CHAPTER 8

HEALTH

> *Health is an essential component of active citizenship as without health a person cannot access other rights and cannot enjoy quality of life. Equitable access to health prevention services and care is therefore vital.*[1]

8.1 Affordable and timely access to healthcare services is vital for all Australians, including the poor and the disadvantaged. It was emphasised during the inquiry that the provision of healthcare should be on the basis of need and not the capacity to pay; and that Australia needs to avoid the development of a two-tiered healthcare system where an inferior and underfunded health system would be reserved for the poor and disadvantaged.[2]

Poverty and health

8.2 The link between health and socioeconomic status has been clearly shown in studies both in Australia and overseas, with lower socioeconomic status generally being associated with poorer overall health. For example, people from lower socioeconomic status are more likely to have serious chronic illnesses than people from higher socioeconomic backgrounds. Australian Institute of Health and Welfare (AIHW) data show that the proportion of people who report their health as only 'fair' or 'poor' shows a marked trend across socioeconomic groups. People who are less well educated, unemployed or living in households with low income report poorer health.[3]

8.3 Poor health can in turn lead to a compounding of poverty, because illness reduces an individual's capacity to take up opportunities such as employment or training. The ill-health of children within families may also result in a cycle of poverty that is difficult to overcome. The extent to which illness may be said to cause poverty depends largely on the type of illness and the preparedness of the community to support the economic participation of people who are ill and the living costs of people who are unable to work. The onset of illness can, however, profoundly affect individuals and families and place them at high risk of poverty.[4]

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1 *Submission* 118, p.16 (VCOSS).

2 *Committee Hansard* 30.4.03, pp.76-81 (Centre for Public Policy/Salvation Army/Catholic Social Services Victoria). See also *Submission*s 118, p.16 (VCOSS); 41, pp.5-6 (Dianella Community Health).

3 AIHW, *Australia's Health 2002*, p.14. See also *Submission* 129, pp.37-38 (Queensland Government).

4 *Submission* 163, p.139 (ACOSS). See also *Submissions* 44, p.31 (SVDP); 118, p.16 (VCOSS); *Committee Hansard* 4.8.03, p.1220 (Doctors Reform Society).

8.4 A range of health and related social problems, including suicide, are also linked to poverty. One witness noted that a number of clients, who are experiencing financial difficulties, actually present to the local council with issues relating to suicide, depression, family breakdown and domestic violence – 'so they may not come in and say, "Look, we can't afford to eat" – they are presenting with other issues – but when you get to the underlying cause, it is financial'.[5]

8.5 The importance to people's lives of ensuring access to healthcare services was emphasised in evidence, with advocacy groups indicting that many people are missing out on a range of health services. SACOSS told the Committee that:

> …the issues of health for a growing number of [poor] people are evident, particularly in the homelessness sector, where we are constantly paying for people to have prescriptions filled and constantly calling doctors into our services because people do not have money to visit doctors.[6]

8.6 Another witness noted that:

> We had two women who were sharing a pair of glasses. It was not quite down to the dentures. It is not just for prescriptions.[7]

8.7 Even for those people in employment, affordable healthcare is often problematic. One witness in a low paid job stated that:

> I have got no health care for my children. I dread every sniffle and cough because I cannot afford to go to the doctor and, if I do go to the doctor, I cannot afford to pay for the prescriptions that they are going to need when I am finished. We may be at the top end of the poverty scale but we are on a downward slide and, if something is not fixed, then that is where we will end up.[8]

8.8 A number of issues were raised in relation to ensuring equitable and accessible health care to people in poverty, including:

- access to Medicare;
- access to public hospitals;
- access to ancillary and specialist health services;

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5 *Committee Hansard* 1.5.03, p.135 (Knox City Council). See also *Committee Hansard* 30.4.03, p.85 (Salvation Army).

6 *Committee Hansard* 29.4.03, p.66 (SACOSS).

7 *Committee Hansard* 29.4.03, p.66 (Lutheran Community Care).

8 *Committee Hansard* 29.5.03, pp.581-82 (Mrs Cox).

- access to preventive health and related services;
- access to maternal and child health services; and
- access to dental care.

Access to Medicare

8.9 It was emphasised during the inquiry that the role of Medicare in providing free or reduced-cost hospital and medical services is of great value to all Australians but particularly important for people on low incomes. Medicare provides people with access to free treatment as public (Medicare) patients in hospitals, and free or subsidised treatment by medical practitioners and participating optometrists. People on low incomes often cannot afford private health insurance and even relatively small medical costs can be a serious obstacle in accessing health services.[9] Concerns were expressed that that the Commonwealth Government is increasingly moving towards a 'two-tier' health system in which Medicare will become a 'second-class' system reserved for the disadvantaged.[10]

8.10 Despite the many positive features of Medicare, a number of submissions and other evidence identified gaps in relation to Medicare coverage and services. Firstly, Medicare does not cover a number of important heath care services such as dental care, counselling, physiotherapy and podiatry. Access to these services is severely limited in the public system but widely available to people who can afford to pay privately, either out of their own pocket or through private health insurance. Secondly, Medicare permits the unregulated levying of patient co-payments for medical services, including specialist, diagnostic and GP services. Thirdly, Medicare has not delivered equitable access to health services for certain sections of the community, especially ATSI people and people living in certain areas of the country, such as rural and remote areas and outer urban areas.[11]

Decline in bulk-billing

8.11 Another key concern identified during the inquiry impacting on the lives of all Australians but particularly many poorer Australians is the decline in the numbers of GPs who provide bulk billing.[12] Bulk billing is vital to the health of people experiencing poverty and disadvantage – it enables people to seek medical checks and

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9 *Submissions* 166, p.28 (Salvation Army); 98, p.22 (BSL); 118, p.16 (VCOSS).

10 *Submissions* 29, p.7 (CPSA); 223, p.9 (APSF). See also *Committee Hansard* 30.4.03, p.76 (Centre for Public Policy).

11 *Submission* 163, p.140 (ACOSS).

12 *Committee Hansard* 30.4.03, pp.76-77 (Centre for Public Policy); 4.8.03, p.1219 (Doctors Reform Society).

assistance as the need arises and allows continuity of care, which improves the success of any intervention. Welfare agencies noted that their work with people on low incomes shows that people in these circumstances rely on bulk billing by GPs for access to affordable medical services.

8.12 Since the introduction of Medicare, bulk billing had grown to cover 80 per cent of GP services by 1996. In recent years bulk billing rates have declined – by the September quarter 2003, only 66.7 per cent of GP services were bulk-billed, a decline of 3.7 per cent compared with the September quarter 2002. The rate had declined further to 65.7 per cent by the December quarter 2003.[13]

8.13 In addition to the decline in the proportion of bulk-billed out-of-hospital services, there is a marked geographic disparity in access to bulk-billed services, with bulk-billing rates varying widely between regions (see Table 8.1). As a general rule, people in capital cities are much more likely to be bulk-billed than those outside cities, that is, those in rural centres and remote areas.

Table 8.1: Proportion of non-referred attendances to GPs bulk-billed, by region

	1996-97	1997-98	1998-99	1999-2000	2000-01	2001-02
Capital city	85.9	85.6	85.4	85.2	83.8	80.8
Other metro centre	81.3	80.1	79.5	78.6	76.2	72.3
Large rural centre	65.7	63.7	61.7	60.8	59.8	59.0
Small rural centre	64.8	63.1	61.7	61.7	60.9	59.3
Other rural area	62.1	59.6	59.1	58.6	57.7	56.6
Remote centre	56.0	56.7	57.6	59.0	60.0	58.9
Other remote area	70.1	69.6	70.1	70.1	69.5	70.0
Unknown	68.8	70.3	71.4	73.4	72.7	71.5
Australia	**80.6**	**79.8**	**79.4**	**79.1**	**77.6**	**74.9**

Source: Productivity Commission, *Report on Government Services 2003*, January 2003, Table 10A.36 available at www.pc.gov.au/gsp/2003

8.14 Submissions noted that this decline in bulk-billing results in uneven access to health services for people on low-incomes, especially in country areas where there is little choice of GP. The decline in bulk billing also impacts on older people, families with children, and people with a chronic illness and/or disability. COTA National Seniors stated that 'for an individual on a full age pension needing to see a doctor once or twice a week, his or her income can be reduced by amounts in the order of $6-$12

13 Department of Health & Ageing (DoHA), *Medicare Statistics*, September & December Quarters 2003.

per week or more. This is yet another factor contributing to the financial hardship reported by many older people'.[14]

8.15 VCOSS cited anecdotal evidence of people delaying visiting a GP to seek diagnosis and treatment. This means that people are not able to access preventive health care measures or receive early intervention treatment or support, raising the likelihood of longer-term health costs due to reliance on treatment at later stages of an illness.[15] Statistics show that the total number of GP visits declined by 1.3 per cent in the December 2003 quarter compared with the December quarter 2002 which may indicate that many people are avoiding visiting the doctor because of the cost.[16]

8.16 Patients are facing increasing out-of-pocket costs for GP visits. The out-of-pocket contribution made by patients for GP services increased from an average of $5.61 in 1984-85 to $12.46 in 2002-03 and to $13.57 by the December quarter 2003.[17]

8.17 The decline in bulk billing is also resulting in people turning to already over-stretched community health centres and the emergency units of public hospitals. The Queensland Government stated the emergency departments in that State are currently being 'inundated' with people who should be treated by GPs – 'these people are reporting that they can not get access to, or can not afford a general practitioner'. The Government stated that over the past three years there has been a 10.3 per cent increase in the number of patients treated by emergency departments, and a 14 per cent increase in the number of non-urgent or semi-urgent cases presenting to the emergency departments.[18]

8.18 The Victorian Government expressed similar concerns. The Government stated that there was an 11.5 per cent growth in emergency department presentations between June 2001 and June 2002 in Victoria and it is estimated that around 30 per cent of emergency department presentations could be better serviced by a GP – 'this suggests that significant numbers of people are not receiving the accessible and responsive primary care they require in a setting most appropriate to their needs'.[19]

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14 *Submission* 184, p.21 (COTA National Seniors). See also *Submissions* 29 p.8 (CPSA); 223, p.10 (APSF).

15 *Submission* 118, p.17 (VCOSS).

16 DoHA, *Medicare Statistics*, December Quarter 2003.

17 DoHA, *Medicare Statistics 1984/85 to September Quarter 2003*, p.41; *Medicare Statistics*, December Quarter 2003.

18 *Submission* 129, p.39 (Queensland Government).

19 *Submission* 69, p.24 (Victorian Government).

8.19 Submissions argued that it is vital that bulk billing is maintained and expanded to ensure access to health services for all Australians.[20] The Brotherhood of St Laurence (BSL), while suggesting that bulk billing be maintained, also argued that it should be extended to a wider group of practitioners, particularly specialists, and be available to people on low incomes in all geographical areas.[21]

Addressing the decline in bulk-billing

8.20 Measures to amend Medicare and address declining bulk-billing have been the subject of considerable debate between the major political parties since the Government released its *A Fairer Medicare* package as part of the May 2003-04 Budget. The package aimed to reduce the costs of accessing health care, particularly for concession card holders. The key element of the Government's proposals was a system of incentive payments for practices that agree to bulk-bill all concession card holding patients and the capacity for participating practices to receive rebates for all their patients directly from the HIC.

8.21 The ALP announced a policy in May 2003 in response to the Government's package that proposes to immediately lift patient rebates to 95 per cent of the schedule fee, with a subsequent increase to 100 per cent for every bulk-billed GP service by 2006-07. In addition, GPs who meet bulk-billing targets would receive additional incentive payments. The ALP initiatives are designed to reach a national target level of bulk-billing of 80 per cent. Overall, the ALP policy represents a rejection of all elements of the *A Fairer Medicare* package except for the workforce initiatives aimed at alleviating doctor shortages, and measures to increase the GP rebate for veterans and war widows.[22]

8.22 The Senate established a Select Committee on Medicare to review the Government's package of reforms. At a practical level, the Select Committee found that the Government's policy 'is focused on 'guaranteeing' bulk-billing of concessional patients in a way that is quite simply unnecessary, since the majority of these people are in all likelihood already bulk-billed'. The Committee concluded that the scheme as proposed would trigger a fall in bulk-billing for all those who are not concession cardholders – 'many Australians in genuine need of bulk-billing will fall just outside the threshold of concessional status – including many working families and those with chronic illnesses. These people will face both more gap payments, and overall, a rise in the level of such payments'.[23]

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20 *Submissions* 98, p.22 (BSL); 166, p.28 (Salvation Army).

21 *Submission* 98, p.ix (BSL).

22 ALP policy cited in Senate Select Committee on Medicare, *Medicare – Healthcare or Welfare?,* October 2003, pp.115-16.

23 *Medicare – Healthcare or Welfare?,* p.xiii.

8.23 In response to criticisms of its original proposal, the Government announced changes to its reform package. Under the new *MedicarePlus* arrangements, announced on 18 November 2003, the Government will pay GPs an additional $5 for every bulk-billed medical service provided to concession card holders and to children aged under 16 years. New safety net arrangements were also announced. The *MedicarePlus* proposals were also considered by the Select Committee that reported in February 2004.[24] The Senate had yet to debate the legislation at the time of drafting this report.

Conclusion

8.24 The Committee believes that bulk billing is a cornerstone of access to primary health care in Australia, playing an indispensable day-to-day role for all Australians and particularly for the poor and the disadvantaged. Bulk billing has been important in limiting barriers to low income people for mainstream health care by minimising out-of-pocket costs and thus impacting positively on the living standards of the poor and disadvantaged in the community.

8.25 The Committee notes that the two reports by the Select Committee on Medicare contain a range of recommendations to improve bulk-billing, in addition to other measures to improve access to health services by low income and other disadvantaged groups and people in society.

Access to public hospitals

8.26 Submissions and other evidence to the inquiry noted the importance of ensuring timely access to hospital services for those on low incomes and commented on the increasing pressures placed on public hospitals in providing adequate services as a result of, *inter alia*, a general lack of funding, the diversion of funds to the private system and the funding complexities arising out of the Commonwealth-State division of responsibilities in the area of health.[25] The Doctors Reform Society stated that:

> Public hospitals cannot meet the demands on them. Despite promises that propping up the private health insurance industry with an enormous public hand-out – somewhere between $2 billion and $3 billion annually – would take pressure off the public system, the demands are still increasing.[26]

8.27 This Committee's 2000 report into public hospital funding concluded that public hospitals in Australia need an urgent injection of funds. The Committee found that:

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24 Senate Select Committee on Medicare, *MedicarePlus: the Future for Medicare?,* February 2004.

25 *Submissions* 134, p.2 (Centre for Public Policy); 184, p.20 (COTA National Seniors). See also *Committee Hansard* 30.4.03, pp.76-79 (Centre for Public Policy).

26 *Committee Hansard* 4.8.03, p.1220 (Doctors Reform Society).

> Whilst the current funding shortage has arisen because of the Commonwealth's failure to properly index hospital grants, the problem is deeper. There has been a long term pattern of cost shifting by both the States and the Commonwealth which has continually squeezed the public hospital system….Evidence presented to the inquiry has indicated that the key problems that needs to be addressed as a priority is the fragmented nature of the roles and responsibilities of the Commonwealth and the States and Territory Governments in the funding and delivery of public hospital services.[27]

Australian Health Care Agreements

8.28 Under the Medicare arrangements, public hospital services are provided under Australian Health Care Agreements (AHCAs) with the State and Territory Governments. Under the 2003-08 AHCAs, the Commonwealth will provide funding of $42 billion to the States, a 17 per cent real increase over the 1998-2003 AHCAs. The AHCAs provide funding growth on the basis of inflation, population growth, ageing, and other demand factors such as increased availability of medical technology. AHCA expenditure in 2002-03 was over $7.240 billion.[28]

8.29 State Governments argued that the 2003-08 AHCAs fail to provide an adequate level of funding to the States. The NSW Government argued that the new AHCAs left NSW about $1.3 billion worse off than the previous five year Agreement and will place further pressure on the public hospital system in that State. The Government argued that the Agreement did not take sufficient account of the impact on the public hospital system of increased health-related costs, the ageing population and the cost of new technologies.[29]

8.30 While the Commonwealth and States continue to argue over funding levels and cost-shifting within the public hospital system, it is Australians at the lower end of the socio-economic spectrum that are further disadvantaged in accessing timely and appropriate health care.

8.31 The latest AHCAs have been criticised for not including health reform proposals and should have had an emphasis 'on illness prevention strategies and developing a new model of "continuous care"'.[30]

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27 Senate Community Affairs References Committee, *Healing our Hospitals: Report on Public Hospital Funding,* December 2000, p.x.

28 DoHA, *Annual Report 2002-03*, pp.83-84.

29 NSW Health, 'NSW response to Commonwealth Medicare proposal', *Media Release*, 23.4.03; 'Federal Government cuts NSW hospital funding by $1.3 billion', *Media Release*, 2.5.03.

30 AHRA, 'Health industry and consumers in last ditch effort to rescue $42 billion care agreements', *Media Release*, 17.7.03.

8.32 A number of access and equity issues in relation to public hospitals were identified during the inquiry and by commentators in the healthcare area. These include:

- the increasing occurrence of hospital access block and hospital ambulance bypass – 'the effects of access block on acute hospital services are most disturbingly reflected by patients on trolleys in emergency department corridors and ambulances circling hospitals, waiting to deliver ill patients...Access block has been with us since the 1980s, but in recent years, in Australia, it appears to have become both endemic and critical across all our major cities'.[31]

- increasing waiting times for elective surgery – 'public hospital waiting lists, which disproportionately apply to those without private health insurance, constitute a real problem of equity'.[32]

- the problem of hospital exit block, reflecting the short supply of community-care services, particularly for older people – 'concurrently with decreasing acute hospital bed numbers, access to residential care beds in the community has decreased, especially beds designed for high-dependency patients. This has increased demand on acute hospital services as elderly inpatients wait for long term placement or are inappropriately sent back to the community to avoid pressure on an already congested residential care system'.[33]

- the inability of a system organised for acute, episodic care to efficiently provide continuous long-term care.[34]

8.33 Evidence and commentators also pointed to the need to improve public hospital infrastructure, including substantial additional capital funding, as well as ongoing funding.[35]

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31 Cameron P & Campbell D, 'Access block: problems and progress', *Medical Journal of Australia*, Vol. 178, No.3 2003, p.99.

32 Leeder S, 'Achieving equity in the Australian healthcare system', *Medical Journal of Australia*, Vol.179, No.9, 2003, p.477.

33 Cameron & Campbell, p.99.

34 Van Der Weyden M, 'Australian healthcare reform: in need of political courage and champions', *Medical Journal of Australia*, Vol. 179, No.6 2003, p.280; Leeder S, p.477; Australian Health Reform Alliance, 'New "Health Reform Council" is a test of leadership for today's COAG meeting', *Media Release,* 29.8.03.

35 *Submission* 134, p.2 (Centre for Public Policy); Leeder, p.477.

Impact of the private health insurance rebate

8.34 Submissions also argued that the introduction of subsidies for private health insurance further undermine the capacity of the health system to provide equitable access to health care. VCOSS claimed that the current funding of private health care is 'unsustainable, inequitable and, arguably, an inappropriate use of public funds.'[36] The Commonwealth has estimated that it will spend $2.26 billion on the private health insurance (PHI) rebate in 2003-04.[37]

8.35 The Doctors Reform Society noted that the major users of public hospitals are people from lower SES groups who suffer from chronic illnesses – 'it is the same people who cannot afford private health insurance who do not get the alleged benefits of the private health insurance rebate. Public hospitals are in crisis because the money spent on the private health insurance rebate is not being spent on health'.[38] The Centre for Public Policy similarly noted that 'if private insurance was funded at a lower level or not funded at all by the state, there would be funds available to pay for a great deal more of the sort of universal public health provision which the poor are most in need of'.[39]

8.36 The Select Committee on Medicare, which reviewed the impact of the PHI rebate, concluded that while there was limited data on the equity and effectiveness of the rebate to make unequivocal judgements:

> …sufficient evidence has already been presented to cast doubt on the overall effectiveness of the PHI rebate in contributing to the improvement of Australia's health system. In the light of the large amount of money involved in the subsidy, and the alternative uses to which it could be put, these criticisms must be taken seriously.[40]

8.37 Submissions emphasised that for efficiency and equity reasons it is essential that public hospitals continue to provide a viable and quality alternative to the private system. The Victorian Government stated that, for these reasons, 'balance needs to be exercised in ensuring that incentives to take up private health care through the health care rebate are not achieved at the expense of efficiency or the wellbeing of the public health system'.[41]

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36 *Submission* 118, p.17 (VCOSS).

37 DoHA, *Portfolio Budget Statements 2003-04*, p.217.

38 *Committee Hansard* 4.8.03, p.1220 (Doctors Reform Society).

39 *Committee Hansard* 30.4.03, p.78 (Centre for Public Policy).

40 *Medicare – Healthcare or Welfare?,* p.167.

41 *Submission* 69, p.24 (Victorian Government).

Conclusion

8.38 The Committee believes that the public hospital system needs to be adequately funded and supported and that the Commonwealth should re-examine its funding priorities vis-à-vis the public and private health systems to ensure equitable access to hospital services for low income and other disadvantaged Australians.

Access to ancillary and specialist health services

8.39 Ancillary or allied health services play an important role in overall health care. Allied health professionals can provide both primary care services and a wide range of specialist diagnostic and treatment services for both referred and unreferred patients. These services are provided in an effort to create a more integrated and prevention-focused health care system. Allied health services presently included on the Medicare Benefits Schedule (MBS) are limited to prescribed psychiatry and optometry services. No other allied health services are funded under Medicare.[42]

8.40 Submissions and other evidence raised concerns that people on low incomes have limited access to a range of ancillary or allied health services such as dental and optical services, chiropractic and out-of-hospital specialist medical practitioner services.[43]

8.41 COTA National Seniors Partnership illustrated the problem as it relates to older Australians. COTA stated that:

> Medicare also does not cover many important areas of treatment under the umbrella of allied health services such as physiotherapy, podiatry, chiropractic and psychology. Low income, older people have difficulty accessing these services if they have not taken out "extras" in private health insurance. However insurance is expensive and may not offer a large enough rebate to make the premium affordable, especially for people paying health insurance out of a full age pension.[44]

8.42 A NATSEM study found that a range of ancillary and specialist health services are more heavily used by people on higher incomes than those on lower incomes. Most notable were dental, chiropractic and out-of-hospital specialist medical practitioner services. There was also less use made of podiatry and optometry services by lower income groups, although this was less marked than for the services previously referred to. The study found that differences in access between high and low income groups was largely due to the high out-of-pocket costs as these services are mainly provided through private practices. The study concluded that there are

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42 *Medicare – Healthcare or Welfare?,* p.134.

43 *Submission* 118, p.16 (VCOSS); *Committee Hansard* 30.4.03, p.76 (Centre for Public Policy).

44 *Submission* 184, pp.20-21 (COTA National Seniors).

some ancillary and specialist health services which, because of their high out-of-pocket costs fall into a 'second tier' of health services that are less accessible to people with low incomes.[45]

8.43 It has been argued that there should be an extension of the MBS to cover allied health services. A reform of this nature has, however, considerable economic and financial consequences.[46] The Select Committee on Medicare noted that the cost implications would be substantial, requiring an increase in Commonwealth funding of potentially $3-4 billion, depending on the scope of the additional services covered. While the measure would in all likelihood result in overall savings from reduced demand for GP and public hospital services, these savings would be difficult to quantify.

8.44 Secondly, the broader cost effects of wide scale additions to the MBS are difficult to predict. An extensive range of allied health services included on the MBS could lead to a substantial rise of supply-induced demand for allied health services, with attendant stress on Medicare funding. Thirdly, extending the MBS to cover allied health services also raises the issue of which services would receive priority for Medicare funding and which would not qualify. The decision about which allied health services to include on the MBS is difficult because of, *inter alia*, the varying allied health needs of different regions in Australia. Finally, given the problems inherent in the fee-for-service model of payment used by Medicare, it is not desirable to exacerbate the issue by increasing the number of MBS rebateable items.[47]

8.45 Accepting the arguments of the Select Committee, this Committee also does not favour any immediate broadening of the scope of services covered by the MBS. While there is a need to enhance accessibility to allied health services, the Committee considers that there are more targeted and effective mechanisms for addressing the issue. These include enhancing successful aspects of current initiatives, such as the More Allied Health Services Program. This program began in 2000-01 as part of the Commonwealth's *Regional Health Strategy: More Doctors, Better Services*. The program has facilitated links between rural GPs and allied health professionals by allocating targeted funding to employ additional allied health professionals in rural areas. Other initiatives that should be further encouraged include the funding of primary health care teams, and providing funding for shared access to resources via groups such as the Divisions of General Practice.[48]

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45 Schofield D, 'Ancillary and Specialist Health Services: Does Low Income Limit Access?', NATSEM Discussion Paper No. 22, June 1997, pp. 1-3, 18.

46 For a discussion see *Medicare – Healthcare or Welfare?,* pp.133-43.

47 *Medicare – Healthcare or Welfare?* , pp.143-44.

48 For further discussion see *Medicare – Healthcare or Welfare?,* pp.137-38, 169-205.

Access to preventive health and related services

8.46 Preventive health services/public health interventions focus on prevention, promotion and protection rather than on treatment; on populations or population groups rather than on individuals; and on factors and behaviours that affect health and cause illness and injury. Well-structured health priorities and interventions have the ability to reduce illness, cut healthcare costs and improve quality of life. Studies have demonstrated the value to the community of such interventions, in particular the substantial benefits, relative to costs, flowing from immunisation and tobacco control campaigns.[49]

8.47 Submissions pointed to the value in promoting preventive health strategies, especially for people from socio-economic disadvantaged backgrounds. Data indicate that people from these backgrounds make greater use of doctors and outpatient/casualty services, but are less likely to use preventive health services.

8.48 Socio-economic disadvantaged people generally experience greater ill-health than people from higher SES groups. The mechanisms by which socioeconomic status influences health status are many and varied. However, those most often postulated are diet, health behaviour, education, access to heath services (both preventive and treatment), quality of housing and psychosocial factors. On all these indices people from disadvantaged backgrounds perform less well than people from higher SES groups. Socioeconomic disadvantage as a risk factor for ill health also interacts with other risk factors. People from lower socioeconomic groups, when compared with people of higher socioeconomic status groups, are more likely to smoke and smoke regularly; report less physical activity during their leisure time, and are more overweight or obese, all of which are significant risk factors for a number of major health conditions, such as cardiovascular disease and respiratory diseases.[50]

8.49 The Committee believes that preventive health measures as well as other measures such as early childhood programs; nutrition programs; and other programs to assist families, the elderly and people with disabilities and others in the community; especially community-centred programs where services are provided at the local level are important in addressing poverty and disadvantage, especially in more socioeconomically disadvantaged areas.

Recommendation 31

8.50 That the Commonwealth provide additional funding for preventive health and related measures, and that this funding be directed particularly at socioeconomically disadvantaged areas.

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49 AIHW, *Australia's Health 2002*, pp.323-24.

50 AIHW, *Australia's Health 2002*, pp.212-13.

Access to maternal and child health services

8.51 Evidence indicates the importance of universal maternal and child health services. Increasingly, research demonstrates that maternal health influences health outcomes for the child. Recent research has given new insights into the long term health outcomes which relate to birth weight and growth through infancy. For the child, low birth weight is associated in the short term with delayed growth, and in the long term, with the development of conditions such as adult hypertension, coronary heart disease and diabetes.[51]

8.52 Improving the accessibility and appropriateness of health services for children is important especially for children living in socioeconomically disadvantaged families, Indigenous children, children with chronic illnesses and/or disability and children living in rural and remote areas. This recognises the poorer health outcomes of children from these backgrounds. Improving health outcomes for children requires a reorientation of health services to focus on prevention and early intervention strategies.

8.53 One example of a successful strategy in this area is home visiting. This has been advocated as a means of supporting the development of healthy parenting; as a strategy to promote child health; and as an intervention to protect children from abuse and neglect. These programs have been shown to impact positively on a number of health indicators including breastfeeding rates; decreased accidental injury rates; increased immunisation rates; decreased behaviours among parents associated with physical abuse and neglect; and decreased Emergency Department visits and paediatric inpatient admissions.[52]

Access to dental care

8.54 Evidence to the Committee highlighted the serious lack of access to affordable dental services for people on low incomes.[53] Under current arrangements, dental health care in Australia is largely performed by privately billing dentists, with relatively small public dental programs provided by State and Territory Governments.

8.55 The Centre for Public Policy, commenting on the parlous state of dental care for the poor in Australia, submitted that:

> …[it] is an absolutely extraordinary and worldwide scandal. If you are poor, your teeth can rot…They rot because it is impossible to get an appointment

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51 NSW Health, *The Start of Good Health: Improving the Health of Children in NSW*, September 1999, p.22.

52 *The Start of Good Health*, p.36.

53 *Committee Hansard* 30.4.03, p.78 (VCOSS); 4.8.03, p.1220 (Doctors Reform Society); 2.7.03, pp.922-24 (Illawarra Dental Health Action Group).

> with a publicly funded dentist within the period of time when the condition can be repaired Even emergency cases are often in a situation where they have to put up with pain and bleeding if they cannot find a pro bono private dentist.[54]

8.56 Submissions noted that people living on low incomes visit dentists less frequently than the rest of the community; are likely to have teeth extracted rather than filled; and are less likely to get preventive care. Some people who have all their teeth removed during emergency treatment may wait up to a year to receive dentures.[55]

8.57 These observations were reflected in the findings of this Committee's 1998 report into public dental services. The report found that:

- people aged 45-64 in the lowest quintile of household incomes are eight times more likely to have no natural teeth and 1.7 times more likely to wear a denture, than people from the wealthiest quintile;

- Health Card holders aged 45 years and over are more than 1.7 times more likely to be edentulous (without teeth) and 1.4 times more likely to wear a denture than non Health Card holders; and

- people from disadvantaged backgrounds are more likely to have poor oral health than the general population and are about twice as likely to have lost their natural teeth.[56]

It is evident from the submissions received that the situation with oral health has not improved since the 1998 report, indeed it appears to have deteriorated.

8.58 Poor dental health causes a range of consequences including pain, difficulty in eating and the avoidance of certain foods (which can lead to wider health problems), and is associated with a range of serious medical conditions. It also affects self-esteem, employability and social and community participation. Generally, a person's overall quality of life is affected.[57]

8.59 For many people on low incomes the high dental fees charged by private dentists are prohibitive and thus they are reliant on public dental services. However, access to public dental services has declined dramatically since the cessation of the

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54 *Committee Hansard* 30.4.03, p.78 (Centre for Public Policy).

55 *Submissions* 98, p.22 (BSL); 166, pp.28-29 (Salvation Army).

56 Senate Community Affairs References Committee, *Report on Public Dental Services*, May 1998, p.6.

57 Dental Services report, p.4; *Submissions* 143, p.6 (NCOSS); 29, pp. 9-10 (CPSA); 69, p.24 (Victorian Government); 230, pp.1-5 (Illawarra Dental Health Action Group). See also *Committee Hansard* 2.7.03, pp.922-23 (Illawarra Dental Health Action Group).

Commonwealth Dental Health Program (CDHP) in 1997 with a significant increase in waiting lists since that time. One witness noted that with the abolition of the CDHP 'all those who were on, below or in the vicinity of the poverty line found themselves disadvantaged to a degree comparable to a Third World country'.[58]

8.60 The CDHP was introduced in 1994 and provided basic levels of dental care for holders of Health Cards and their dependants aged 18 years and over and Commonwealth Seniors Health Card holders. Full and partial dentures were excluded from the Program, as were specialist services such as crowns, bridges, and orthodontics. Under the Program a total of 1.5 million services were provided to eligible adults. A total of $245 million was provided by the Commonwealth under the Program over the four years from 1993-94 to 1996-97 inclusive. The Commonwealth ceased funding the Program on 31 December 1996, following which the States resumed full responsibility for public dentistry.[59] Evaluation studies of the Program found that it was generally successful in providing improved access to services for low income groups; a reduction in waiting lists; and a shift in treatment options away from extractions and towards restorative treatments.[60]

8.61 Waiting lists and waiting times have increased significantly since the cessation of the CDHP. There are currently about 500 000 people on waiting lists around Australia for public dental treatment and only about 11 per cent of those eligible for treatment receive it each year. Waiting times are three to four years in some areas.[61] In NSW, NCOSS stated that in 1997, when the CDHP ceased, there were 111 8504 people on the waiting list in that State for public dental treatment. This number had increased to over 250 000 by March 2001.[62] In Victoria, waiting lists for dental health services provided through community health services are up to three years or longer in certain regional areas as well as in some urban centres.[63]

8.62 Submissions noted that it was ironical that since the abandonment of the CDHP access to public dental care has decreased, however, tax subsidies are provided for private dental care to assist wealthier members of the community. The Victorian Government stated that the Commonwealth Government has spent some $360 million

58 *Committee Hansard* 2.7.03, p.922 (Illawarra Dental Health Action Group).

59 The States were required to maintain their baseline level of recurrent funding to adult dental services under the Agreement with the Commonwealth. See Dental report, pp.27-29.

60 For further details see Dental report, pp.29-32.

61 *Submission* 98, p.22 (BSL). See also *Submission* 166, p.29 (Salvation Army).

62 *Submission* 143, p.6 (NCOSS).

63 *Committee Hansard* 30.4.03 (VCOSS).

over the period 1997 to June 2000 subsidising private dental treatment through the private health insurance rebate.[64]

8.63 Submissions argued that there is a need for the establishment of a publicly funded national dental health scheme to improve access to dental services for people on low incomes.[65] While the States direct funding into dental health services, funding is clearly not sufficient to meet unmet need and there is a clear case for Commonwealth involvement in this important area to reduce the numbers of people on low incomes who experience poor oral health without access to adequate dental treatment.[66]

8.64 ACOSS suggested that funding needs to be targeted to disadvantaged groups with particular dental health needs including nursing home residents, Indigenous people, people living in rural and remote areas, people with a disability, homeless people, people with a mental illness and people on social security benefits.[67]

8.65 NCOSS proposed that a public dental program should incorporate a number of targets, including:

- that no person should have to wait more than 24 hours for emergency dental care;
- that treatment should be available for preventive care in time to avoid expensive, complicated dental care or tooth loss; and
- that regular dental checkups should be available, at least every three years.[68]

Conclusion

8.66 Dental health plays a crucial role in a person's overall health, and the Committee is concerned that many low income Australians experience significant problems in accessing timely and effective dental care. The Committee believes that there is an urgent need for the Commonwealth and the States to address the dental health care needs of low income Australians. The Committee sees public dental care as a responsibility that is shared with the States, and one in which the Commonwealth should take an active leadership role.

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64 *Submission* 69, p.25 (Victorian Government). See also *Submission* 98, p.23 (BSL).

65 *Submissions* 98, p.ix (BSL), 143, p.6 (NCOSS).

66 *Submission*s 69, p.25 (Victorian Government); 143, p.6 (NCOSS).

67 *Submission* 163, p.143 (ACOSS).

68 *Submission* 143, pp.6-7 (NCOSS).

8.67 The Committee considers that a national dental health scheme needs to be established to provide dental services to people on low incomes and that such a scheme should be jointly funded by the Commonwealth and the States. Evidence to the inquiry pointed overwhelmingly to the benefits of the earlier Commonwealth Dental Health Program. This program represented a targeted measure of limited cost that was shown to achieve significant increases in access to dental care for those most in need. As with the original scheme, the introduction of a new public dental health program needs to be developed in close consultation with State Governments to ensure that it does not simply substitute for current dental funds.[69]

Recommendation 32

8.68 That a jointly funded Commonwealth-State national dental health scheme be established to improve access to dental services for people on low incomes, and that it be modelled on the former Commonwealth Dental Health Program.

69 Similar conclusions and recommendations were made by the Select Committee on Medicare that examined issues relating to allied and dental health care, *Medicare – Healthcare or Welfare?*, pp.121-132.