6th Australian Women's Health Conference

Dr Gwen Gray

Wednesday, 19 May 2010

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Australian women's access to treatment services jeopardised by

- user charges for medical and diagnostic services
- user charges for pharmaceuticals
- geographical maldistribution of services

Australian women's access to health services limited by

- undue focus on hospital and medical (treatment) services
- lack of investment in community-based, primary health care

Health disparities among Australian women maintained/exacerbated by

- refusal of policymakers to recognise access issues
- refusal of policymakers to recognise social determinants

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USER CHARGES AND ACCESS

2007 Commonwealth Fund study of seven OECD countries found for Australia

- 13% did not visit the doctor when sick
- 17% skipped recommended medical test, treatment or follow up due to cost
- 13% did not get a prescription filled or skipped doses to make pills last (Health Affairs 26 (6): w717-34)

2010 Australian study found mental health service users with no fixed abode had very low GP usage (MJA 2010; 192 (9): 501-6).

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USER CHARGES AND ACCESS, PEOPLE WITH CHRONIC CONDITIONS IN AUSTRALIA

2008 Commonwealth Fund study of patients with chronic conditions found

- 20% did not fill prescriptions or skipped doses to make pills last
- 21% did not visit a doctor when had medical problem
- 25% did not get recommended test, treatment or follow up because of cost
- 36% experienced at least one of these access problems in the previous year (Health Affairs 28 (1): W 1-16)

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SOCIO ECONOMIC INEQUALITY AND WOMEN'S USE OF SPECIALIST MEDICAL AND NON-MEDICAL SERVICES, 2009, AUSTRALIA

Substantial economic inequality exists in use of

- specialist medical services
- allied health services (explained partly by PHI holding)
- alternative health services (explained partly by PHI holding)
- dental services
- general practitioner services

Socio-economically advantaged women less likely to use hospital based medical services.

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Possession of a concession card

- reduced inequality of access to GP services
- had no impact on use of specialist services -- (Korda, Banks, Clements and Young 2009).

2002 Australian study of people in disadvantaged communities found

- higher levels of chronic disease; low rates of preventive care
- shorter consultations with GPs. Nationally, "a highly significant increase in the rates of long plus longer consultations per head of population with increasing socio-economic advantage" (Furler et al 2002).

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REVIEW OF THE MEDICARE SAFETY NET, 2009

- benefits have flowed to services more commonly used by the better off
- 55% of safety net benefits went to top quintile
- Least advantaged quintile received less than 3.5% of benefits
- 30% of benefits for obstetric services; 22% for assisted reproductive
- 8% for general practitioner services
- safety net has had little benefit for low socioeconomic or rural dwellers

- Safety net has allowed doctors to raise fees, leaving user charges nearly as high as ever. Where user charges are high, 78% of benefit went to providers, 22% to patients
(Commonwealth of Australia 2009).

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GEOGRAPHICAL ACCESS

Rural shortage of

- hospital beds, GPs, maternity services, dental services, allied health professionals
- lack of reproductive health services of all kinds, including abortion facilities
- lack of transport and accommodation assistance
- lack of services for women and children escaping violence
- food and fresh water insecurity -- and so on

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HEALTH STATUS OF RURAL AND REMOTE AUSTRALIANS

- Australians living outside major cities have shorter life expectancy and higher rates of disability
- are more likely to be overweight, to smoke and to drink alcohol excessively
- immunisation rates are lower, dental problems higher (Australian Institute of Health and Welfare 2005).

THE INVERSE CARE LAW

The availability of good medical care tends to vary inversely with the needs of the population served.

This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced.

Julian Tudor Hart, Lancet, Saturday 27 February, 1971

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AUSTRALIAN GOVERNMENT'S HEALTH REFORM RESPONSE, 2010

- 1,300 new sub-acute hospital beds
- Over 6000 new doctors
- An additional 2500 aged care beds
- Emergency department waiting times capped at four hours
- Elective surgery delivered on time for 95 per cent of Australians
- An historic agreement to reshape mental health services and help 20,000 extra young people get access to mental health services
- More coordinated care for patients with diabetes in general practice
- A Commonwealth takeover of primary care
- A Commonwealth takeover of aged care

Total: $5.1 billion

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HEALTH SPENDING, 2010 COMMONWEALTH BUDGET

- $355 million for 23 GP super clinics
- $390 million for more nurses in GP clinics
- $60 million for additional aged care nurses
- $69 million for rural nurses
- $467 million for electronic health records
- $417 million to increase after-hours access to doctors

(apparently Medicare Locals included in this but no detail)

Total: $2.2 billion -- offset by $2.5 billion saving in prices paid to pharmaceutical manufacturers.

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FOCUS ALMOST ENTIRELY ON MEDICAL MODEL

- No allocations for community health, women's health, Aboriginal community controlled health services
- no budget allocation for mental health
- no spending on dental care and no new Commonwealth Dental Scheme (dental problems key indicator of social disadvantage)

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BUDGET MOVES THAT MAY INTENSIFY SOCIAL CAUSES OF ILL HEALTH

- access to disability support pensions tightened
- family tax benefit part A cut if 16 to 20-year-olds are not participating in education and training
- no increase in unemployment benefit, now lagging behind other pensioners by up to $100 per week
- no extra funding for wages for low paid community sector, including women's health sector, and aged care workers
- cuts to childcare rebates, saving $86 million next year
- cuts to Family Court staff

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STRATEGIC REVIEW OF HEALTH INEQUALITIES IN ENGLAND, POST 2010 (Marmot Review)

Aim: to create the conditions for people to take control of their own lives by

- giving every child the best start in life -- rebalance spending towards early years
- enabling children, young people, adults to maximise capabilities and control of lives
- creating fair employment and good work for all
- ensuring a healthy standard of living for all, minimum income standards for adequate nutrition, housing etc
- creating and developing sustainable places and communities -- physical environment and social environment (good quality neighbourhoods, walking cycling and green spaces)

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