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Access to Australian health care is not universal or fair

By Tim Woodruff
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Inequalities in health outcome and health status are very obvious in Australia despite the continuing increase in life expectancy and decline in infant mortality. One could argue that inequalities are inevitable. We are not born equal and we can never have and nor might we want equality. When inequalities are due to potentially remediable differences in our society however, the issue is one of equity. This is an issue of social justice. It is also a reflection of the overall health of our society. Trends over the last decade makes one wonder whether our policy makers and society as a whole are content to simply tackle gross inequity in a piecemeal fashion rather than tackling the much more challenging task of aiming for equity.

Health status

Males from the poorest fifth of Australians have a mortality rate 80 per cent higher than the richest fifth and for females the figure is 50 per cent. Much, but not all of this difference is related to the increased mortality of indigenous Australians. Over decades mortality rates for all socioeconomic groups are declining but when one compares the poorest with the richest, the ratio is increasing, especially for males. Our society is becoming more unequal in terms of mortality. The same pattern emerges if one compares the differences between those from inner urban areas with areas of increasing remoteness. Importantly, as well as differences between the extremes, there is a gradient of increasing mortality as one moves down the socioeconomic ladder or into more rural and remote areas.

Why are there inequalities?

What leads to these remediable differences? The first reason is the variability in timely and affordable access to appropriate services. The Australian Bureau of Statistics 2009 survey of patient experiences found that up to 10 per cent of Australians delayed or avoided seeing a doctor or getting a prescription because of cost. If we survey sick Australians, the figure is 34 per cent. Despite these figures federal government policy is that everyone will pay copayments for prescriptions. Costs to see a doctor exist because the government continues to fund doctors through fee for service Medicare rebates with the added condition that the doctor can charge a copayment of any value. While only 20 per cent of GP consultations have a copayment the figure is 70 per cent for specialists. As well as these cost barriers many patients can’t find a doctor because of the uneven distribution of the workforce. Many factors over which the Government has no control contribute to this: the primary funding system (Medicare rebates) pays doctors to work where they wish rather than where there is the greatest need.

The second explanation for these differences is a group of factors called social determinants. These factors include access to income, education, housing, employment, health care, and many others but fundamentally all these factors affect the perception of control over one’s life. Evidence suggests that income inequality in rich nations is the most important single factor affecting health and well being. Thus there is a clear gradient of greater levels of health and well being correlating with decreasing levels of income inequality measured by comparing the income of the top 20 per cent with the bottom 20 per cent. While this does not establish that simply decreasing income inequality will address the problem it does raise that possibility. It is of deep concern that on most comparative measures of disposable income over the period 1994 to 2008, there has been increasing inequality in Australia.

How are these inequalities addressed?

There is no doubt that at the highest levels of government the issue of inequitable access has been recognised

for decades. More recently there is evidence of an increasing understanding of the importance of social determinants, best illustrated in the approach to indigenous health.

There have been several approaches to address the issue of inequitable access. Safety nets have been devised, expanded, and revised. In addition to safety nets, governments have developed many programs over the years to target particularly disadvantaged groups. Many charitable groups also provide programs to target disadvantage. In addition, doctors are crucial in addressing disadvantage as they decide which of their patients belong to the group of deserving poor whom they will therefore bulk bill rather than charge a copayment. The need for safety nets, targeted programs, and charity are a reflection that the structure of the system is flawed. But nothing is done to address the structural flaws in the system.

Copayments, which stop people accessing services, are the prerogative of the provider, a prerogative given to the provider by the government. For prescription medication the copayments are imposed by Government despite the evidence that they reduce access. The capacity of doctors to be largely publicly funded through fee for service Medicare rebates and work where they wish, rather than where they are needed, is supported by government. This is not an approach that aims for equity, it is one that accepts some degree of inequity and is satisfied with the aim of reducing gross inequity.

The World Health Organisation’s Commission on the Social Determinants of Health (CSDH) recommends several key approaches. Firstly an improvement in daily living conditions with an emphasis on early childhood development, fair employment and decent work, having a universal social welfare system, and universal health care. We are doing reasonably well in most of those areas although particular groups are still missing out a lot. But in terms of universal health care, the evidence about inequitable access indicates we have universal entitlement but not universal access.

The second key approach recommended by the Commission is to tackle the inequitable distribution of power, money, and resources, which requires ‘a strong public sector that is committed, capable, and adequately financed’. This is not evident in our health system. Instead we see continuing taxpayer support for the expanding private hospital system, and increasing corporatisation of pathology and radiology services. In addition primary care (general practice etc), has previously run as multiple very small publicly subsidised private businesses, controlled by one or two providers. That is changing as the size of practices increases (not necessarily a bad thing) but with that change a more robust business model is required. The Government shows no concern as the profit motive of publicly listed companies determines how such practices are run and what financial barriers to access are acceptable to the business. Primary care is becoming more privatised, weakening the required strong public sector.

Improving employment and long term plans for improved housing affordability and availability will help to address the inequitable distribution of power, money, and resources. There is a reluctance to address structures, which guarantee inequitable income distribution and therefore power. Thus, despite the Henry tax review which did have improving equity as one of its intentions, the government has made only minor changes in the budget this year and the tax changes attached to the climate change policy are aimed at ensuring inequities do not increase rather than decreasing the current inequities.

Education is crucial to equity. The basic funding structure in primary and secondary education continues to support inequitable access to high quality well resourced schools. Despite lots of programs and projects to address these issues the federal government continues to fund the richest schools in the nation with money that could be spent on the most disadvantaged schools.

Barriers to addressing social determinants

There does not seem to be sufficient recognition that there are fundamental structural barriers to equity in our society, particularly in the health and education systems and in income distribution. There also appears to be a lack of recognition of the social gradient, which therefore supports the concept of targeting the most disadvantaged and ignoring those structural barriers.

Instead, the approach to health inequities appears to be largely focused on targeted programs, safety nets, and other forms of charity. The other concern about a reliance on charity is that it deflects those interested in equity from pursuing that idea through the much harder to achieve structural reform. Those who spend all their

time in charity work including well targeted programs, feel they are doing the right thing. They are. But while they may believe strongly in equity, they have no time left for the pursuit of the big changes required.

Politicians who start off with ideals of equity must turn into practical people, doing what is possible. Thus, even the well intentioned target gross inequity and feel they are doing well, and then they ignore or have no time and energy to address the structures which are amenable to change. The changes required to tackle the root causes of the inequity are major, but well within the power of governments. What is being done is minor if not minimal. For politicians, targeting gross inequity is perfect as they don't actually believe in equity, and much prefer the idea of charity, which fits well with their belief in a class based tiered society.

There is recognition amongst our politicians that to achieve health equity one needs to address both the health system and many factors outside the health system. There is a failure of recognition however that heath inequity follows a social gradient, and structural change is required to address this issue. A targeted approach to the most affected groups ignores this gradient and ignores the structural causes of the inequities. Indeed, one could view the approach of relying just on targeting as another form of charity, striving to reduce gross inequity but ignoring the goal of equity.

Dr Tim Woodruff is Vice-President of the Doctors Reform Society.

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