Access to health care for children in low-income families

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Abstract

This paper draws on data from the Health Care for Children Project to consider issues of access to health care for children in low in~ome families in three geographic areas. Group and individual interviews were held with mothers in an inner city area and two outlying suburbs. Financial geographic, socio-cultural and other b~ers to use of health services are discussed. Major difficulties identified QYthe !ll0thers in ~ccess to health care for their children included cost of medication, hours o~opening, transport a?d language. The paper highlights the impact of even quite small charges for health services on low income families.

Introduction

Poverty has a negative impact on children's health, an impact which has been described as pervasive and multifaceted. 1Access to health services can be a most important factor in children's health and is seen to be one of the factors which can link family poverty and poor health in children. However only limited research has been carried out on this subject.

Australian society has expressed its belief in the right of all children to have access to health services irrespective of income by the provision of various free universal preventative and early intervention health services for children such as maternal and child health centres and school health services. By the end of the Second World War all states had infant health centres and school health services in operation. 2Provision has also been made to meet or assist with treatment costs such as Medicare in relation to medical and hospital costs and the Pharmaceutical Benefits Scheme in relation to cost of medication.

Patricia Harris in the paper *All our Children* argues that all children have the right to good quality health services and that public subsidy of universally available health services is necessary to ensure that the consequences of economic and geographic inequality are counteracted. 3She points out, however, that universality is not sufficient to achieve children's rights to good quality health and that the greater needs of poor, Aboriginal and other ethnic minority children must be given some priority within a universal framework. She advocates a system of 'progressive universality' which includes positive discrimination to allocate extra resources on the basis of need. Harris points to a number of interlocking factors that produce substantial inequalities in children's access to and participation in health services, the most important being financial barriers, geographical barriers, socio-cultural barriers and asymmetrical power relationships.

The role and extent of some universal health services for children such as school health services have been subject to recent debate[4] and recently some services have been reduced, as have aspects of the Pharmaceutical Benefits Scheme. It is important for the experiences of low-income families to have a place in such discussion.

In her recent extensive review of the literature linking poverty and disadvantage with children's health Diane Jolly noted the inadequate information in Australia on access to health services and, in particular, differences in small geographic areas and she recommended research in this[l].

This paper explores the experiences of low-income families in getting health care for their young children, drawing on data from the Health Care for Children Project undertaken by the Brotherhood of St Laurence and Dr Paul Ekert of the Royal Children's Hospital, Melbourne in

the second half of 1990. It considers issues of access to health care for families in three geographic areas.

Health Care for Children Project

The project involved provision of health screening and follow-up for children at the Brotherhood of St Laurence child-care centre in the inner suburb of Fitzroy, interviews with the children's parents and group interviews with mothers of preschool children in two outlying areas of Melbourne. The child-care centre in Fitzroy was selected as the main focus for the project as a centre which catered particularly for low-income families of both Australian and non-English speaking background. However as the inner suburbs are relatively well served with health facilities and with public transport it was relevant to explore issues of access to health services for low-income families in outer areas. The two outer groups were selected as living in relatively low-income areas on the outskirts of Melbourne. Overall, 32 parents of 77 children participated in the project.

Individual interviews were held with 18 parents in Fitzroy. (The interviews were typically with mothers with the exception of one father who reported the views of his non-English speaking wife.) Nine of the parents were Australian-born and nine born in Asia. Birthplaces included Vietnam (5), Malaysia (2), China (1) and Laos (1) and major languages spoken were Cantonese (6), Vietnamese (2) and Hmong (1). The Australian-born women were typically sole-parent pensioners, the Asian families were typically two-parent families on low wages or unemployed. These families lived in Fitzroy and in adjoining inner suburbs.

Group interviews were held in two outer areas of Melbourne and the women also completed a questionnaire. One group was at a kindergarten in a Ministry of Housing estate at Hastings some 80 km from Melbourne (six mothers) the other at Craigieburn Community Health Centre 25 km north of Melbourne (eight mothers). The Hastings families were typically two-parent families on low wages or unemployed, the Craigieburn families were two-parent families with husband working as sole breadwinner. These families were predominantly Australian-born.

Sixteen of the families relied for their income on pensions or benefits and another seven received low wages supplemented by Family Allowance Supplement. The remaining nine families did not receive any such support but were living on relatively low incomes either as Ministry of Housing tenants (5) or as single income families in an area typified by relatively low incomes and high mortgage repayments. (It should be noted that not all families eligible for Family Allowance Supplement are aware of their eligibility.)

This paper focuses on the findings from the interviews (individual and group).

Barriers to the use of health services for children

The most commonly used health services for the preschool children were general practitioners, the maternal and child health service and the immunisation program. A smaller number had used hospital services, including outpatients, emergency or inpatient services. Some parents used their chemists for advice about their children's health. Some children had had dental checkups and treatment when this was provided free, for example at a child-care centre and community health centre.

The women involved in the study were asked to indicate what difficulties they had in using health services for their children. The overall results are presented in Table 1 and show that cost of medication was the most frequent difficulty (reported by 17 of 32 mothers), followed by hours of opening, transport, language, health service providers not understanding the women's situation and health service providers having different ideas from their own. However the difficulties varied considerably between the four groups. The most frequent difficulty for the Australian mothers in Fitzroy was the lack of understanding by health service providers and the different ideas of health service providers, while for Asian mothers in Fitzroy language was the most mentioned difficulty, for mothers in Craigiebum it was the cost of health services and for mothers in Hastings the cost of medication.

Overall, 21 of the 32 mothers mentioned some aspect of difficulty (including cost of medication, services, transport or other costs). They included four of the nine Australian mothers in Fitzroy, five of the nine Asian mothers, four of the six in Hastings and all eight of the Craigiebum mothers.

(TABLE 1)

The barriers to access to and participation in health services for children are examined in more detail below.

1. Financial barriers

By definition one would expect costs of health care to be a barrier to families with low incomes, although there should be few barriers under Medicare. The situation however is made complex by the concessions available to some low-income families which allow them to use services free or at reduced cost, but which are not available to all low-income families.

a) Cost of medication

Cost of medication was the most frequently mentioned difficulty for the families in the study with 17 of the 32 reporting this as a problem.

When the study commenced in July 1990 pensioners and sickness beneficiaries were able to receive prescriptions at no charge under the Pharmaceutical Benefits Scheme while Health Care Card holders (including unemployment beneficiaries and Family Allowance Supplement recipients) were charged $2.50 a prescription, and those with no concession card up to $11 for medication on the 'free' list.

In November 1990 a $2.50 prescription charge was introduced for pensioners and sickness beneficiaries (subsequently raised to $2.60) and the maximum charge for a non-concession card holder raised to $15. Other changes which involved 'minimum pricing policy' and changes to the 'safety net' will not be elaborated here, but would create additional complexity and difficulty for low-income families. While compensation was made to pensioners for the increased fees in the form of the equivalent of $2.50 per week additional payment, this did not mean the money was available when the additional cost was incurred.

The $2.50 prescription charge represented a significant cost for these low-income families in this study:

> Alright, it's only $2.50 a script you've got to pay, but it makes it hard. Like last week I went to the doctor three times and medication each time. I've been out of money so I have to book it up until pay day, but when you take it out of your pay it means you're short again on your pay.

Not all women were aware that they could keep a record of their prescriptions at the chemist so that they would know when they were entitled to free prescriptions under the safety net provisions.

In addition to the cost of prescribed medication the cost of 'over the counter' medication was emphasised by a number of mothers. Examples given included Panadol and cough medicines. The variability of what different pharmacists charge for medication was also noted. An additional problem for one of the Asian families was the costs of Chinese herbs and the difficulty in obtaining them.

Table 2 indicates the relationships between cost of medication being a difficulty and the amount paid for prescriptions, with 75 per cent of those with no concession card finding cost a . problem, 64 per cent of those who paid $2.50 a script and 11 per cent of those who did not have to pay for prescriptions.

(TABLE 2)

b) Cost of services

All families had access to the free maternal and child health service, to free immunisation and to free public hospital treatment. However the cost of general practitioner services had a very different impact for the different families.

Cost of medical services was reported as a difficulty by all of the Craigieburn families but by none of those in Fitzroy or Hastings (see Table 1). This reflects two factors, the holding of health concession cards and the willingness of doctors in particular areas to 'bulk bill' patients, low-income and otherwise. The Fitzroy families were typically sole-parent pensioners, unemployment or sickness beneficiaries or low-income families receiving Family Allowance Supplement and as such had health concession cards (Pensioner Health Benefit Cards, Health Benefit Cards or Health Care Cards depending on their status). Not only did local general practitioners not charge these families for their services, a number of local practices bulk bill all patients. In contrast, in Craigieburn the families relied on income from the husband's job and while their incomes may have been relatively low (all were one wage families) and expenditures high (mortgage repayments) none had health concession cards to label them as low-income earners. They reported that Craigieburn local doctors not only charged them for their services, but often demanded full cash payment rather than allowing the bill to be sent to Medicare. (The latter would mean the patient need only pay the gap between the Medicare rebate and the full fee, rath~r than find the money for the full fee and have to wait to receive the rebate.)

The cost of seeing the doctor was thus a major issue for many of the Craigieburn women and they put off seeking treatment for their children because of it. In the words of one mother:

> I was going to the doctors every week with my two children. Each time it was $21 and then I'd go to the chemist and spend another up to $20 on medication. So you think can I ride this out and see if I can survive without the doctor. Like one time I gave left over antibiotics to my child. That's why it would be nice to go to the doctor and use your Medicare card. That's what Medicare's about.

One Craigieburn mother noted that one doctor would bulk bill 'if you're in financial difficulties, but you have to discuss it with the doctor'. Such a discussion could be a humiliating experience and was certainly seen as a barrier by some families. Some of Craigieburn's families travelled considerable distances to go to doctors who bulk billed in other suburbs. This travel brought its own costs.

In contrast, one Hastings woman whose child had had a lot of illness was very aware of what her Health Care Card was saving her as her doctor did not charge her:

> My husband is on a very low wage and I get a Family Allowance Supplement to help supply what my husband doesn't get. If I didn't have the Health Care Card, I wouldn't know how to survive, I'd be up for a fortune.

The cost of taking children to the general practitioner thus varied considerably among the families.

Few families had taken their children to private medical specialists and none seemed to have taken their children for private dental treatment and so, in general, cost of health services was minimal for many of the families.

c) Cost of transport and other costs

While getting to health services was a difficulty for 10 of the families, the actual cost of transport was mentioned specifically by four families. Inner suburban families talked of tram fares. **In** outer areas bus fares, the cost of taxis and the cost of petrol were discussed. The cost of transport was described as a difficulty:

> Sometimes when you haven't got money left in your pocket. When you've spent all your money on bills and that.

Five families specified other costs which caused difficulties associated with health care for their children. The cost of equipment for children with asthma was prominent. One mother noted that an asthma pump cost $375, but that her doctor had one from the Asthma Foundation which she could rent and for which her mother would pay the $40. Another mother had paid $80 deposit on an asthma pump for one year.

Other costs mentioned were the patient contribution necessary to pay specialists who charged above the Medicare rebate and the cost of infant formula.

2. Geographic barriers

Ten of the families listed getting to health services as a problem. These included both inner suburban and outer area families. The Fitzroy families had a range of health services, particularly general practitioners, within easy walking distance, while other services, such as the Royal Children's Hospital, were within two or three kilometres. However, many families did not have a car (11 of the 18 had no car) and found particular difficulties in getting a sick child to hospital or to a preferred doctor in another suburb who, for example, spoke their own language. For the families in the outer areas getting to services was considerably more difficult, particularly if they did not have cars. Four of the 14 families had no car; but in families with a car the women did not necessarily have access to it as the husband needed it to get to work. One Hastings mother commented on getting to the doctor (a 40-minute walk):

> Without a car when your kids are sick its either a bus or taxi and if you haven 't got the money you're pushing kids down in either rain or boiling hot weather. I wore myself out walking back and forward.

Women also spoke of the problems, including the embarrassment, of trying to get on and off trains or buses with prams and pushers.

For the women in the study the easy proximity of the Maternal and Child Health Centre was a major benefit of that service.

3. Socio-cultural and other barriers

a) Information

Two issues related to health information provided difficulties for some of the women in this study, firstly deciding when to take children to a health service, in particular trying to judge the severity and likely outcome of an illness, and secondly finding out where to take their children (see Table 1). The main sources of information about the availability of health services for the Fitzroy families (both Asian and Australian), were the visibility of the services in the neighbourhood, information from other services particularly the Maternal and Child Health Centre and from friends. Lack of information was a less prominent issue for the women in the outer areas. However in group discussions it was clear that some women knew little about the availability of services out of their immediate area.

b) Language

Language was a major difficulty in the use of health services for many Asian families (six of nine) where the mothers spoke no or little English and could not find health professionals or interpreters who spoke their own language.

For the Asian families in Fitzroy lack of English was not a total barrier to services as there were a few doctors available locally who spoke Cantonese and, somewhat further a field, a Hmong doctor. Seven of the Asian families at least sometimes saw a doctor who spoke their own language. There was also a Cantonese speaking pharmacist. The local Community Health Centre and the Maternal and Child Health Service both used interpreters readily.

Nonetheless language was mentioned as a prominent factor in ease of service use for the Asian families. For example before a Hmong interpreter become available, the Hmong mother found the Maternal and Child Health Centre very difficult to use before a Hmong interpreter become available. Doctor's services were seen as easy to use when the doctor spoke the same language, difficult when not: 'It's difficult to explain to a doctor what the child's symptoms are'.
Language was a problem in seeing specialists and in hospitals. Even when booked in advance, hospitals could not ensure an interpreter would be available.

An outline of the situation of a Chinese-speaking woman illustrates the interaction of some of the difficulties:

> The family have been in Australia for two years and have four small children. The mother speaks no English. Her husband receives a relatively low income as a chef and the family receives Family Allowance Supplement. She sometimes attends a local Chinese-speaking doctor but he is not always available. Her new baby was born with a blocked kidney, had to attend the Royal Children's Hospital for a scan and was referred to a specialist. Her problems have included lack of transport (no car, problems of using either public transport or a taxi because of lack of English), lack of child-care and the alternative of taking her four children with her and inability to speak English to specialists or nurses in the hospital. She has a bill for $54 from the specialist. The Maternal and Child Health Centre sister (through an interpreter or the telephone interpreter service) suggested she receive home help but she declined because the home help would speak only English. She has missed some of the children's immunisations because they were sick. She has also missed dental appointments for her children because they had to be made so far ahead to ensure an interpreter. She finds medication which is not on the government 'free' list very expensive. She finds the appointments system difficult. Her mainstay has been an unemployed neighbour who has been able to drive her to hospitals and to interpret for her.

Language, however, was not only a barrier for non-English speaking people. Three of the Australian-born women found the type of language used by medical professionals a barrier:

> When the doctors talk they're talking big. Like half the times you don't understand what they're talking about. It makes you feel like you're a dumby that you don't understand it. Sometimes I say can you use proper words and they explain so I can understand.

c) Interaction with health service providers

The way health service providers interacted with the women was also a problem, in particular health service providers having different ideas to the women's own (nine responses) and health service providers not understanding the women's situation (nine responses). A few mothers also noted the difficulty of understanding what they need to do to help their child and also the difficulty of looking after their children's health when they themselves are unwell or depressed.

The three Asian women who mentioned difficulties in interaction included a Chinese women who found that the doctor recommended treatment that ran counter to her beliefs, for example fruit juice for her child who had a bad cough. She and others also pointed to the failure of Australian health service providers to allow for the Chinese tradition that 'cold' foods should be avoided by the mother for some weeks after giving birth. Another woman failed to be reassured by doctors that her son, who was not eating or growing, was in fact alright.

More of the Australian-born mothers in Fitzroy (five of the nine) reported difficulties with health service providers having different ideas from their own or failing to understand their situation than did the mothers in the other groups. Some talked of the problems of getting conflicting advice from different doctors, one spoke of her dislike of the infant welfare sister 'telling me what to do'. One mother found doctors' failure to appreciate her financial position particularly difficult:

> Sometimes when I get a prescription they prescribe medicines you have to pay for. I have to say I'm on a pension can you prescribe something else. I hate saying this. I don't like saying I'm on a pension and need handouts.
> (22-year-old single mother with two children)

d) Hours of opening

Hours of opening of health services was a major issue for six of the eight families at Craigieburn and the mothers talked of driving long distances to find medical services and pharmacists who opened longer hours than the local services. Hours of opening of medical services were not a difficulty for most of the Fitzroy families who mentioned variously, the 24-hour clinics, the availability of locums who bulk bill and the availability of 'out of hours' care through hospitals. However four inner suburban mothers did list hours of opening of some services as a difficulty and commented on problems when they were working, for example, in getting to the Maternal and Child Health Centre.

e) Child-care

Finding child-care for their other children was a difficulty reported by a few (7) mothers particularly if a sick child had to be taken to hospital at night. Others, while recognising the problems, said they had neighbours or relatives who could help in an emergency. Some women gave vivid descriptions of trying to take a number of small children on public transport to a health service and of the length of time needed to walk quite short distances with toddlers.

Discussion

The findings of this project highlight the problem of access to health services for children experienced by low-income families.

Cost remains a barrier to health services for children in many low-income families in spite of various measures aimed to limit the financial impact of health care. Cost is a barrier both to access to health service providers and to participation in necessary health care, for example, following through necessary treatment once a health service provider has been seen.

Overall the cost of medication was the most frequently mentioned difficulty reported by the mothers interviewed in using health services for their children. The 1990 changes to the Pharmaceutical Benefits Scheme which eliminated free prescriptions to pensioners will have spread this burden to sole-parent pensioners, who at the time of interview were not charged for their children's prescriptions.

For the low-income families in this study $2.50 is an amount of money which matters. They are aware that it does not sound much to the decision makers in Canberra or to doctors providing services. However to families living near the poverty line whose incomes regularly

do not quite cover basic expenses of rent, energy bills and food, it is money they do not necessarily have in their pocket. If there are several children it is a cost that can be incurred many times. If families do have the money to spend on medication or on Medicare co-payments it is money no longer available for food for their children that week despite the provision of 'compensation' in terms of increased pensions and potential 'safety nets'. For medication not covered by the Pharmaceutic Benefits Scheme and for doctors who do not bulk bill the costs of courses are considerably more than $2.50.

The financial barriers to health services vary according to a number of factors. These range from the possession of a Health Concession Card (strictly defined for pensioners, beneficiaries and Family Allowance Supplement recipients) to the discretionary billing practices of local general practitioners. The financial barriers are particularly prominent for low-income families in outer suburban areas where there is limited choice of doctor, and the cost of travelling is a factor in limiting choice.

The government's rationale for introducing charges for formerly free pharmaceuticals and the debate about the introduction of a compulsory patient charge for medical services has been to discourage 'overuse'. Such measures certainly discourage *use* for the low-income families we interviewed. As a result prescribed medication is not purchased and visits to doctors are avoided because of costs. However this is an inappropriate and inequitable way of preventing overuse. Overuse of prescribed medication should be dealt with through the prescribing doctors as mothers are not often in a position to know the applications of medication. The appropriate use of medical services would be assisted by more education of parents, but cost barriers can readily lead to inappropriate 'under-use' of services which at worst could lead to serious health risks for the children and to charges of neglect against the parents.

Issues of the costs of medical care for low-income families and the effects of consumer co-payments in medical care are examined in recent National Health Strategy papers and confirm the concerns of this study5.6.

Just as relatively small costs can have important implications for low-income families, the study found that what are relatively small distances for car drivers can prove major barriers for women with small children and no car, as they struggle with prams on public transport or walk in rain or heat.

Language proved a major barrier to health services for the non-English speaking women, but one which could be overcome to some extent by the use of interpreters and by bilingual health professionals. The availability of interpreters remains a key policy issue for Iloll-English speaking families. Language was also a barrier for some English speaking mothers as the specialist language used by doctors failed to communicate to them.

A number of mothers found a lack of understanding by health service providers a barrier to using services for their children. Some mothers felt their situation as low-income families was not understood, others found cultural barriers, for example, lack of understanding of traditional Chinese health practices.

Of the health services discussed by the mothers, the Maternal and Child Health Service provided a model of an accessible service, both providing a free service to all families and being situated in the immediate geographic area. The mothers typically saw the service as easy to use, spoke of knowing and liking the nurses, appreciated the regular use of interpreters (in Fitzroy), and felt they obtained good information. On the other hand, the difficulties the mothers found in using the service reflected the stresses of a single person service, including that the nurse was too busy, not always available and that the hours of opening were difficult for working mothers. More back-up support for this service is indicated and government action to downgrade the service would have an adverse effect on children in low income families.

The concept of free universal health services for Australian children is being undercut by a number of recent measures by both federal and state governments. A free health service remains preferable on grounds both of equity and efficiency to ensure that children get the health care they need. Introducing payments for health care has greatest impact on low-income families and will limit their use of necessary and unnecessary services. The targeting of some services to low-income families provides very uneven benefits across low-income families. This study highlights the impact for low-income families of even quite small charges for health services and points to the need for services to be accessible in terms of cost and geographic location. It also indicates the very real barriers that factors such as language, and lack of understanding by health service providers raise for these families' use of essential services for their children.

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References:

1. Jolly, D L, *The impact of adversity on child health - poverty and disadvantage.* Melbourne: Australian College of Paediatrics, 1990.

2. Mellor, E, *Stepping stones: the development of early childhood services in Australia.* Sydney: Harcourt Brace Jovanovich, 1990.

3. Harris, P, *All our children: children's entitlements to health, education and community services,* Child Poverty Policy Review 4. Melbourne: Brotherhood of St Laurence, 1990.

4. For example, Nowotny, M, 'Health of primary school-age children' in Vimpani G, Parry T, (eds), *Community child health: an Australian perspective.* Melbourne: Churchill Livingston, 1989; 287-311.

5. McClelland, A, *Spending on health: the distribution of direct payments for health and medical services;* National Health Strategy Background Paper NO.7 July 1991.

6. Richardson, J, *The effects of consumer co-payments in medical care.* National Health Strategy Background Paper NO.5 June, National Health Strategy, Melbourne, 1991.

Table 1 Reported difficulties in using health services for children

Difficulties	Number of re~onses				
	Fitzroy Australian-born N=9	Fitzroy Asian born N=9	Hastings N=6	Craigieburn N=8	Total N=32
Deciding when to go	3	3		1	7
Finding out where to go	1	3		1	5
Getting there - transport	3	3	3	1	10
The cost of transport	3		1		4
The cost of the selVice				8	8
The cost of the medication	1	5	4	7	17
Other costs	1	1	2	1	5
Child-care for other children	1	2	1	3	7
Language	3	7			10
Hours of opening	1	3	1	6	11
Understanding what you need to do to help your child	2	2	1	1	6
Health selVice providers having different ideas from your own	4	2	2	1	9
Health selVice providers understanding your situation	4	1	2	2	9
Your own health, feeling down or depressed	2	1	3		6

Source: Health Care for Children Project, Brotherhood of St Laurence, Melbourne.

Table 2 **Reported difficulty of the cost of medication for children**

Payments for prescriptions	Cost of medication is a difficulty*		
	Yes	No	Total
No charge (Pensioner Health Benefit and Health Benefit Card holders prior to Nov 1990)	1	8	9
$2.50 (Health Care Card holders; Pensioner Health Benefit and Health Benefit Card holders after 1st Nov 90)	7	4	11
Full charge	9	3	12
TOTAL	**17**	**15**	**32**

Source: Health Care for Children Project, Brotherhood of St Laurence, Melbourne.
* Medication refers to both prescribed medication and 'over the counter' medication.