National and NSW
Councils for
Intellectual Disability

Australian Association of
Developmental Disability Medicine

Australian Productivity Commission
Submission on the health of people with intellectual disabilities
National and NSW CID & AADDM

There are over 500,000 Australians who have intellectual disabilities. This is a similar proportion of the population as Indigenous people and "with health outcomes at least as bad" (RACGP, 2006). The Australian research shows:

- Only 29% of health conditions being diagnosed and appropriately treated in people with intellectual disabilities.
- Very high rates of dental disease and both obesity and being underweight.
- Life expectancy up to 20 years lower than the general population.

This stark inequality arises from a range of factors including challenges to communication between health professionals and patients, high rates and complex ranges of health problems, problems with skills and available time in the mainstream health workforce, a lack of specialised intellectual disability health services to back up the mainstream, health promotion and research tending to ignore people with intellectual disabilities, and lack of co-ordination within and between governments. Furthermore, poverty and inadequate supply of free and subsidised health services further reduces the accessibility of health and allied health services for people with intellectual disability.

People with intellectual disability have high rates of co-morbid physical and mental health problems. Physical health problems include high mortality (late 50s for people with Down syndrome and early 60s for people with intellectual disability) and high morbidity with an average 5.4 medical conditions per persons, two conditions of which are unrecognised or poorly treated. Hidden health issues include pain, sensory impairment, infections, osteoporosis and epilepsy. Additionally, many people with intellectual disability are over-medicated. They have considerable lifestyle and nutritional issues including obesity, gut problems, constipation, H. Pylori bacteria, and reflux; neither do they receive regular immunisation, blood pressure checks, breast and Pap tests, skin checks, medication reviews, weight reviews and hearing and vision reviews. Mental health issues include not only schizophrenia (which is more common in people with intellectual disability), but also the highly prevalent conditions of depression, anxiety and post traumatic stress disorder. They also have lower rates of accessing appropriate services. Their risk is further compounded by difficulties accessing the health system, reliance on others as carers and high rates of poverty.

Many of the current Australian Government's health reforms benefit the wider community but they leave out people with intellectual disability, e.g. hospital funding allocations will be based on "efficient price" of services and this will create yet another barrier for people with intellectual disability to access crucial services. Specific health care planning for people with intellectual disability, despite many years of lobbying, has not appeared on the national health agenda.

Additionally, people with intellectual and developmental disability as a population of interest are excluded from most current Australian research agendas. Researchers cannot derive data from a national dataset because it doesn't exist and where national and population surveys are undertaken people with intellectual disability are usually excluded. We continue to urge the National Health and Medical Research Council (NH&MRC) and Australian Research Council (ARC) to specifically address the systemic neglect of research that specifically examines the unmet physical and mental health needs of people with intellectual disability.

As an example of the invisibility of this population in the health provision context, the Australian Government recently changed the Medicare item numbers which clearly identified health assessments for this population by merging the items for intellectual disability health assessment items into generic items. This means that the data that researchers had been accessing since July 2007 when the Medicare items came into play, is now lost. This was the one piece of data collected by the Commonwealth on the health of people with intellectual disability. Obviously the needs of this population are yet again being minimised.

Without good healthcare, a person's health suffers and puts them at risk of consequent problems in employment, daily living, learning, participating in society and more. The lives of people with intellectual disability are already impoverished by discrimination (Emerson, 2007; Wagstaff, 2002), and yet as a society, we continue to accept their poor health status.

We urge attention to the healthcare of people with intellectual disability by this current inquiry into disability care and support in Australia, and ask the Australian Productivity Commission to examine the cost of poor healthcare to this group of Australians. We commend the Australian Productivity Commission for initiating the debate.

Professor Nicholas Lennox, Director of the Queensland Centre for Intellectual and Developmental Disability (School of Medicine, the University of Queensland) and President of the Australian Association of Developmental Disability Medicine, n.lennox@uq.edu.au

Jim Simpson, Advocate, National and NSW Councils for Intellectual Disability, jcsimpson@optusnet.com.au

References

Emerson, E. (2007). Poverty and people with intellectual disabilities. *Mental Retardation and Developmental Disabilities Research Reviews, 13*, 107-113.

RACGP. (2006). *RACGP Budget Proposal, Medicare Benefits Schedule – Annual health assessment item for people with intellectual disability*.

Wagstaff, A. (2002). Poverty and health sector inequalities. *Bulletin of the World Health Organization, 80*(2), 97-105.