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CATHOLICS IN COALITION FOR JUSTICE AND PEACE

Catholics in Coalition for Justice and Peace

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# "Health – A quick check-up"

**Transcript of paper us for the address given by Jack de Groot, Group Leader of Mission St Vincent's Health Australia**

## About Jack de Groot

Jack de Groot is the Mission Director for St Vincent's Health Care Australia and former CEO of Caritas Australia and former Board Member at St.John of God Hospital.

Jack is an experienced senior executive in the Not-For-Profit sector who for the last 13 years has been CEO within one of the world's largest networks of social services and community development organisations. A compassionate leader with strong commitment to mission driven organisations who seek to make a difference in the lives of those living with the effects of injustice and poverty.

## Introduction

CCJP would initially like to thank Jack for stepping in to cover for Frances Sullivan at short notice and presenting a wonderful and enlightening address.

Thank you so much

### Core Policy Issues of recent years

- COAG agreement in August 2011 National Health Reform Agreement[1]
  - Move to Activity Based Funding and end to block funding
  - Medicare local networks – can do more if mandated to
- Productivity Commission Report on Aged Care 2011[2]
  - Leaders debate – there is a productivity commission report. Implement it
- WHO 2008 report *Closing the Gap in a Generation – Health Equity through action on the social determinants of health*[3]
- Senate Report on SDOH in 2013[4]

[1] http://www.federalfinancialrelations.gov.au/content/npa/health_reform/national-agreement.pdf
[2] http://www.pc.gov.au/projects/inquiry/aged-care/report
[3] http://www.who.int/social_determinants/thecommission/finalreport/en/index.html

- Est of Health Workforce Australia in 2011[5]

## Who should our Health Policy and Systems be for?

People who suffer a disproportionate share of poor health outcomes and are not served well by the current arrangements are[6]:

- First Australians
- People living in certain geographic areas including regional ,rural, remote and outer suburban areas
- Less financially well off
- Those with Mental illness
- Those with dental health problems
- Those with intellectual disability and ill health (and their carers)

## The realities for Australia

- We are as a whole suffering ever-increasing burden of chronic disease
- Lifestyle and ageing profile of population
    - We live to 82 now – 2 years more than the average in the OECD[7]
    - Type II diabetes will become leading cause of disease burden by 2023 – 10 years
    - Put together smoking, obesity, harmful use of alcohol, physical inactivity, poor diet and the risk of factors of high blood pressure and high blood cholesterol cause approximately 32% of Australia's illness – this costs $6 billion per year and we lose $13 billion in productivity
- Australians by international standards pay significantly more out of their own pocket than people in other countries.
    - 18.2% of health expenditure comes from our own pockets (greater than USA and UK)[8].
    - In some instance people are not accessing GP services or purchasing prescription medicines when they need to because of cost pressures.
    - Out of pocket expenses are increasing between 4-5% faster than CPI over the last decade and thus we fail the Medicare objectives.
    - On average the spend is $1075 per person (including children)[9]. We spend 1/3 of this on medication. 20% on dental and 11% on medical services. Many families do not have the financial resources. If you have multiple chronic conditions then you are hit hard.
    - Once you spend more that $610 out of pocket if you are low income then you can get 80% of Medicare cover to a certain level. But you have to be able to spend $610. If you are healthy the threshold is $1221[10]. This favours the rich disproportionately who can already afford to pay. **So in the seat of**

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4 http://www.aph.gov.au/parliamentary_business/committees/senate_committees?url=clac_ctte/completed_inquiries/2010-13/social_determinants_of_health/report/index.htm

5 http://www.hwa.gov.au/

6 http://www.cha.org.au/images/resources/Mend%20Medicare%20Final.pdf

7 http://www.oecdbetterlifeindex.org/topics/health/

8 http://www.cha.org.au/images/resources/Mend%20Medicare%20Final.pdf

9 http://www.cha.org.au/images/resources/Mend%20Medicare%20Final.pdf

10 http://www.humanservices.gov.au/customer/enablers/medicare/medicare-safety-net/medicare-safety-net-thresholds

**Wentworth $11 million was claimed in safety net benefits but in Braddon in NW Tasmania was $460,000[11]**

- Compared to other OECD countries, Australia's health system in relatively hospital centric.
- Lack of healthcare professionals where people need them
- Rationing of those services that are available, which arises where demand for services exceeds those which are made available. i.e. Hospital waiting lists

## MEDICARE

The objectives of Medicare are[12]:

- To make health care affordable for all Australians
- To get all Australians to health care services with priority according to clinical need, and
- To provide a high quality care

The average out of pocket cost for visiting a non-bulk billing doctor is $46.50 in 2012. Up from $30.00, 5 years previously[13]

GP bulk billing is now 82.4% nationally but there is huge variation. In some Medicare local networks it can be as low as 49% and up to 95.8% in other regions[14]. Unfortunately, the low bulk billed areas might not be the wealthiest population centre.

The proportion of people delaying a visit to the GP was 8.7% in 2011 – up from 6.4% the previous year.

Oral health never part of Medicare. To see a dentist costs you on average $203 out of pocket

PBS scripts not being filled due to cost is up to 15% in some Medicare local districts[15]

Waiting lists now 36 days – an increase. If you are in a less advantaged area then you wait 38 days and 27 days in the most advantaged areas in 2009 – this gap increase in the year 2011. Longest wait list in most disadvantaged areas was 231 days – 61 days longer than the most advantages areas. Those 61 days was in 2009. By 2011 the gap was 94 days[16]

## Private Health Insurance

Family cost is about $3,000. They then spend another $1170 on out of pocket expenses if they go to hospital[17].

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11 http://www.health.gov.au/internet/main/publishing.nsf/Content/71AEFE9116DE64F2CA257641000D4333/$File/Medicare%20Safety%20Net%202010.pdf

12 http://www.medicareaustralia.gov.au/provider/medicare/

13 http://www.health.gov.au/internet/main/publishing.nsf/Content/Quarterly-Medicare-Statistics

14 http://www.health.gov.au/internet/main/publishing.nsf/Content/Quarterly-Medicare-Statistics

15 http://www.cha.org.au/images/resources/Mend%20Medicare%20Final.pdf

16 http://www.cha.org.au/images/resources/Mend%20Medicare%20Final.pdf

17 http://www.cha.org.au/images/resources/Mend%20Medicare%20Final.pdf

## Challenges of Response – Understanding the Social Determinants of Health

Getting Doctors to move from cure to prevention in their policy approach or at least getting the balance stronger to asking if people are ill, we want to know what made them ill. What are the factors that contributed to their sickness or poor health? How can we address these problems?

The social determinants are the social and environmental conditions in which people live and work every day of their lives. These conditions affect our lives in many ways, including our health[18].

The physical environment affects our health – air quality, temperature, the weather, the vegetation, and the water, among other things.

Our housing affects our health. For many people it is a lack of housing, or the poor quality of housing.

Employment affects our health. Being out of work, especially for long periods, can have a serious impact on both physical and mental health of a person, and the people around them.

Education is a major factor in maintaining good health. Knowledge and health literacy and a hunger for learning – all-important factors in staying healthy[19].

World Health Organisation Commission that, in 2008, released a major report calling on governments to take action to reduce health inequities by addressing the social determinants of health which it defines as "the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels". It says these are responsible for health inequities (Globally and locally) – "the unfair and avoidable differences in health status seen within and between countries"[20]

The report outlined three principles for action.

- The first was improving the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.
- The second principle was tackling the structural drivers of those conditions – the inequitable distribution of power, money and resources.
- The third principle was measuring the problem, evaluating action, expanding the knowledge base, developing the workforce, and raising public awareness about the social determinants of health[21].

The Australian Government has not yet responded to this report[22].

THE SDOHA encourages governments to consider all the social determinants of health when developing health policy.

[18] http://socialdeterminants.org.au/

[19] https://ama.com.au/media/ama-president-dr-steve-hambleton-social-determinants-health-alliance-public-forum-13-august

[20] http://www.who.int/social_determinants/thecommission/finalreport/en/index.html

[21] http://www.who.int/social_determinants/thecommission/finalreport/en/index.html

[22] http://socialdeterminants.org.au/

In Australia 65% of those in the lowest income group report a long term health problem compared with just 15% of the most wealthy[23].

If the WHO Report was implemented in Australia then[24]:

- 500,000 Australians could avoid suffering a chronic illness
- 170,000 extra Australians could enter the workforce, generating an extra $8 billion in extra earnings
- Thus reducing welfare support payments by $4 billion
- 60,000 fewer people would need to be admitted to hospital annually with a resulting saving of $2.3 billion in hospital expenditure
- 5.5 million fewer Medicare service would be needed saving $273 million
- 5.3 million fewer PBS scripts would be filled with a saving of $184.5 million

**Indigenous peoples and other disadvantaged groups[25]**

Many of these communities have or may have had poor housing, a lack of clean water, Third World sanitation, a lack of teachers, or no jobs. The cumulative effect of these hardships takes its toll on human health - both immediately and over time.

Disadvantage is one, and disadvantage has many forms. It can be absolute – for example, not having access to quality education or housing. Or it can be relative – for example, poorer education, and insecure employment.

Poverty - absolute and relative - has a major impact on health and premature death. Poverty denies people access to full participation in the life of the community.

In the international context, those who are homeless have the highest rates of premature death.

Social exclusion also results from racism, discrimination, stigmatisation and unemployment.

The greater the length of time that people live in disadvantaged circumstances the greater the risk for ill health, particularly cardiovascular disease.

Generally, those with the lowest health status also have low educational and literacy levels.

**Employment and job security**

As a general rule, having a job is better for health than being unemployed. However, stress at work also increases the risk of disease.

Jobs that are demanding and where employees have little control or decision making in their employment are the most detrimental to health.

Being in debt can have health implications increasing effects on mental health, heart disease, and the risk factors for heart disease.

Adequate income affects the ability to have safe housing and to afford sufficient and quality food and health care.

[23] http://www.cha.org.au/images/policy/CHA%20Health%20Blueprint.pdf
[24] http://www.cha.org.au/images/policy/CHA%20Health%20Blueprint.pdf
[25] https://ama.com.au/position-statement/aboriginal-and-torres-strait-islander-health-2005

In the past 20 or so years, income inequality has been increasing in Australia.

As an example, between 1994-95 and 1998-99, there was a 20 per cent increase in the taxable income of Australians. However, the poorest postcodes achieved an increase of only 16 per cent, whereas the wealthiest postcodes achieved an average increase of 25 per cent.

### Social Cohesion – Violence alcohol abuse and drugs

A criminal record can severely limit employment prospects, leading to poor health. Prisoners also require equity in access to health services given their burden of disease.

Institutional racism and other biases against minority groups can occur are at many levels, and negatively affect health.

## Food quality and exercise

Quality food poverty can exist side by side with an abundance of food. Ready access to good quality food makes a greater difference to what people eat than nutritional education.

Generally, people on low incomes – including young families, elderly people and those who are unemployed - are often most at risk from poor nutritional choices.

In Australia, there is a particular issue with food quality for isolated Aboriginal and Torres Strait Islander communities. Fresh fruit and vegetables often must be carried many hundreds of kilometers, often in un-refrigerated trucks, and much of the nutrient value of the food can perish on the journey.

### The policy issues

The context of an ageing population, burgeoning chronic disease burden, and rising health care costs pose fundamental challenges to our health system and the sustainability of health care expenditure.

What does the AMA advocate:

- strong policy on climate change and health[26]
- have called for tighter controls on the marketing of alcohol to young people[27].
- a policy on the health of people in detention, including in prison[28].
- We have called for an independent panel to monitor the health of asylum seekers[29].

Health is about much more than hospitals and medical practices. It is also about the promotion of wellness.

### What to do?

- Health in All policies approach across the public policy agenda

[26] https://ama.com.au/position-statement/climate-change-and-human-health-2004-revised-2008
[27] https://ama.com.au/position-statement/alcohol-consumption-and-alcohol-related-harms-2012
[28] https://ama.com.au/position-statement/health-and-criminal-justice-system-2012
[29] https://ama.com.au/position-statement/health-care-asylum-seekers-and-refugees-2011

- Address the social determinants of health in order to reduce the gap in health outcomes between the most and least advantaged
    - Audit and assess effectiveness and efficiency of current govt progs on SDOH
    - Annual report by PM to Parliament outlining progress in reducing health inequity and actions taken
- Increase focus on preventative health and health promotion
    - Unhealthy food, alcohol and tobacco. Encourage healthy lifestyles
    - Adequate resourcing got National Preventative Health Agency
- Strengthen primary and community care
    - As opposed to hospitals alone
    - A strong primary health care system will help reduce the burden of illness
    - Hospitals feed that model
- Improve Integration
    - More sub-acute care
    - Greater access to palliative care
    - Examine contribution of private health insurance
    - Redesign workforce
    - The health system and its many parts needs to work far better together
- Facilitate consumer engagement, empowerment and resourcing
    - Improve health literacy & right to more information
    - Denticare
    - Consumers in resource allocation and sustainability
- Reform Healthcare governance
    - Funding \
    - Who makes the decisions[30]
- Mend Medicare[31]
    - Find why it no longer provides universal access to healthcare
    - Identify who is missing out on essential health service
        - People are not to be prevented from accessing care due to their financial status.
    - Communicate consequences of poor access to health outcomes
    - Find waste in system and redirect it to improve access
    - Remodel Medicare then
    - Build sdoha into Medicare services through prevention

**Core References**

http://www.cha.org.au/images/resources/Mend%20Medicare%20Final.pdf
http://www.cha.org.au/images/policy/CHA%20Health%20Blueprint.pdf
https://ama.com.au/media/ama-president-dr-steve-hambleton-social-determinants-health-alliance-public-forum-13-august

**CCJP wishes to thank Jack for an extremely informative and interesting presentation and discussion.**

**Please see our website www.ccjpoz.org for other Sunday Seminar summaries and reports.**

[30] http://www.cha.org.au/images/policy/CHA%20Health%20Blueprint.pdf
[31] http://www.cha.org.au/images/resources/Mend%20Medicare%20Final.pdf