

BACKGROUND 02: TARGETING AND THE COMMUNITY SERVICES CARD

Backgrounder No 2, July 1996

Child Poverty Action is very concerned about the current operation of the Community Services Card (CSC) and the impact on child health. There has been little official monitoring of the effectiveness of the card since its introduction in February 1992. As the card is the primary means by which health resources are targeted to low income families, its operation is crucial to the ability of at risk children to access appropriate and affordable health care.

A recent study by D Parks¹ completed in 1996 as part of the requirements for a Master of Health Science is one of the few systematic studies of the CSC. This study, based on interviews of 508 people in the Auckland region attending general practices targeting low income earners, showed that the CSC is seriously flawed.

First, many individuals and families who are eligible do not have CSCs, and are therefore not receiving subsidies to which they are entitled. Second, having a CSC by no means guarantees a person (adult or child) access to health care.

While people who qualify for a means-tested benefit receive a CSC automatically, all others must apply. However the criteria for eligibility are complex and therefore difficult to understand, as are the application forms. Many people are under the erroneous impression that they are ineligible because they are working

There are difficulties with the "family" as the unit of assessment in this time of rapid social change. Incentives are perverse, for example a person might want part-time work but elect not to because this may take them over the income limit for card eligibility. There is little incentive for providers to educate patients about cards other than to reduce the potential for bad debts, particularly as the cards incur higher administration costs, and little incentive for general practitioners to provide services to those on low incomes, particularly where the relative value of benefit levels has been severely eroded.

The Parks study further demonstrated that for people who did hold CSCs health care access was still problematic because the level of subsidy paid to cardholders is insufficient to meet health care costs. 67% of CSC holders still found fees posed barriers to accessing a fee-for-service doctor, and this was found to be more of a problem for Pacific Islanders and Maori, who are known to have greater health needs. This is because subsidy levels (currently set at \$15 for an adult, \$25 for a child under 5 and \$20 for a child over 5) are lower than fees currently charged by many general practitioners, and some card-holders are unable to afford the co-payment, or difference between the subsidy and the fee charged. 27% of CSC holders reported leaving a prescription unfilled within the last year because they could not afford to collect it. This was most significant for beneficiaries, with 57% reporting leaving prescriptions unfilled as opposed to 7% of non-beneficiaries.

While there is no doubt that attempts have been made to improve health care access for children by way of higher subsidies, the fact remains that because many parents (and their children) are eligible for CSCs but do not have them, many children are missing out on subsidised health care. Further, many are not receiving subsidies afforded by the card because the onus is on the CSC holder to make the fact known that they have a card. Only 6% of total respondents could say accurately what the benefits of a CSC were, despite the fact that 58% had current cards, and 36% of the remainder had held one previously. Consequently some people were being charged for hospital outpatient attendances, not realising that if they produced their card they would not have to pay. In some cases they did not have their CSC with them at the time of hospital

¹<mailto:deeparks@adr.co.nz>

attendance, and were asked to return with their card before a refund could be issued. However this may not have been cost-effective where, for example, transport, time off work and/or child care were problematic.

A similar situation arose with fee-for-service providers who were not the patient's usual GP, as is the case for after-hours fee-for-service A & E providers, where a fee had to be paid at the time of consultation by card-holders, and would only be refunded if the patient returned in person with his/her card. These factors combine to dissuade the very people who need it most from receiving primary health care services, and delaying treatment until an emergency occurs and admission to hospital is sought. Under such circumstances the patient is sicker, and more time in hospital is needed for treatment than may have been the case if appropriate primary health care were freely available.

While the institution of a universal, adequately funded primary health care system would overcome these problems and is undoubtedly the best way to ensure equitable access to primary health care this is unlikely to be considered in the current environment. Nevertheless it is difficult to design a system that targets health resources so that everyone who is entitled to receive targeted health benefits actually receives them.

Universal access for all children to the level of benefits currently available to card holders, is not beyond the resources of the community and would remove some of the complexity. In the short run at least those children under the age of five could be covered universally. If society fails to grapple with the problems of access, the expense is not saved, but will emerge for society in another form.