The New Liberals and Health Equity

"In all human societies, health and education have an intrinsic value: the ability to enjoy years of good health, like the ability to acquire knowledge and culture, is one of the fundamental purposes of civilization."
– **Professor** Thomas Piketty, *Capital in the 21st Century.*

The 1975 introduction of Australia's universal healthcare system Medibank – providing access to health care based on need, not income - was a key reform that defined the Whitlam Government's progressive legacy.

In his 1972 election campaign speech, Whitlam stated: "I personally find quite unacceptable a system whereby the man who drives my Commonwealth car in Sydney pays twice as much for the same family cover as I have, not despite the fact that my income is 4 or 5 times higher than his, but precisely because of my higher income".

This statement is startling for a number of reasons, not least in highlighting how wide the disparity in wealth has grown in the intervening decades. This compares to the current disparity between the PM's *base* salary of approximately $550K and that of a Commonwealth car driver of approximately $58 per annum[1].

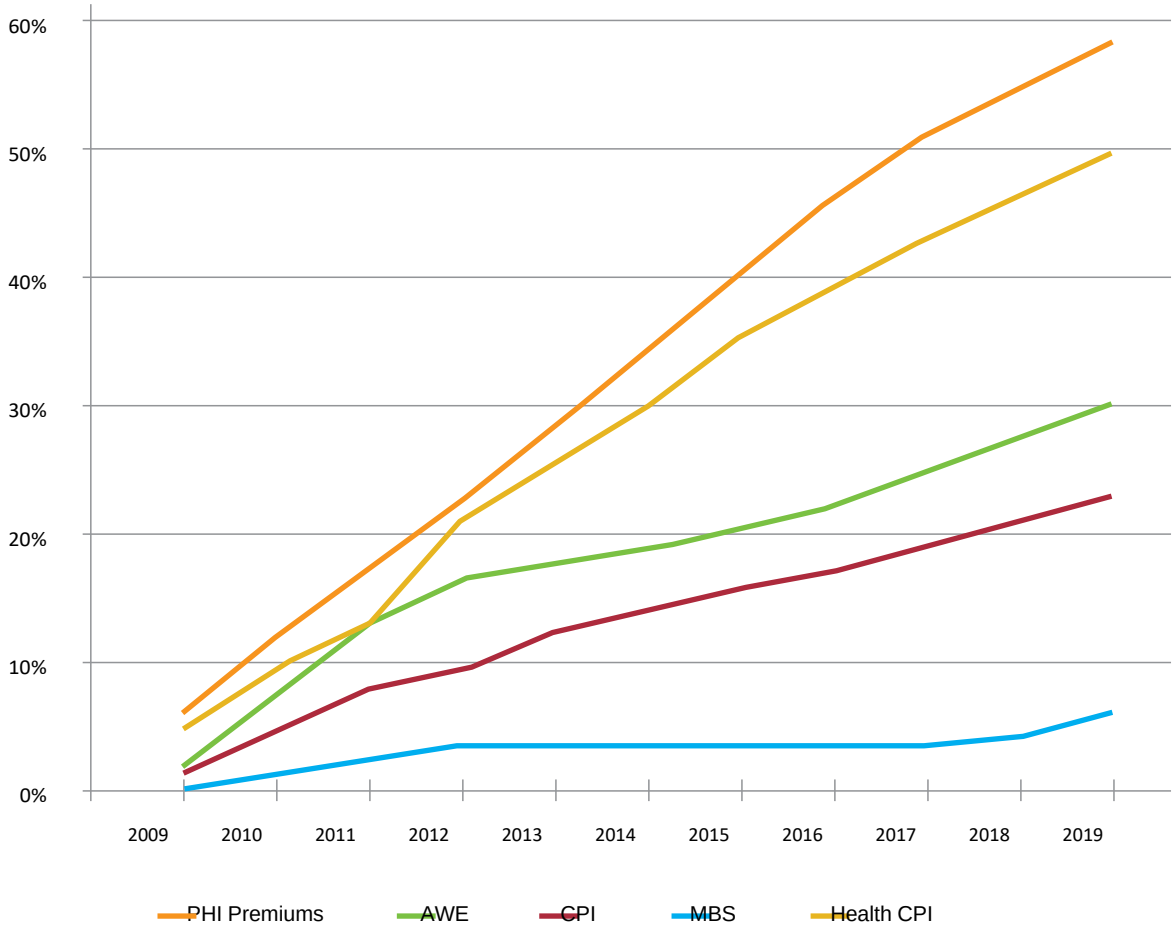
Resurrected as Medicare in 1984 after Medibank's dismantling by the Fraser Government, subsequent decades of neoconservative economic policies followed by both major political parties resulted in a profound disconnection between medical fees & Medicare rebates that makes equity of access a fantasy.

While the Federal Government[2] advises that the Medicare rebate remains 85% of the *schedule* fee for out-of-hospital medical services, it doesn't disclose that while the schedule fee set several decades ago *was* more or less 85% of the actual fee charged, successive governments have ensured the schedule fee was increased – in between freezes – by an amount less than that year's CPI.

The funds (mis)appropriated by bleeding off the value of the Medicare rebate has been transfused directly into private insurer and private hospital profits. This has led to fees that render ambulatory, non-emergency medical services out of reach for many Australians.

[1] https://psa.asn.au/wp-content/uploads/2018/02/Crown-Employees-Public-Sector-Salaries-2017-Award.pdf
[2] https://www.health.gov.au/health-topics/private-health-insurance/what-private-health-insurance-covers/out-of-pocket-costs.

Increasing health costs; private health insurance premiums, health consumer price index and medical benefit schedule increase versus average weekly earnings and general consumer price index[3,4].



Who suffers? Certainly not the members of successive Governments who made these decisions, nor their 'donors' whose quid pro quo is favourable policies that entrench inequality. In my profession GPs are hardest hit, as they are the segment least able to regulate supply and hence set fees.

But can GPs relocate to remote and rural areas, where competition is sparse and the need is great. Unfortunately, relentless government cuts to rural and remote services have ensured facilities are few and support not forthcoming. It is for many, an undesirable option.

[3] https://patch.australiancentre.muhosting.com.au/publication/private-health-insurance-in-australia-policy-reform-approaches-towards- greater-competition-and-efficiency-to-improve-health-system-performance.
[4] https://www.apra.gov.au/operations-of-private-health-insurers-annual-report

This explains the reliance of such areas on foreign trained doctors without full registration, and fly-in fly-out medical providers paid several multiples of permanent appointees.

A peer reviewed Australian study[5] found substantial socioeconomic inequity exists in access to specialist ambulatory care in Australia. Inequities affecting the allocation of services deny the sickest, the geographically isolated, and those with the lowest economic resources the benefit of necessary specialist out of hospital care.

This is the result of political decisions made to adopt economic and social policies that price many medical services out of reach of the economically disadvantaged. Additionally, the complete absence of rebates for dental care deny subsidised access to ancillary services essential to the avoidance of many serious illnesses, including cardiovascular disease[6]. Apart from issues of equity, this is a false economy paid for in serious, avoidable health issues.

Such policy reflects political decisions to progressively impoverish the majority to enrich a small minority. The solution must be a political stance that harnesses policy that benefits the most, and which restores access to health services based on need.

Achieving equity in universal health care requires we all, but especially the wealthy and powerful, retain a vested interest in the quality of and access to the public health system. This necessitates policies anathematic to the neoconservative politics favouring private profit at public expense which helps maintain a two-tier health system with access based on income.

These subsidies alone divert an estimated $26+ bn pa from public health services into private profits[7,8]. A further estimated $4-6 bn pa is lost to the public purse by exempting those who can afford private health insurance premiums from payment of the Medicare levy.

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[5] Korda RJ, Banks E, Clemens MS, Young AF. Aust N Z J Public Health. 2009; 33:458-65 doi: 10.1111/j.1753-6405.2009.00430.x

[6] Sabbah, W., Folayan, M. O., & El Tantawi, M. (2019). The Link between Oral and General Health. *International journal of dentistry*, *2019*, 7862923. https://doi.org/10.1155/2019/7862923

[7] Health expenditure Australia 2017-18. https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure- australia -2017-18/contents/ summary

[8] Why private health insurance needs a rethink. htt ps:lj grattan.edu.au/ne_ws/wh_y-private-health-insurance-needs-a-rethink/

From a health and equity perspective, these funds would be better employed to promote full CPI increases (including 'catch-up' for lost decades of increases) in Medicare schedule fees, in concert with a 100% rebate for low income, welfare & sickness benefit recipients, and anyone below the age of majority.

Other initiatives required to achieve equity are the inclusion of dental services within the Medicare rebate scheme, and the redress of the relative shortage of medical/health services in rural and remote areas by increasing the Schedule fee (and the rebate) to between 100-200% of the standard schedule fee, depending on degree of remoteness and area need. For example, practice in remote aboriginal communities would attract the maximum increased fee and Medicare rebate.

It can be done, it will be done, and if elected we will get it done.

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