Health Equity and Access

“Good health is a major resource for social, economic and personal development and an important dimension of quality of life.”

World Health Organisation

The health system is not fair for everyone. Some people miss out on health services or access them too late for effective preventative intervention or treatment. This leads to high usage and health care costs at the acute end of the health care continuum. If the socially excluded and those at risk accessed hospitals at the same (lower) rate as the average Australian, it would mean savings of nearly a quarter of the total public hospital budget ($1.22 billion for the socially excluded and $773 million for at risk groups).ii

More accessible and equitable health care benefits individuals, communities and society as a whole. This includes improved well-being, better mental health, less disability, thriving children and more sustainable, cohesive communities.iii As many of these factors are amenable to intervention, health inequalities are largely avoidable. Equitable access to quality health care is a matter of social justice.

QCOSS recognises that the conditions in which people are “born, live work and age”iv impact on health. These issues are explored in more depth in the Social Determinants of Health policy.

Recognising Progress

QCOSS recognises progress by the Australian and Queensland governments in relation to:

- National health reform aimed at improving patient care and delivering a more efficient and transparent health system.
- The establishment of Health Consumers Queensland
- The requirement for Local Health and Hospital Networks in Queensland to develop consumer and community engagement plans and protocols to work in collaboration with Medicare Locals.
- The targets in Towards Q2: Tomorrow’s Queensland to cut by one third obesity, smoking heavy drinking and unsafe sun exposure.
Key Issues

Cost
Many people delay or do not get some types of medical care due to cost. Even if bulk-billing General Practitioners are available, medication, specialist treatment and other follow up care can be unaffordable for people on low incomes.

For example in 2009-2010:
- 1 in 16 people had delayed seeing or not seen a GP;
- nearly 1 in 10 people with a prescription had delayed getting or did not get their medication; and
- around 1 in 10 people referred to a medical specialist had delayed seeing or did not see the specialist.

The reasons are many and include: cost; mistrust; lack of services particularly in rural and remote areas; different culture or language; and lack of connected care for people requiring complex care.

To promote greater equity, universal entitlement needs to be overlaid with targeting of health services to ensure that disadvantaged groups have the best opportunity for improved health outcomes.

Models of care
Health care needs to respond to the needs of people affected by poverty and disadvantage. There is no “one size fits all” approach. Integrated planning and flexible service models are required to identify and address service gaps. In particular Medicare Locals need flexible funding to strengthen the primary health care response for disadvantaged and marginalised groups.

This includes a range of service delivery options such as:
- alternative settings for the delivery of primary health care such as community based care and outreach services;
- specialised responses to meet the needs of specific population groups; and
- flexible human service models particularly in rural and remote locations.

This requires partnerships between health and community service organisations.

Aboriginal and Torres Strait Islander people have a much higher rate of preventable hospital admissions (4.9 times greater) than the general population. This means the primary health care system is not operating effectively. There are many cultural, economic and geographical barriers for access to health care for Aboriginal and Torres Strait Islander people in both urban and rural and remote settings.

The prevalence of risk factors leading to poor health is much higher in people affected by poverty and disadvantage. To reduce crisis driven health responses, the balance of expenditure needs to shift from acute care into primary and preventive care.

Targeted interventions to support behaviour change need to be directed at disadvantaged groups along with more universal population level interventions. These strategies need to be overlaid with policies to reduce social inequalities and improve the social and environmental conditions (for example, poverty, unemployment, education and housing) that influence health behaviours and health outcomes.

QCOSS supports the aim of the Queensland Aboriginal and Islander Health Council to progress the individual and collective development of community controlled health services for Aboriginal and Torres Strait Islander people in Queensland. These services provide comprehensive...
primary health care which take into account the physical, social, spiritual and emotional health of people. It is also important that Aboriginal and Torres Strait Islander people have equity of access to mainstream health care. Mainstream services and Medicare Locals and Local Health and Hospital Networks need to work closely with community controlled organisations to build capacity for the provision of culturally sensitive quality health care services.

**Access**

All Australians should have equitable access to appropriate health services, regardless of where they live. In particular, there is a need for more equitable distribution of health services to rural and remote communities.

This requires health funding that targets areas of high need, as well as innovation in service delivery. There are already many examples of innovation in the delivery of health care in rural and remote Queensland. Medicare Locals and Local Health and Hospitals Networks will need to work together to build on existing services and ensure that their activities are complementary. Medicare Locals will need to work closely with organisations such as the Royal Flying Doctor Service, patient assistance travel schemes and multi purpose services.

For those that need to travel long distances to access health services, more travel and accommodation support is required. eHealth is a significant opportunity to improve health care in rural and remote communities in Queensland. Investment in adequate infrastructure is critical to provide a sound foundation and training and education to support uptake.

**Poor health literacy** is a significant issue affecting access to health services. Three out of every five Australian adults lack basic proficiency in health literacy – they do not have the skills to manage their health and health problems. They also find it difficult to navigate an often complex health system.

**Community and Consumer Engagement**

Health organisations need to get better at engaging people and communities in planning and delivering health services. Local Health and Hospital Networks (LHHN) will be required by legislation to develop consumer and community engagement strategies.

These strategies need to include specific consideration of the needs of disadvantaged and marginalised groups and mechanisms to effectively reach them: These groups include:

- population groups such as culturally and linguistically diverse groups and Aboriginal and Torres Strait Islander people;
- people or groups with special health needs such as people with a disability, people with a mental illness;
- community service organisations;
- communities of interest such as lesbian, gay, transgender and bisexual communities;
- community members that may be in need but not accessing health services, or accessing services inappropriately, such as people who are homeless.

It is critical that LHHN’s and Medicare Locals work together in developing their approaches to engagement to ensure consistency in planning processes and to avoid unnecessary duplication of engagement mechanisms.
QCOSS Recommendations

QCOSS recommends that the Queensland Government:

1. Deliver a suitable mix of universal and targeted health programs to meet the needs of socioeconomically disadvantaged groups including:
   a) Developing a health equity assessment tool to ensure the needs of people affected by poverty and disadvantage are considered and evidence based models of care implemented.
   b) Supporting the continued and sustainable growth of Aboriginal and Torres Strait Islander community controlled health services.
   c) Working with the Australian Government to prioritise the availability of flexible funding for Medicare Locals to fill primary health care service gaps and more equitable funding for the delivery of health services in rural and remote communities.

2. Support effective consumer and community engagement in health care planning and delivery through:
   a) the establishment of an independent health consumer organisation, and
   b) building the capacity of Medicare Locals and Local Health and Hospital Networks to effectively engage with consumers and communities.

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1 World Health Organisation. (1986). Ottawa Charter for Health Promotion
2 Mangan, John, Implications for the Queensland Economy from current world economic conditions. University of Qld (on behalf of QCOSS) 2009
9 National Rural Health Alliance Inc. Fact sheet 29 Medicare Locals in rural Australia June 2011
10 National Health and Hospitals Reform Commission Interim Report 2009