RACGP
Royal Australian College of General Practitioners

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Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Via email: community.affairs.sen@aph.gov.au

Dear Committee Secretary,

RE: Inquiry into the extent and nature of poverty in Australia

The Royal Australian College of General Practitioners (RACGP) is Australia's largest professional general practice organisation, representing more than 43,000 members working in or towards a career in general practice including four out of five general practitioners (GPs) in rural Australia. The RACGP sets and maintains the standards for high-quality general practice care in Australia and advocates on behalf of the general practice discipline. As a national peak body, our core commitment is to support GPs to address the primary healthcare needs of the Australian population.

The RACGP thanks the Senate Standing Committees on Community Affairs for the opportunity to provide a submission to the Inquiry into the extent and nature of poverty in Australia.

This submission will outline the impact of poverty on health outcomes, both relating to poverty and associated circumstances on the causes of ill health, the impact on behaviours that cause ill health and the impact on health services serving deprived communities. It will then outline how appropriately structured, well-funded health services are one of the necessary measures to address and reduce poverty. Health outcomes and health services will be the main focus of this submission, but some of the other areas of interest to the Committee will also be covered in passing.

1. The health consequences of poverty

The health consequences of poverty are well described the world over, and are no different in Australia. Poverty causes ill health through a range of social circumstances – so-called adverse social determinants of health, through limiting the choices and agency that people have over their own lives, and through reduced access to health services for a range of reasons.

1.1 Social Determinants of Health

The social determinants of health are described by the World Health Organisation as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life." There are multiple determinants of health, as acknowledged in the Department of Health's National Preventive Health Strategy 2021–2030, including environmental, structural, economic, cultural, biomedical, commercial and digital factors, which frequently act adversely on people living in poverty.

It is worth illustrating with specific examples the way that some selected social determinants can impact on health, though this outline is not exhaustive, and the effects are often complex, impacting each other, and impacting health jointly.

1.2 Housing

People living in poverty are more likely to be homeless or to live in structurally substandard housing. This prevents shelter from (increasingly frequent) weather extremes, of heat, cold, rain or wind. Houses are more likely to have mould or to have pests. People are much more likely to be in government or housing agency homes, with little control over making changes to the housing. There is more likely to be overcrowding. All these factors have impacts on physical health, on communicable disease spread and on mental health.

1.3 Childhood

Children are less likely to attend preschool in areas of poverty – 95% of 4-year-olds in the highest socioeconomic status (SES) areas attend pre-school, compared with 76% in the lowest.[1] Children in the lowest SES are more likely to be vulnerable on the Australian Early Development Census, which has implications for their educational needs at school, usually in the under-resourced public education system, and has long term implications for future employment prospects and health outcomes.

1.4 Employment and work

Secure, good quality work has an impact on health, self-esteem and positive self-identity. People living in poverty are more likely to be unemployed long term or to be dependent on social security for their income, but even those in work struggle with paying their bills, as wages fail to cover the cost of living. 42% of low-income households were in rental stress in 2017, spending more than 30% of their income on housing[1].

1.5 Environment

Air quality in areas of low socioeconomic status is worse than in areas of high socioeconomic status[2]. While the gradient is not large, exposure is long term, likely to lead to respiratory and cardiovascular disease. Access to green space is reduced in poorer areas compared to richer areas, which has implications for opportunities for physical activity and worsen mental health[3].

1.6 Social Inclusion

There is evidence that people in lower SES communities experience much more loneliness than those in higher SES communities, which has adverse impacts on physical and mental health. Exclusion may be experienced as loneliness, but can also include racism, discrimination and stigma, which is important when Aboriginal and Torres Strait Islander people are over-represented among people living in poverty[4].

As a result of the complex and adverse circumstances in which people in poverty frequently live, the behaviours that lead to poor health are more common in lower SES areas. People living in poverty are 3.6 times more likely to smoke daily, 1.3 times more likely to be insufficiently active, and 1.6 times as likely to be obese[5]. Food security is most often driven by material hardship and inadequate financial resources. Fast food is more readily available in low socioeconomic areas.[6]

Rates of chronic conditions are more common in low socioeconomic areas. These include Chronic Obstructive Pulmonary Disease (twice as likely, compared to the highest SES areas); diabetes (1.9 times as likely); Chronic kidney disease (1.6 times as likely); chronic heart disease (1.6 times as likely) and a new cancer diagnosis (1.1 times as likely).[5]

People in low SES areas are 2.2 times more likely to die from a preventable cause than in the highest SES areas. The burden of disease (measured as Disability Adjusted Life Years (DALY)) is 1.6 times as much for low SES compared to high SES area.[5]

Importantly, these conditions don't occur in isolation. The prevalence of more than one selected chronic condition – multimorbidity- in low SES areas was 24%, compared to 14% in the highest SES areas[7]. Additionally, people with multimorbidity are much more likely to have high or very high psychological distress (35% compared with 4.3%) compared to those with no long term conditions[7]. This has profound implications for mental health of people living in poverty, compounded by the effects of trauma from family violence arising from the lack of family support.

2. Health Services and Poverty

The health outcomes described above and elsewhere show the need for health services accessible to people living in poverty to manage and alleviate these health consequences. However, the difficulty in providing health care to those who need it most has become such a recurring problem over such a long time that it was named in 1971 as "The Inverse Care Law": "The availability of good medical care tends to vary with the need for it in the population served."[8]

Data from the Australian Bureau of Statistics in 2010[9] show that 11% of GPs worked in the most deprived areas, while 24% worked in the least deprived areas. Surprisingly, this data does not seem to have been collected since. The increased complexity described above, in managing higher levels of multimorbidity amid increased rates of mental health problems, psychological distress and trauma means there is a need for longer consultations, and a broader range of health professionals. Much time is spent in consultations with people living in poverty completing paperwork and forms for agencies such as Centrelink, the National Disability Insurance Scheme, or State Departments of Housing. The way that Medicare is structured, means that where most people are unable to afford a co-payment for general practice care, longer consultations are required to manage the complexity, but this results in worse Medicare rebates per hour. These rebates are the only income for practices to pay staff, such as nurses, receptionists, practice managers, and to pay the usual business overheads. Medicare rebates have failed to keep up with the costs of business for many years now. Clearly, the income for GPs themselves is also reduced compared to their peers. The result is systematic underfunding of general practice, making it unviable in low SES communities.

Where this complex mix of physical and mental health and social circumstances exist in low SES communities, the range of other health professionals available is also very limited, such as allied health and psychology, again, because Medicare rebates don't keep up with the cost of care and patients can't afford co-payments. Similarly, access to non-GP specialist medical care is severely limited, either by the cost of seeing them privately or through the lack of availability or the very long wait times in the public system. Not only is general practice underfunded in poorer communities, but there is evidence that the hospitals serving these communities are also underfunded – in NSW funding per patient is less for Liverpool and Campbelltown hospital in the southwest of the city than it is for the central hospitals.

The complex and challenging nature of providing general practice care in low SES communities, combined with the lack of funding for health services and the lack of community and social infrastructure investment means the workforce challenges will only get harder into the future. While there is some evidence that working in poorer communities provides excellent training for GP Registrars working towards their higher Fellowship exams[10], these pressures mean they can do work that is less complex and better supported and be paid more in higher SES communities.

3. Solutions to poverty include primary health care

The solutions to poverty in Australia will be multifaceted and include multiple agencies, including government, non-government and private, and must come from the affected communities themselves.

Improving the health outcomes for people, living in poverty must be part of the solution, as health is an enabler for everything that people want to do with their lives. With poor health it is much harder to work, to volunteer, and to care for family. Clearly, as described above, there must be action on the social causes of ill-health to make progress on this. It is impossible for health services to act to try to improve someone's health if they are sent straight back into the circumstances that cause poor health in the first place. Action that improves the social determinants of health, including particularly specific support for women and for children, including antenatal care, will have profound long lasting impacts on health.

This submission will concentrate on the provision of quality primary health care services as a specific measure to alleviate poverty. However, without broader action to alleviate poverty, health care services just become an unsustainable band aid to treating the effects of poverty.

Primary Health Care has as one of its key goals, equity of access and equity of health outcomes[11]. There are several features of Primary Care that help alleviate poverty.

3.1 Affordable care

Care must be affordable, which for people affected by poverty means that there should be no out of pocket costs. Even minimal out of pocket costs mean that people struggling to afford their food or rent will put off necessary medical care. Similarly, other costs of care, such as medication co-payments, or the cost of fuel or parking, are considerations that people make in deciding whether they can afford to attend for care.

As described above, current funding arrangements through Medicare mean that where people can't afford a co-payment for care, the funding available to the service is too small to make it sustainable. A significant increase in funding in primary care is required to achieve this. While alternative models of care may be required, these will fail if they are funded at the same level as bulk-billed private general practice, without significant additional funding.

While systemic reforms will take time to develop and implement, there are a range of measures outlined in the RACGP pre-budget submission 2023-24 which could be implemented quickly and bring significant relief to people struggling to access general practice care due to affordability. A tripling of the Medicare rebate for the bulk billing incentives would allow more general practices to bulk bill more patients who may struggle to afford care.

The RACGP has also recommended the introduction of targeted funding for patients with complex needs, which would help to ensure this type of care is more affordable for all. Funding service incentive payments for older people, people with mental health concerns and people with disability, as well as a 20% increase to patient rebates for GP consultations over 20 minutes, are key measures to support the affordability of complex care. These measures will help to ensure that people who need to spend more time with their GP are supported to do so.

There is a clear economic argument for this level of investment in primary care. Even aside from the consequences of enabling people to work, every dollar invested in primary health care in a remote Indigenous community, result in savings in hospital care from $4 to $12[12].

3.2 Embedded care

The service should be embedded in the local community, and the community should have a say in the way the service is run. This ensures that care is provided locally, as close to home as possible, but also that the people in the service understand the local context and the local services to allow care to be tailored to local need.

Primary health care is not just about the provision of services to people. It can be an opportunity for training and employment for many people in the community, serving as a way out of poverty for many, either through the direct provision of training pathways in primary health care provision, and jobs, or through partnerships with social enterprises. This benefits the individuals involved, strengthens links between the service and the community, and enhances the workforce, capacity and effectiveness of the service itself.

Primary care is most effective when based on sustained, longitudinal therapeutic relationships. Many people living in poverty have to engage with multiple agencies, and with multiple professions. Some systems may be complex and difficult to navigate, posing a barrier, especially for people with poor physical or mental health. Long term therapeutic relationships with people allow a mutual understanding and trust to develop, allow discussions and support for behaviour change and engagement of other services at the appropriate time for the person themselves, and enables them to develop more agency and choice in their life. There is good evidence that personal continuity of care makes healthcare more effective. Support and funding for primary care is an important way to address poverty in Australia. Additional primary care investment should be based on supporting such sustained long term therapeutic relationships.

As per the *RACGP Vision for general practice and a sustainable healthcare system*, voluntary patient enrolment (VPE), if implemented appropriately, is one measure which could strengthen a patient's long term therapeutic relationship with their GP. However, any model of VPE in Australia must be fit-for-purpose, with sufficient additional investment on top of fee-for-service funding.

3.2 Multidisciplinary care

Care should be multidisciplinary, and multi-agency, to enable the multiple complex problems to be managed by experts. The model of care should support and fund nursing care, midwifery, Aboriginal and Torres Strait Islander health Practitioners, dental care, allied health disciplines, psychologists, lactation consultants, and pharmacists to work together in multi-disciplinary teams, with a focus on continuity of care with a person's usual GP.

GP stewardship of patient care in the community needs to be central to any health approach to poverty. GPs are trained to lead and coordinate multidisciplinary healthcare teams, where a number of professionals with diverse skills work together to help a patient. The GP care coordination role helps ensure continuous, comprehensive, patient-centred and high-quality care. This is critical in mitigating the risk of mis- or delayed diagnoses, inappropriate or delayed treatment and adverse events resulting in physical or psychological harm. It also enables better follow-up care, facilitated through timely and meaningful communication with other service providers.

Teams should be truly multi-disciplinary, drawing on everyone's expertise, and not just try task substitution as a way of restricting funding. Broader teams should also be accessible to the primary care team, such as health-justice partnerships, community gardens, TAFE, employment agencies, or housing departments. Multidisciplinary care in these circumstances, and of this nature, crossing disciplines and agency boundaries is complex, and can be very difficult for patients to navigate. There is a clear role for care co-ordination, both at a practical level – arranging appointments, transport, funding, paperwork – and at an oversight level, ensuring patient preferences, convenience and priorities are balanced in among the multiple team members, a role that will often be performed by the GP.

These features of high quality, well-funded primary health care are consistent with the RACGP's Vision of General Practice. There are already successful models of primary health care working in Australia, including some private general practices, Aboriginal Community Controlled Health Services, not for profit health services and some government run primary care services, including the network of established Community Health Centres in a number of states. All of these serve their local communities on models similar to those described above but depend on funding beyond just the Medicare rebate with no patient contribution in order to provide the longer consultations and multidisciplinary care required for the increased complexity. Many of these services are subject to extra reporting of data to their funding bodies, and, while this is necessary for accountability reasons, if applied without thought for the health consequences, health inequalities can actually worsen, because service capacity is taken away from the provision of clinical care toward the reporting of data. Inappropriate measures, too, based on adherence to guidelines intended for people with single conditions and control over their lives will give a misleading impression of the achievements of a service. Investment in appropriate high quality information technology and highly skilled staff in addition to clinical staff is needed, if reporting is not to take away from the provision of high-quality care.

4. A note about population groups

In describing the effects of poverty, we should not lose sight of other characteristics that play a significant role.

Aboriginal and Torres Strait Islander people are over-represented in people living in poverty, which is in itself a consequence of centuries of colonisation, and racism, the effects of historical and current policy, such as child removals from family, and the lack of cultural safety in health services. People living in rural and remote Australia experience higher rates of poverty than those who live in metropolitan areas[13], and have the challenges of geographic distance, workforce shortages, and limited infrastructure and resource availability to contend with. Refugees and asylum seekers have often experienced significant trauma, from which they have fled, and may not speak or understand English. Many people who have been in prison are also in poverty, and have their own challenges in contact with the justice system. Many people with disabilities live in poverty, caught between inadequate benefits, and work opportunities limited by systems and stigma.

The particular circumstances of all these groups must be taken into account, and solutions should be considerate of specific community needs.

5. COVID 19

To conclude this submission, it is worth taking a recent example that shows in concrete fashion how poverty impacts health in Australia, in a way that is predictable and preventable. There was a clear difference in the way that COVID-19 spread and the way it was handled in different communities. The spread of COVID 19 in the early days of the pandemic was through the poorest areas of Sydney, enabled by poor overcrowded housing with limited ability to social distance. The potential consequences of COVID-19 were large because of the higher rates of other chronic diseases in these communities. Vaccination rates were lower in poorer areas, and information about vaccines wasn't translated into other languages until community volunteers did so. There were stories of tower blocks being locked down from police, and even evidence that poorer communities were over-policed regarding lock-down restrictions, even though the restrictions were breached less frequently. General Practices in these areas were frequently closed as exposure sites, but received no funding for Personal Protective Equipment, and weren't prioritised in the vaccine rollout.

6. Conclusion

Poverty has complex causes and complex effects. Health outcomes, in higher rates of chronic diseases, higher rates of psychological distress, and higher rates of multimorbidity at a younger age are caused by poverty, and impact on people's ability to reduce their own poverty, The effects start during pregnancy and continue through childhood, and become increasingly difficult to alleviate as time goes on. Health services, and specifically Primary Health Care Services are part of the solution to alleviating poverty, if they are set up and funded appropriately, and there is a clear economic case for governments to do so, even just in savings of hospital costs.

However, the example of COVID-19 shows that government, social and health systems don't routinely consider the effects on poverty, or how appropriate their models will be for people living in poverty. This can be changed. The health consequences show that health is not just a measure of illness and disease, but is a measure of community functioning. By considering health outcomes in all policies, this is likely to result in improved outcomes for all. The benefits for the whole of society from acting on poverty, in more effective use of taxes, in reduced crime and increased trust, in improved health outcomes for all, mean that there is a clear case for specific action, even for those not especially interested in the drivers or consequences of poverty.

We commend this submission to the inquiry, and are happy to provide clarification or further details on request, or provide oral presentation to the committee if required.

Yours sincerely

Dr Nicole Higgins
RACGP President

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