

Poverty and Health in Australia

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Introduction

Poverty, socio-economic status (SES) and inequality affect health. In turn, one's health affects one's SES.

Government socio-economic policies impact in myriad ways upon wealth distribution, inequalities and the health of the population. These, along with specific health care policies, affect both access to, and benefits from, the health care system.

Poverty, SES and Health

Class-related inequalities in mortality rates are observed in almost every country for which data is available. These inequalities are seen for over 75% of all causes of deaths and are found for all age groups.¹

The effects of poverty and SES on health are relative rather than absolute.^{2,3} The relationship is linear. There is a gradient and not a threshold effect i.e. there is not one poverty line below which health is adversely affected and above which it is not. This has been indicated in many studies, for instance, the well-known Whitehall study of British Civil Servants in the UK.

Social and environmental factors are important health determinants in themselves. This still occurs after individual risk factors have been taken into account.⁴ Factors such as low income, job insecurity, unsatisfying work, unemployment, overcrowded and substandard housing, living in a poor locality with few facilities, poor education, reduced social approval and self-esteem, and social exclusion are all important.

People's SES affects their health throughout their life. The cumulative experience of social conditions across the life course impacts on health. Evidence indicates the importance of prenatal and early childhood environment to the subsequent health, behaviour and learning of individuals. Poor nutrition in pregnancy can produce lifelong susceptibilities to adverse health outcomes.^{1,5}

Individual behaviour is influenced by the environment in which we live. Healthy responses of individuals require an environment in which one can make healthy decisions. When your social and economic circumstances are poor and there is lack of hope for the future, people are disempowered to make healthy decisions on such things as smoking, drugs, alcohol, diet or exercise. Health promotion and lifestyle choices are a privilege for the middle and upper classes.

It has been shown that programs aimed at behaviour change often fail to reach lower socio-economic groups. People with lower SES make less use of preventive health services e.g. lower-SES women are less likely to have Pap tests, breast

checks or mammograms independent of age, health status or frequency of doctor visits.²

Inequality

Income inequality within a population is an important determinant of both individual and population mortality.⁶⁻⁸ Cross-national research shows that the greater the degree of socio-economic inequality within a society, the steeper the gradient of health inequalities.⁵ The fact that class differences in health are smaller in Sweden than the United Kingdom and the USA has been attributed to Sweden's more even distribution of income.²

Of fifteen OECD nations, the USA has the highest level of income inequality⁹ and worse health outcomes. In the USA, life expectancy has consistently been lower and infant mortality higher than other developed nations in the OECD. In ranking for life expectancy of nations in 1997 the USA was 25th, behind all other rich nations and some poor nations.¹⁰

Inequalities are growing both between and within nations.¹¹⁻¹⁵ According to the United Nations (UN), the gap between the rich and poor has been growing over the last 50 years and the rate of growth has been greatest during recent decades. Although global wealth has never been greater the distribution is 'extraordinarily unequal'.¹⁴

Reports such as St Vincent de Paul's *Two Australias - Addressing Inequality and Poverty 2001* and Harding and Greenwell's *Trends in Income and Consumption Inequality in Australia* highlight growing inequalities in Australia.^{16,17} Poverty among adults has increased steadily during the past decade.¹⁸ Benefits from wealth generated in recent decades have gone largely to the wealthiest in society.

Government Policy

Governments have traditionally been responsible for distributing and channelling resources, for instance via public services such as health care. The World Bank's *World Development Report 2000/2001 Attacking Poverty* stresses the importance of political, state and social institutions along with public investment in education and health in dealing with poverty.¹⁴ The basis of public services is redistribution. Risks are pooled across society and entitlement is based on need not the ability to pay.

Paying for health communally through taxation redistributes health care expenses according to ability to pay. Universal health insurance schemes, such as Medicare, with risk pooling across society in both funding and service delivery, provide the most effective and efficient health systems.¹⁹⁻²⁴

The World Health Organization's *European Health Care Re-*

form Analysis on Current Strategies concluded that a comparatively high level of government involvement is required to ensure that health services are accessible, efficient and adequately funded.

Until the mid-1990s, rising market income inequalities in many OECD nations were offset by progressive tax and public transfer systems.¹⁰ As public spending and investment declines, post-tax and transfer income inequalities in several countries, notably the US, are now growing more rapidly than market income inequalities alone.²⁵ Many governments are actively participating in the upward redistribution of wealth and power.

The current Australian government's policy has been to shift health care financing to the private sector and household income through user-fees such as co-payments. This move away from taxation-based to private insurance and user-fees hurts the less well-off and benefits the wealthy both in costs and access.

Assistance to the private health insurance (PHI) industry in Australia is an example of subsidies and taxation exemptions that redistribute money to the wealthy and PHI industry away from public services. It has been estimated that the total cost of the private health insurance (PHI) rebate to Australian taxpayers is over \$3.6 billion annually.²⁶ This represents an average annual cost of \$185 from every man, woman and child in the country.⁴³ The PHI rebate abounds with inequities. Approximately half of the PHI rebate subsidy goes to the top 20 per cent of taxpayers and nearly three-quarters goes to the top 40 per cent. This contrasts to progressive distribution of direct public spending on health.

Although these tax subsidies are highly regressive in themselves, there are other incongruous equity consequences. For instance, the federal government, via the PHI rebate, subsidises private dental services, received principally by high income earners, by over \$103 million annually while a successful federal public dental health scheme directed at low-income earners at a cost of \$54 million annually was axed as a cost cutting measure in 1996.²⁷

There are further health and socio-economic consequences for those unable to afford dental care or on long waiting lists for state-funded dental schemes. Consequences such as poor nutrition, chronic health problems (e.g. cardiac disease) and reducing employment opportunities associated with poor dentition.

Many Australians are unable to access public dental care and unable to afford private dentists. All GPs working in a poor areas find themselves providing piecemeal dental treatment with antibiotics and pain killers for large numbers of people. No attempt is made to quantify the direct and indirect costs of this. It is not acknowledged by government that failure to provide public dental services results in many millions of dollars of public money going to bulk-billing GPs who are not dentists and cannot provide full dental treatment.

The Medicare levy surcharge exemption provides further tax subsidies for the wealthy. The cost of revenue forgone by the Medicare levy surcharge exemption has been estimated to be between \$750 and \$1,100 million annually.^{28,29}

To make a saving from their tax exemption, high-income earners (>\$50,000 for individuals, >\$100,000 for families) only need to buy a PHI package costing less than 1% of their taxable income. It has been documented that high-income taxpayers who have no desire to take out health insurance are purchasing low price packages specifically for the purpose of avoiding the Medicare Levy Surcharge. The amount of tax avoided by the use of such PHI policies has been estimated to be between \$99 and \$180 million per annum.³⁰

Policies have resulted in a reduction in bulk-billing and increasing reliance on co-payments for health care and pharmaceuticals. Health care co-payments restrict access and place a heavier burden of costs on the poor and sick. Direct payments are highly regressive - the most regressive way to pay for health.³¹ All co-payments redistribute money from users of health care to health care providers and upper-income taxpayers.³²

Co-payments adversely affect access to health care for lower-income groups. The Rand Health Insurance experiment of the 1970's in the USA showed that cost-sharing tended to be associated with especially marked reductions in the probability of medical use and outpatient visits among lower-income groups. These effects were strongest in relation to services for children from low-income families.³³

Co-payments can deter the utilisation of appropriate health services and adversely affect health outcomes.^{34,35} For example, after co-payments were introduced on optometrist visits in the UK, cases of undiagnosed glaucoma increased.³⁶

Co-payments improve access and increase utilisation for upper income groups by deterring those with lower incomes.^{37,38} For people with the necessary resources, any form of partial out-of-pocket payment within a predominantly tax-financed system allows the purchase of preferred access to a service primarily paid from the taxes of others.³² Introducing or increasing charges results in a redistribution of services away from those on low incomes towards the well off, as doctors provide more services for their remaining patients.

Kerala, one of India's smaller and poorer states, provides an example of a poor community achieving high health outcomes and literacy levels through redistributive policies such as egalitarian social services and a land tenure system.³⁹⁻⁴¹ There has been radical land reform, public food distribution, special measures for agricultural workers, employment opportunities for low-caste people and health service availability of 100% for urban and 91% for rural people.

The literacy rate was around 90% (>86% for women), life expectancy 72 years (national average 61 years) and infant mortality rate of 17 per 1,000 in 1991. The life expectancy in Kerala

approaches that of the United States and is greater than that for Washington DC.^{14,42}

This demonstrates how government policies can determine the wealth and health of individuals and communities. Shifting resources from the public to the private health sector does not merely fail to help those in the community with the greatest need. It actively harms them.

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