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## ***Widening the Gap: GP Co-Payments and Aboriginal Health Outcomes***

### **VACCHO Submission to the Senate Community Affairs References Committee Inquiry into out-of-pocket costs in Australian healthcare**

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The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) was established in 1996. VACCHO is the peak Aboriginal health body representing Aboriginal Community Controlled Health Organisations (ACCHOs) in Victoria. The role of VACCHO is to build the capacity of these members and to advocate for issues on their behalf. Capacity is built amongst members through strengthening support networks, increasing workforce development opportunities and through leadership on particular health areas. Advocacy is carried out with a range of private, community and government agencies, at state and national levels, on all issues related to Aboriginal health.

Nationally, VACCHO represents the Community Controlled Health sector through its affiliation and membership on the board of the National Aboriginal Community Controlled Health Organisation (NACCHO). State and Federal Governments formally recognise VACCHO as the peak representative organisation on Aboriginal health in Victoria. VACCHO's vision is that Aboriginal people will have a high quality of health and wellbeing, enabling individuals and communities to reach their full potential in life. This will be achieved through the philosophy of community control.

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This submission addresses the impact of co-payments on consumers' ability to access health care, health outcomes and costs; and the effects of co-payments on other parts of the health system, in accordance with the Committee's Terms of Reference. Our submission also outlines the effect co-payments will have on Aboriginal Community Controlled Health Organisations, which for over 40 years have been providing free and accessible comprehensive primary health care to their communities.

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#### ***Our Position***

Introducing co-payments from patients for visits to their GP and for out of hospital pathology and radiology services is bad public health policy and jeopardises the future of universal health care in Australia. VACCHO and our members are opposed to the introduction of co-payments. Co-payments will place greater stress on hospital emergency departments and increase financial and administrative burden for many primary health care providers, including Aboriginal Community Controlled Health Organisations (ACCHOs).

Most importantly, the proposed co-payments will further disadvantage Aboriginal and Torres Strait Islander people, who on average have lower incomes and poorer health status, lower levels of access to primary health care and poorer health outcomes once they enter the health system, than non-Indigenous Australians.

In March 2008, both the Government and then Opposition signed the *Statement of Intent*, a commitment to work together to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by the year 2030. Despite this clear commitment, the co-payments were delivered in a budget which contains \$534 million in cuts to Indigenous programs over 5 years, including cuts to evidence based lifestyle prevention programs such as tobacco cessation. Preventive health and long term economic management of our health system have been placed in grave danger by this Budget. There is no doubt that should the co-payments take effect, the "Gap" will only widen.

## **Acknowledgements**

*In the course of preparing this submission, VACCHO has conducted a series of interviews and collected impact assessments from CEOs, clinical and non-clinical staff, and clients of Aboriginal Community Controlled Health Organisations across Victoria. Their valuable personal commentaries have been interlaced with our evidence-based arguments, set out below.*

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## **Terminology in this Submission**

VACCHO uses 'Aboriginal' or 'Aboriginal and Torres Strait Islander' in all correspondence 'Indigenous' is only used in an international content or when referencing external materials such as quotes or the formal titles of Government strategies.

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## **Creating Further Barriers to Access**

*"I probably won't go to the doctor so much... (there's) no chronic disease in the children but when (my) kids take days off school they have to have a medical certificate... we won't be able to afford the visit, so I may get a fine because they can't see a doctor. I have to get regular blood tests because of a health condition; this will mean I will delay the space between regular tests, which can be dangerous as I have a cyst in my brain which the blood tests detect changes in.*

Client, Wathaurong Aboriginal Co-operative, Geelong

Available evidence shows us that Aboriginal patients currently under-utilise primary health care and their un-treated conditions are known to escalate more frequently to the acute, expensive, crisis end of care.<sup>i</sup> This results in Aboriginal people presenting at hospital emergency departments in the absence of accessible bulk billing GPs.<sup>ii</sup>

Since 2007, average out-of-pocket costs for healthcare have risen by a quarter, with all Medicare items and visits to the GP being among the costs which have risen the most.<sup>iii</sup>

The last report from the now disbanded COAG Reform Council, *Healthcare in Australia 2012-13: Five years of performance*, found that for many Australians, affordability and accessibility of healthcare are already major concerns, with nearly six percent of Australians avoiding visiting their GP due to cost. The same report found that Australians are facing an obesity epidemic, with 62.7% of all adults overweight or obese.<sup>iv</sup>

The overall picture painted by this empirical evidence is that Australians are in need of preventive health interventions and are in danger of developing long term, chronic and complex conditions. It also clearly illustrates that some Australians are already struggling to pay for our basic primary health care.

In the same report, for Aboriginal and Torres Strait Islander people, new data indicates that cost is a much more substantial barrier to access than for the population as a whole:

Data available to us for the first time show that, in 2012–13, more than two out of five (43.9%) Indigenous people aged 15 years and over delayed or did not go to a dental professional due to cost. One-third (34.6%) delayed or did not fill a prescription and one in eight (12.2%) delayed or did not go to a GP.<sup>v</sup>

In a recent interview with Fairfax media, Professor John Glover, a health inequalities expert who led Australia's most detailed analysis on the correlation between a person's wealth and their willingness to visit a doctor, noted that

there is “very strong” evidence that poorer people were already under-utilising healthcare in proportion to their level of illness<sup>vi</sup>.

Since the May budget, there has been consistent and sustained outcry against the introduction of co-payments from a broad range of health experts, all sending the same message; current health inequalities such as those experienced by Aboriginal people, both in terms of access to health care and in terms of health outcomes, will only worsen if the co-payments measure is implemented.<sup>vii</sup>

### **Loss of Focus on Prevention**

*“My concern is .... What about the cost of preventative care? Now we really push preventative care, so we have our health assessments, you know... are you going to come in if you’re going to have to be paying for all of those things as a result of your health assessment? We like to see what your cholesterol is doing, we do an overall ECG and you’re going to have to pay for each and every one of those now. So are people going to come in for their preventative health? No.”*

Staff member, Njernda Aboriginal Corporation, Echuca

The evidence clearly shows that increased focus on prevention and appropriate access to primary health care providers for the management of chronic and complex conditions are crucial to better health outcomes.<sup>viii</sup> Further measures that have the effect of limiting use of GP services amongst Aboriginal and Torres Strait Islander peoples will undermine health outcomes. The proposed \$7 co-payment measure will work counter to these best practice principles and will, in the long term, increase financial stress on the Australian health system. It will also lower Australia’s productivity as a whole, through flow on effects including absenteeism from work for illness or carer’s leave.

### **Poorer Management of Chronic Conditions**

Chronic disease is a major contributor to the life expectancy gap Aboriginal and non-Aboriginal Australians. Approximately 80% of the mortality gap between Aboriginal and Torres Strait Islander and other Australians aged 35-74 years is due to chronic disease.<sup>ix</sup>

*“So, I’ve just been through the process of finding out that my (two year old) daughter has hearing issues... so I think about six tests it took, to find we had a hearing issue. I think we had to see the doctor about five times and had to visit a specialist. Then you know, even that \$7, when it’s an illness or an on-going problem that you have to keep going back about, that can actually impact quite readily on whether you go to a doctor or not.”*

Full-time employed mother of one, Melbourne

Chronic illnesses are not better managed by discouraging contact with the primary health system.<sup>x</sup> Aboriginal people suffer chronic diseases at a significantly higher rate than the non-Indigenous population and often have poorer health outcomes and lower rates of successful medical intervention and medication management. For example, in 2007-08, diabetes complications were the most prevalent PPH condition among the Indigenous population; occurring at nine times the rate of the non-Indigenous population<sup>xi</sup>. Increased access to preventative and early intervention management, provided by a GP, is needed to reduce avoidable hospitalisation admissions.

*“It worries me because my chronic illness mob get to come and get free medication and if they need to see a specialist or allied health we will arrange that, then we pay for it and then take it to Medicare*

*and then we get it back (from our Medicare Local). But you know, they'll have to pay that \$7 for that four or five things they have to do. If it's going to cost money they won't do it, they won't go."*

Staff member, Njernda Aboriginal Corporation, Echuca

The Commonwealth-funded Audit for Best practice in Chronic Disease (ABCD), which monitors best practice measures for the purpose of Continuous Quality Improvement (CQI), found that ready access to GP services resulted in best outcomes for Aboriginal patients. This was done via the delivery of core primary health care programs, including maternal and child health and/or chronic disease prevention, detection, management and follow up for patients at risk of, or already suffering from, chronic conditions.<sup>xii</sup> Creating additional barriers to access, such as introducing co-payments in the way of medical 'best practice' is inappropriate.

The Audit for Best practice in Chronic Disease found that increasing co-payment for medications was associated with significant decreases in purchase of prescribed medications, particularly so for people with low and fixed incomes<sup>xiii</sup>, and a similar effect is anticipated with the consultation co-payment. Australians already privately contribute 32% of our health care costs, a higher proportion than seventy percent of OECD countries, and more than New Zealand and the United Kingdom<sup>xiv</sup>.

Recommendations originally made to the Commission of Audit in late 2013 argued that the introduction of a co-payment will decrease use of GP services for 'trivial conditions'. Indeed, a co-payment will discourage patients seeking care; however, this does not improve health system efficiency but instead forces unqualified community members to make judgements about the severity of their own and family member's medical conditions.

*"I wouldn't be able to cope, as I need government approval for medication... that means I have to see the doctor to get my medication. I would have to go without something; this would mean a choice between medication or paying my rent. I also use other medical services, to cope with anxiety, (and for) the dentist and hearing aids. I use (Wathaurong) because I have literacy issues; here they explain everything to me."*

Client, Wathaurong Aboriginal Co-operative, Geelong

The danger of this approach is empirically demonstrated by NSW health department data from July to September 2011. Emergency departments reported that 28% of category 4 patients, whose conditions were considered upon triage to be non-urgent and suitable for primary health care, were later admitted to hospital.<sup>xv</sup>

### **Less Cost Effective Care**

*"I think it's strange the Government is targeting primary health care which is efficient, cheap and effective. Obviously there will also be a roll on effect on the numbers of people attending hospital Accident and Emergency departments for primary care issues which will be a waste of resources and more expensive."*

GP, Goolum Goolum Aboriginal Co-operative, Horsham

The proposed co-payment also reduces the capacity of the service system to deliver cost effective care. The co-payment is being proposed as a mechanism to shift the projected rise in expenditure on health care away from governments and on to individual consumers, to lower overall costs to governments over time, as health care costs are projected to rise from 10 % to 20% of GDP by 2050.<sup>xvi</sup> However, there is not ample evidence to show that introducing a co-payment measure will effectively slow the rising costs of health care. In fact, introducing a co-payment measure in order to shift costs to patients may actually increase the overall cost to government of primary

health care delivery, by increasing the complexity and time required to administer services, thus reducing the efficient allocation of government resources.<sup>xvii</sup> This a particular concern for ACCHOs which are not adequately resourced to cover the cost of administering the co-payment measure.

### ***Unfair Disadvantage to Community Controlled and Community-Oriented Providers***

*"I think the Victorian Aboriginal Health Service (VAHS) will make the conscious decision if and when it comes in to play in July next year... we would not charge. We just can't do that to community."*

Jason B. King, CEO, Victorian Aboriginal Health Service, Fitzroy

If it is implemented, ACCHOs and other service providers which opt not to impose the \$7 co-payment on their clients will make their service a less attractive place of employment for GPs. ACCHOs are already competing with private and community practices that provide higher income to GPs, with some ACCHOs currently supplementing GP salaries with a proportion of Medicare income:

*This Co-Op had difficulty recruiting a GP for a couple of years. Income generated (by Medicare) contributes to my salary. This is a "triple whammy"; it's obviously unfair for Indigenous clients, and for non-Indigenous clients, those who are not over the age of 65, not a child (under 16 years), and who have chronic illness: they must pay up front: this is a two-tiered system.*

GP, Goolum Goolum Aboriginal Co-operative, Horsham

The possibility that other practices' GP remuneration will include the \$7 co-payment places ACCHOs at a greater competitive disadvantage in attracting medical staff. ACCHOs who decide to absorb these costs will therefore have less funding available to contribute to other programs and services which meet the specific needs of their local client population:

*So at the moment for VAHS we've done calculation on last year's Medicare income. We are looking just off (the \$5 reduction in MBS rebates for non-exempt GP consultation items); we are looking to lose \$100 -110,000 dollars. If we don't collect the extra \$7 we are probably looking at in excess of \$250,000 or in that vicinity. That doesn't include the \$7 co-payment for blood tests, X-rays, and pharmacy bits and pieces, so it is going to be quite expensive for community in general, but for us that \$200 grand is two and a bit Aboriginal health workers.*

Jason B. King, CEO, Victorian Aboriginal Health Service, Fitzroy

The sustainability of not only Aboriginal Community Controlled Health Organisations, but of Australia's not for profit health sector, which currently supports the most vulnerable people in our community, is significantly threatened by the implementation of co-payments. The measures will increase health care costs and administrative burden for both Government and health care providers. Ultimately, this diverts funding from front-line services and reduces the efficiency and effectiveness of the health dollar.

## ***Conclusion and Recommendation***

On the basis of existing evidence, the proposed co-payment is unlikely to achieve its stated objective of reducing health care cost and is likely to exacerbate already poor health outcomes for Aboriginal and Torres Strait Islander people and those sections of the wider community who can afford it the least.

This budget measure runs counter to the principles of universal health care inherent in the establishment of the Medicare system in Australia in 1975. The impact of co-payments on the basic human right of access to health care for the most vulnerable sections of our community cannot be supported.

Sustaining and increasing investment in primary health care is the most effective way to ensure that the Australian health system is cost effective and that the health outcomes of all Australians, including those most in need, are foremost in all policy and practice.<sup>xviii</sup>

VACCHO supports the need for a cost effective, efficient and sustainable health system. The proposed co-payment measures will undermine efforts to achieve this outcome.

Introducing co-payments will not serve to close the gap in health outcomes; it will only widen the gap between Aboriginal people and the rest of the community. VACCHO and our members, on behalf of the communities we serve, strongly recommend that the Australian Government does not implement the proposed co-payment measures.

## References

- <sup>i</sup> McInerney, M (2014) "GP visit co-payment proposal 'puts most vulnerable and primary prevention at risk'" published on *Croakey*, 02 January 2014. URL: <http://blogs.crikey.com.au/croakey/2014/01/02/gp-visit-co-payment-proposal-%E2%80%9Cputs-most-vulnerable-and-primary-prevention-at-risk%E2%80%9D/>
- <sup>ii</sup> Aboriginal and Torres Strait Islander patients' uptake of effective primary health care services is already limited, as evidenced by data on potentially preventable hospitalisations (PPH). PPH is used nationally and internationally as an index of problems with access to health care; the Australian Indigenous population were at approximately five times greater risk of being hospitalised for a PPH condition than the non-Indigenous Australian population in 2007-08. Clinical Epidemiology & Health Service Evaluation Unit (2009), *Potentially preventable hospitalisations: a review of the literature and Australian policies Final Report*, Melbourne Health 27 July 2009
- <sup>iii</sup> Duckett, S and Peter Breadon (2014) *Out-of-pocket costs: Hitting the most vulnerable hardest*. Grattan Institute submission to the Senate Community Affairs References Committee Inquiry into Out-of-pocket costs in Australian healthcare, p. 4.
- <sup>iv</sup> Council of Australian Governments (2014) *Healthcare in Australia 2012-13: Five years of performance*.
- <sup>v</sup> Council of Australian Governments (2014) *Healthcare in Australia 2012-13: Five years of performance*, p. 50.
- <sup>vi</sup> Swan, J "John Glover voices fears GP fee will make poor suffer", published by Sydney Morning Herald, 31 December 2013. URL: <http://www.smh.com.au/federal-politics/political-news/john-glover-voices-fears-gp-fee-will-make-poor-suffer-20131231-304go.html#ixzz2p8w8aZ3vAs>
- <sup>vii</sup> Sweet, Melissa, "Health Funding: Beginning of the end for universal healthcare in Australia?" *BMJ* 2014; 348: <http://dx.doi.org/10.1136/bmj.g4041> (Published 17 June 2014)
- <sup>viii</sup> Australian Government Department of Health (2008) *The Link Between Primary Health Care and Health Outcomes for Aboriginal and Torres Strait Islander Australians: Audit for Best Practice in Chronic Disease (ABCD)*
- <sup>ix</sup> Australian Institute of Health and Welfare (2012) *Contribution of chronic disease to the gap in mortality between Aboriginal and Torres Strait Islander and other Australians*. Cat. No. IHW 48. Canberra.
- <sup>x</sup> Gillespie, J in Hughes, M (2014) "Mind the gap: \$6 GP visit proposal ignores the evidence" published on *Croakey*, 09 January 2014. URL: <http://blogs.crikey.com.au/croakey/2014/01/09/mind-the-gap-6-gp-visit-proposal-ignores-the-evidence/>
- <sup>xi</sup> Clinical Epidemiology & Health Service Evaluation Unit (2009), "Potentially preventable hospitalisations: a review of the literature and Australian policies Final Report", Melbourne Health 27 July 2009
- <sup>xii</sup> Australian Government Department of Health (2008) *The Link Between Primary Health Care and Health Outcomes for Aboriginal and Torres Strait Islander Australians: Audit for Best Practice in Chronic Disease (ABCD)*
- <sup>xiii</sup> Hynd A, Roughead EE et al (2008) "The impact of co-payment increases on dispensings of government-subsidised medicines in Australia". *Pharmacoepidemiol Drug Saf.* 2008 Nov;17(11):1091-9. doi: 10.1002/pds.1670.
- <sup>xv</sup> NSW Bureau of Health Information (2011) *Background Paper: Approaches to reporting time measures of emergency department performance*. URL: [http://www.bhi.nsw.gov.au/\\_data/assets/pdf\\_file/0003/171066/HQ8\\_BackgroundPaper\\_June2012.pdf](http://www.bhi.nsw.gov.au/_data/assets/pdf_file/0003/171066/HQ8_BackgroundPaper_June2012.pdf)
- <sup>xvi</sup> Organisation for Economic Co-Operation and Development (2011), *Expenditure on health by type of financing*. URL: [http://www.oecd-ilibrary.org/sites/health\\_glance-2011-en/07/05/index.html;jsessionid=isehm25oj68s.delta?contentType=&itemId=/content/chapter/health\\_glance-2011-64-en&containerItemId=/content/serial/19991312&accessItemIds=/content/book/health\\_glance-2011-en&mimeType=text/html](http://www.oecd-ilibrary.org/sites/health_glance-2011-en/07/05/index.html;jsessionid=isehm25oj68s.delta?contentType=&itemId=/content/chapter/health_glance-2011-64-en&containerItemId=/content/serial/19991312&accessItemIds=/content/book/health_glance-2011-en&mimeType=text/html)
- <sup>xviii</sup> For evidence of the direct links between access to and quality of primary health care and health outcomes for Aboriginal and Torres Strait Islander peoples, see Australian Government Department of Health - Office of Aboriginal and Torres Strait Islander Health (2008) *The Link Between Primary Health Care and Health Outcomes for Aboriginal and Torres Strait Islander Australians : Chapter 2*.