pocket expenses.

Primary and preventive health

Access to bulk billing GPs was the number one concern of CHF members and friends who responded to a recent survey on primary health needs. They also called for:

- more coordinated/wrap around care, particularly for the most vulnerable people in the community
- more GPs in rural and remote areas, and
- better access to mental health services.

CHF has considered how that might be achieved. It is well understood that the Government is unwilling to commit to an across the board increase in MBS rebates for GP consultations that catches up on years of freezes, given the prohibitive cost of such a measure. As a member of the Minister's Better Medicare Taskforce, CHF has regarded this limitation, as well as innovative ideas and solutions offered through the life of the Taskforce. CHF also recognises that increasing the patient rebate may, on its own, not reduce the out of pocket cost for consumers, as GPs will make independent decisions about charging co-payments and whether to extend bulk billing.

On balance, CHF still believes that some general increase to MBS rebates for GP consultations is needed, accompanied by other payments and services targeted to vulnerable patients and populations.

Recommendation

- **Reduce out of pocket costs, and eliminate costs for low income patients, to Improve affordability of GP and specialist consultations**

Incentive payments

There are already some incentive payments that encourage greater availability and improved primary health services. These include the Practice Incentive Program, the Workforce Incentive Program, the Practice Nurse Incentive Program, and the Aged Care Access Incentive. These payments support general practices to improve the quality and capacity of their services, and increase services to target populations (for example, in rural areas, or aged care residences)

Additional targeted incentive payments could be used to complement a small, general increase to MBS rebates. These could be used to:

- enable GPs to bulk bill a higher proportion of their patients, especially in priority population areas, for example rural and remote locations, practices with a high proportion of Indigenous and/or CALD patients, and areas with high levels of socioeconomic disadvantage
- offer more person centred and holistic care, for example by helping patients with chronic/multiple conditions and their carers navigate the health services they need (such as specialists, mental health care, allied health care), and offer social prescribing, for example by employing coordination support for referral to services that can help address general wellbeing (such as exercise classes, social supports, housing services).

Recommendations

- **Introduce a General Practice Bulk Billing Incentive Payment to encourage practices to bulk bill a higher proportion of payments, particularly for priority populations.**
- **Introduce a General Practice Extra Support Services Payment to encourage practices to offer whole of patient care, particularly for vulnerable patients.**

Access through community based health care

There are many models of community and place based care that work well for their communities. National Aboriginal Controlled Health Organisations, Cohealth in Victoria, collaborative commissioning in NSW, models supporting migrant and refugee communities, offer some examples.

I've been bin diving within the last 2 years to eat leftovers that people have thrown in the bin, even though I have inflammatory bowel disease where I should be following a diet and supplementation regime.

These health services offer coordinated, person centred care, without restricting consumers' access to Medicare funded services through private GP practices, allied health services, or specialists.

Recommendations

- **Increase and improve funding to community based organisations to work with their communities to address disadvantage and deliver equitable healthcare.**

Social prescribing

The term, "social prescribing", is used to describe the practice where health professionals, including GPs, link consumers to non-medical services that can improve their overall health and wellbeing. These services can vary from exercise classes to improve their fitness, to social groups to help them overcome loneliness and isolation. Social prescribing can be particularly effective in supporting consumers who face poor health outcomes because of their social and economic disadvantage.

The benefits of, and outcomes from, social prescription are well known and documented. Social prescription is a key component of whole of person care and should be embedded in Medicare reform, with delivery through a funded network of care coordinators and health system navigators, including digital navigators.

Recommendation

- **Start a roll out of national social prescribing for people experiencing loneliness, social isolation, and other mental health risks or conditions.**

Mental health services

Australians have a right to a universal mental health care system that integrates seamlessly with other parts of the system to give person-centred access to essential services in the right place, at the right time and the right way.

The division of responsibility for policy and services across the Commonwealth, states and territories continues to confound integration – and mental health care consumers.

Governments need to work together to set out short, medium and long term agendas for action. The simpler and clearer the visions and principles of the mental health system can be, the better it will help health consumers and the health sector understand what world class mental health care should look like and how to navigate its complexity as it reforms. Obligations placed on each Commonwealth department and each state and territory government need to be clear. They need to give consumers confidence that they can get the care they need, when they need it, and they need assurances that the system is properly funded and sustainable. A whole of government policy and implementation roadmap that includes co-design, high visibility and accountability is likely to improve community trust and provide the assurances people need.

Consumers with multimorbidity, who are the norm, are not well served by accessing mental health services in isolation. They need a mix of clinical, treatment focused interventions, together with clinical and non-clinical services to support their recovery and help avoid relapse.

To achieve this, mental health services need to be integrated across all health care services, and especially with primary health care services that address fragmentation, stigmatisation, structural discrimination, cost and accessibility.

Recommendation

- **Increase funding for crisis care, that supports people with significant mental health and episodic conditions in the community.**
- **Deliver comprehensive and multidisciplinary services, both within a service and across service settings, that are coordinated by a team of providers trained in consumer centred care.**

Dental health

There is a significant and growing body of evidence proving the relationship between oral health and overall health status, yet dental care is not covered by Medicare and is unaffordable for too many Australians. Many low income consumers do not meet tight eligibility criteria for public dental schemes, and those who do, face long waiting lists.

There is no convincing argument for excluding dental care from Medicare. Cost is clearly the barrier. This can be dealt with by taking an incremental approach to absorbing dental care into Medicare.

Recommendation

- **Introduce a dental benefits scheme that offers income support recipients and other low income adults basic dental care with capped funding and choice of provider.**

Income support

Increasing interest rates and inflation have conspired against the most vulnerable members of the community. They are the people whose incomes do not allow for reducing their spending or increasing their savings – every cent of their income is used to survive. Increasing interest rates are a double whammy, resulting in higher rents, that they simply cannot afford.

Rents are rising ... so there's a lot of people with stress. Now, when you're on a pension like myself, that adds more stress. So our health is deteriorating because the conditions of uncertainty are now embedded.

Targeted support to people with low incomes, to enable them to pay for basic needs, can be provided through the social security system without affecting inflation or interest rates.

Recommendation

- **Increase JobSeeker, Youth Allowance and related income support payments to the pension rate.**
- **Apply the same indexation to JobSeeker, Youth Allowance and related income support payments, and to family assistance payments, as pensions.**
- **Introduce a pension/payment supplement for people unable to work due to illness or disability and for sole parents, to recognise additional costs of living**
- **Increase Commonwealth Rent Assistance payments by 50 per cent.**