National Rural Health Alliance

SUBMISSION

SENATE STANDING COMMITTEES ON COMMUNITY AFFAIRS

INQUIRY INTO THE EXTENT AND NATURE OF POVERTY IN AUSTRALIA

Let's make a 'place' for place-based solutions

10 February 2023

Healthy and
sustainable rural,
regional and remote
communities
across Australia.

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1. About the Alliance and this submission

The National Rural Health Alliance (the Alliance) welcomes the opportunity to make a submission to the Community Affairs References Committee's Inquiry into the extent and nature of poverty in Australia.

The Alliance is the peak body for rural, regional and remote (hereafter rural) health in Australia. We represent 45 Members and our vision is for healthy and sustainable rural communities across Australia. Our Members include healthcare professionals, service providers, health educators and students, carers and consumers, and the Aboriginal and Torres Strait Islander health sector.

The Alliance is focused on advancing rural health reform to achieve equitable health outcomes for rural communities – the 7 million people residing outside our major cities.

The Alliance believes that all Australians, wherever they live, should have access to comprehensive, accessible and high-quality health, disability and aged care, and other social assistance services. The Alliance does not consider that poor access to services, poor health or premature death should be an accepted outcome of living in rural Australia. The Alliance highlights the multidirectional inter-relatedness of health, education and poverty and will explore this relationship in this submission.

The Alliance has published a number of policy papers relevant to this inquiry, including:

- Joint report (with ACOSS) – *A snapshot of poverty in rural and regional Australia*.[1]
- Submission on income inequality experienced by the people of rural and remote Australia.[2]
- Submission to Inquiry into food pricing and food security in remote Indigenous communities.[3]
- *Position paper: Rural health policy in a changing climate – three key issues*.[4]

Most recently, the Alliance has provided a pre-Budget submission to the Government with proposals for initiatives to expand access to health care and improve health outcomes for rural Australian communities.[5] More about this, and the Alliance's proposed Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS) model, is outlined later in this submission.

Focus of this submission

The Alliance's response is focused on the Terms of Reference (ToR) in bold, however other ToR are touched upon in contextual advice on poverty in rural Australia and TOR (c)(iii).

Terms of Reference

The extent and nature of poverty in Australia with particular reference to:

(a) the rates and drivers of poverty in Australia

(b) the relationship between economic conditions (including fiscal policy, rising inflation and cost of living pressures) and poverty

(c) the impact of poverty on individuals in relation to:

(i) employment outcomes
(ii) housing security
(iii) health outcomes
(iv) education outcomes

(d) the impacts of poverty among different demographics and communities

(e) the relationship between income support payments and poverty

(f) mechanisms to address and reduce poverty

(g) any related matters.

2. Key Messages

Reducing poverty is good for health outcomes as well as social and economic outcomes. Investing in actions to address poverty and other determinants of health, is an investment in human capital and is central to health and wellbeing in rural Australia, as are measures that ensure universal access to health care for those who experience inequity.

The Alliance considers addressing poverty, alongside other socioecological determinants of health, is core to achieving healthy and sustainable rural communities across Australia.[a]

Universal access to high-quality primary (and other level) health care in rural Australia is central to addressing health inequalities (to which poverty can contribute).

Universal structural social services approaches to reducing economic inequality are also essential to addressing poverty and health inequity. Due to the inter-relatedness of poverty and ill health, such approaches must work alongside co-designed and tailored solutions that are adaptable and flexible and build upon strengths and capabilities in local communities. This is especially critical in rural areas where there are thin markets and services or support is lacking.

This is why the Alliance recommends that individual eligibility-based structural reforms be accompanied by place-based solutions in areas of need, especially rural areas underserved by health services. This requires solutions driven by communities for communities, inclusive of the diversity of sub-populations and level of advantage of community members, including people experiencing poverty, those on low income or people whose health status is poor.

This submission focuses on **the importance of place when planning and investing in solutions** and preventive policies, programs and interventions to address poverty and health inequity. This is because the:

- geography of underserved smaller rural communities includes their own unique resources and opportunities for responding to inequities, improving inclusion, and improving health outcomes and wellbeing
- place, and the mix of people and resources in a small town, necessarily influences what interventions are practicable and can be built upon
- existing capabilities and infrastructure, and inherent relational strengths of communities, provide a foundation for starting – wherever the best start can be made.

Rural areas are not mini-metropolitan areas where a city solution can be 'helicoptered in' to solve a specific rural problem (no matter how well intended). Tailored measures are likely to be more accepted and embraced by residents, especially if they are co-designed and inclusive of the diversity within the community and the shared ownership can help drive the outcomes.

Key recommendations:

- More rural-led and located research in a range of fields is needed to generate evidence relevant to rural communities. This includes building on existing infrastructure and capabilities, such as University Departments of Rural Health and Rural Clinical Schools, funded by government to improve rural health workforce outcomes.
- Ensure patient assisted travel schemes are well funded, widely publicised, and easy to navigate and utilise.

[a] 'Healthy and sustainable rural, regional and remote communities across Australia' is the vision that drives the work of the National Rural Health Alliance *Strategic Plan 2022–2025.*

- Increase the amount of Medicare funding for out-of-hospital services provided by non-GP medical specialists in rural areas where local low-cost options (such as hospital outpatient clinics) are not available within a reasonable travel time. This will make bulk billing more sustainable and enable the provision of free or low-cost services in private practice to those who need them most.
- Introduce and fund Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS). This is a model proposed by the Alliance of comprehensive, multidisciplinary primary health care for rural Australia that would address the barriers to recruitment and retention of a rural health workforce, in order to increase its size and improve its distribution, therefore enabling improved access to high-quality, culturally safe health care in rural Australia. This model requires block funding, enables a flexible employment model, creates a multidisciplinary team and is locally designed and led, ensuring close links between the service and the community it serves. The PRIM-HS model has the potential to be a key mechanism in the provision of universal primary health care to people experiencing disadvantage in rural Australia.
- That the Australian Government commit to developing an Integrated National Rural Health Strategy and Implementation Plan to address (not limited to) workforce, access and affordability issues, climate change, food security and health promotion and prevention in rural locations.
- Invest in tailored and co-designed health literacy and communication activities, including place-specific measures that draw on the health workforce available in rural areas (multidisciplinary, collaborative across settings) and is integrated with primary health care where possible.
- Prioritise ongoing investment into communications infrastructure in rural Australia in order to improve coverage, reliability and speed, as well as reduce cost, to improve equity in digital inclusion by geography.

3. Context: rural Australia and poverty

3.1 Rural Australia

Those who live in rural Australia enjoy the benefits of living in smaller communities with a strong sense of community spirit, less congestion and, depending on location, more affordable housing.

Rural Australia is home to more than seven million Australians. This nearly one-third of the population adds considerable value to the wellbeing of the remainder of Australia's economy, gross domestic product and society more generally. Around two-thirds of the Australia's exports earnings come from regional industries such as agriculture, mining, tourism, retail, services and manufacturing.[6]

However, people living in rural Australia, on average, have:

- shorter lives, higher levels of disease and injury, and poorer access to and use of health services, compared with people living in metropolitan areas[7]
- higher exposure to health risk factors, reduced access to health services and, ultimately, poorer health outcomes as a result[8]
- **lower rates of employment, lower incomes and lower educational attainment than their metropolitan counterparts**[9]
- **reduced digital inclusion compared to those living in major cities.**[10]

The disparities also extend to research in rural Australia.

> Rural Australians experience significant health disparities compared to their metropolitan counterparts. Research underinvestment in rural areas has resulted in a lack of rural context specific knowledge and this contributes to ongoing health inequity.[11]

Recommendation:

- More rural-led and located research in a range of fields is needed to generate evidence relevant to rural communities. This includes building on existing infrastructure and capabilities, such as University Departments of Rural Health and Rural Clinical Schools, funded by government to improve rural health workforce outcomes.

3.2 Poverty

Poverty is relative. It involves people experiencing deprivation and making difficult life decisions about necessities (for example, choosing to use limited finances to pay for meals or medications but not both). The affordability of food, groceries, energy, housing, fuel or transport and other essentials (including medicines, out-of-pocket health costs) plays an important role in these decisions.

The deprivation that accompanies poverty is much more complex than lack of money or means to acquire necessities such as nutritious food. Beyond material means, when thinking about poverty it is also important to consider the opportunities available to assist people out of poverty.

Poverty is experienced at a point in time over a person's life course. People may experience poverty once in their life but, for others, longer periods of poverty can occur with a range of other interconnected circumstances of disadvantage.

Without entering into debates about the best way to define and measure poverty, the Alliance notes that:

- 'Unlike other aspects of welfare (eg income), health has been relatively neglected when it comes to defining and measuring aspects of poverty.'[12]
- Measurement of poverty is complicated. The data used nationally and internationally typically relates to comparative household income and the proportion spent on housing.[b]
- Information is routinely reported only at state and national level – remoteness is reported simply as a split between 'greater capital city' and 'rest of state'.
- With the majority of the population outside capital cities being in inner regional areas, the extent of poverty in remote and very remote areas is masked. For example, poverty in remote areas may be considerably higher than the general 'rest of state' numbers suggest.[1]

Poverty is influenced by access to affordable goods and services. Purchasing power differs across geography, with costs of services and transport being a factor (as is commonly the case in rural and remote areas). Limited public transport or access to a vehicle (with associated fuel costs) also impact what cash remains for essentials like health care.

Access to community services can help mitigate or ameliorate the effects of poverty and enable disadvantaged people to participate in social and economic life more fully. Lacking access to a bank account, mobile phone, internet or funds to cover urgent repairs are other factors that influence how excluded individuals are from what most people would consider the essentials of life.

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[b] For benchmarking poverty, the '50% of median income' poverty line is often used. It includes adjustments for household size. Other submissions will present detailed trends using poverty lines and other indicators. As the publicly available data by remoteness is not very nuanced, this submission focuses on poverty and health outcomes, the importance of primary health care and the opportunities for place-based approaches to address population health needs in communities.

Global context – leave no one behind

It is an important point in time to pay close attention to reducing poverty globally and locally.

The World Bank reports that COVID-19 has seen the end of a decade of poverty reduction globally. The poorest have suffered disproportionately, including in other areas that directly affect wellbeing, such as health and education. This has implications for lifelong income prospects.[13]

It is 15 years since the 2008 report of the WHO Commission on Social Determinants of Health. Much has been learnt, but there remains much to do. In 2021, the World Health Assembly Member States resolved to publish a new World Report on Social Determinants of Health Equity, specifically to:

> … prepare, building on the report of the WHO Commission on Social Determinants of Health (2008) and subsequent work, an updated report based on scientific evidence, knowledge and best practices on social determinants of health, their impact on health and health equity, progress made so far in addressing them, and recommendations on future actions. [Resolution 74.16 of the 2021 World Health Assembly].[14]

There are opportunities arising from this to reduce health inequity and meet the UN Sustainable Development Goals (SDGs), in line with the associated Leave No One Behind (LNOB) policy. The UN approach to LNOB includes that each country:

> Provide support for reducing spatial or geographical inequalities between rural and urban areas and/or between industrialized and non-industrialized or remote regions, including by promoting responsible and socially inclusive investments.[15]

Within this global context, it is particularly important to pay attention to growth measures that boost the income of the poorest people, families and communities.

The pandemic has shown us the value of working together for a common goal. It has also shone a light on vulnerabilities and disadvantage in our relatively wealthy country. Calls to invest in social, digital and financial inclusion have ensued.[16]

A reinvigorated focus on reducing poverty and addressing health inequities is needed. This includes efforts to narrow geographic disparities (city–rural) and a fairer focus on underserved locations. This is especially the case where there is disproportionate disadvantage (including poverty, poor access to health care, multidimensional/multifaceted disadvantage) and experiences of exclusion (social, financial, digital).

We can and must do more to narrow disparities.

Longitudinal research evidence

Given people experience poverty at a particular point in their life course, longitudinal research is helpful for understanding the influence of poverty over time. Longitudinal research does not typically allow for analysis by rural residence, either because sample size is too small or the study design may have excluded capturing rurality.

Analysis from longitudinal data, from the nationally representative Household, Income and Labour Dynamics in Australia (HILDA) dataset, has been conducted into multidimensional poverty ('low income plus poor health' or 'poor health plus insufficient educational attainment') compared to those in income poverty only. A higher proportion of those in multidimensional poverty continued to be in income poverty in the subsequent five years.[17]

Australian longitudinal evidence confirms that the level of socioeconomic disadvantage in the local area in which children live is known to impact child development.[18] This has included evidence from the first five waves of the Longitudinal Study of Australian Children (LSAC). A very large proportion of children experiencing poverty were living in homes where parents' main source of income was government benefits – the highest proportion during the very early years of childhood when the effects on development are strongest.[19]

> Children who experience poverty at some time in their childhood are likely to have poorer cognitive and social outcomes, are more likely to be obese and are also likely to have lower levels of general health. Furthermore, there are substantial differences in developmental outcomes for children who had experienced persistent poverty, compared to children who were never poor.
>
> Evidence in this report shows that a very high proportion of children who were experiencing poverty were living in households in which the main source of income was government benefits. Furthermore, the proportion of children in poverty whose parents were dependant on government benefits was highest in the very early years of childhood – a time when the effects of poverty are the most detrimental for both cognitive and health outcomes. Estimates of the influence of episodic poverty indicate the negative influences of poverty on cognitive outcomes are strongest in the very early years of childhood. This finding supports the theory of 'self-productivity', by which early capabilities provide the foundation for the development of capabilities in later years.[19]
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> *Low-Income and Poverty Dynamics: Implications for Child Outcomes*, AIFS/DSS, 2017

3.3 Poverty in rural Australia

The experience of poverty is closely connected to where people live and the local resources available to them.

People's spending power is affected by more than their incomes, for example, family size, housing costs.[20] Travel distances, affordable health costs and availability of affordable nutritious food can all contribute to variation in poverty and disadvantage in rural and remote areas compared to major cities.

> In 2017–18, Australians living outside capital cities had, on average, 19% less household income per week compared with those living in capital cities, and 30% less mean household net worth (ABS 2022b).[9]

Households living in income poverty in rural and regional areas have additional problems which often exacerbate poverty. In addition to access and transport issues referred to earlier, inadequate local infrastructure, or vulnerability to drought and other natural hazards, can also intensify the disadvantage experienced.

Farming families often have a measure of wealth in the land that they own and, theoretically, such wealth is offset against low income in 'bad' years. This is the well-known syndrome of being 'income poor and asset rich' with which policies relating to income security have grappled for years. When the Henderson Commission measured farm income in the 1970s they discovered that a considerable number of farming households had inadequate incomes even in a 'good' year.[1] The unpredictable weather events that are accompanying climate change provide another challenge.

Families living in towns and reliant on employment in service industries (for example, the retail sector) rely on the economic boost provided by the expenditure of farm incomes during good seasons; the obverse is that poor seasons and subsequent lack of farm incomes can translate to lower levels of employment and higher levels of underemployment in rural towns.

Setting aside the impact of the COVID-19 pandemic, historically all population groups at the highest risk of poverty and associated physical and economic risk factors, are present in greater proportion in rural and remote parts of the country.

People living in rural and remote Australia have lower incomes and net household worth in comparison to those living in metropolitan areas. In addition, Aboriginal and Torres Strait Islander peoples, of whom around 65 per cent live outside major cities, are disproportionately affected by poverty.[21] This is not to take away from important positives of rural life such as connectedness and connection to Country.

4. Comments against specific terms of reference

4.1 Poverty and health outcomes in rural Australia

This section responds to **term of reference (c)(iii) – the impact of poverty on individuals in relation to health outcomes.**

Individuals and their families can find themselves in poverty due to illness, injury, disability or poor health.

Poverty and the experience of multifaceted health challenges (such as multiple chronic diseases), both arise in the context of multidimensional or interconnected factors or circumstances. Many of these are outside the control of individuals and their families, spanning different sectors. Further, the interaction between poverty and health is multidirectional.

Poverty, disadvantage and deprivation can be complex, multifaceted, cumulative and ultimately lead to poor health outcomes and reduced engagement in economic, social and community activities.

There is a long-established link between unemployment, poverty and poor physical and mental health outcomes. A meta-analysis of literature shows that poor health increases the risk of exit from paid employment due to disability pension, unemployment and early retirement.[22]

Poverty, deprivation and disadvantage can have lifelong effects. Poverty influences the wellbeing of children. Child health and wellbeing is important to lifelong health and wellbeing.[23]

> Children born into socioeconomically disadvantaged families suffer worse child well-being and its lifelong implications, in all societies, worldwide.[23]

Access to high-quality affordable primary (and other level) health care, regardless of where you live, is important to reducing poverty and improving the health, wellbeing and broader social and economic goals of rural communities.

The health workforce reduces with geographical remoteness, with many professions in short supply, including general practitioners (GPs), non-GP medical specialists, nurses, midwives, pharmacists and most allied health professions.[8]

Government spending on health care is also reduced in rural areas – the Alliance has estimated that each year there is a $4 billion deficit of funding for rural health.[8]

The independent Grattan Institute has noted that poorer people are not getting the GP services they need, with disadvantaged Australians facing barriers to care. Further, there are even higher access barriers for allied health services. Compared to GP care, allied health services have higher average out-of-pocket charges and make up a bigger share of household spending on health. [24] This is without considering barriers related to workforce shortages and long wait times in rural areas. For example, in relation to psychologists:

> Psychologist appointments are even more expensive: only about 40 per cent of patients were bulk-billed for all their appointments in 2019. Those who paid for services spent $223 on average; many people paid much more. The costs are a high barrier: one in six adult Australians needing to see a psychologist report skipping it due to cost. Costs are compounded by shortages, with long waits to see a psychologist, particularly in rural areas.[24]

The presence of local services – which are reliant on a well-distributed health workforce – without significant out-of-pocket costs, is essential to enabling people experiencing poverty, deprivation and disadvantage to receive the care they need to maximise their health and wellbeing, with its flow-on effects on social and economic outcomes.

Determinants of health

Poverty is a well-established social determinant of health contributing to poorer health outcomes and health inequities. Poverty, deprivation and social exclusion have a major impact on health and premature death.

The World Health Organization (WHO) defines the social determinants of health as the conditions in which people are born, grow, live, work and age.[25] There is a large and deep body of evidence on the determinants of health, and what works, that can inform action on health inequities.[26,27] Australia has an excellent record of accomplishment in health prevention, however spending on preventive health is still low. In 2018–19, two per cent of total health expenditure was spent on public health and prevention.[28]

Determinants of health may have protective or adverse influences on wellbeing, or a mix of these. In Australia, the *National Preventive Health Strategy 2021–2030* (NPHS) summarises the wide range of protective and adverse influences organised within the domains: social, environmental, structural, economic, cultural, biomedical, commercial and digital. The many factors that sit outside the direct control of our health systems are acknowledged, as is the need for shared responsibility in preventive health actions.[28] This Committee may find the *National Preventative Health Strategy framework* helpful when considering poverty, its impacts across the life course and multidirectional interconnectedness with the health and wellbeing of people and the communities in which they live.

> Australians in good health are better able to lead fulfilling and productive lives, participating fully in their community, in their education and/or in their employment. The benefits of this are experienced system-wide with decreased disease burden leading to a reduction in the pressures on our health and aged care systems, and economic benefits demonstrated by an increase in Australia's gross domestic product (GDP). **In 2017, the Productivity Commission conservatively estimated that GDP could be increased by $4 billion per year if the health of people in fair or poor health was improved.**[28] *National Preventive Health Strategy 2021–2030*

Chronic disease

Many chronic diseases are preventable or, if caught early and carefully managed, can have their impact on health, social and economic activity minimised.

Evidence reported in the Australian Burden of Disease Study has shown that:

> Large inequalities were also found across socioeconomic groups and remoteness areas. A 21% reduction in burden could be achieved if all Australians experienced the same rate of disease burden (DALY) as the most advantaged socioeconomic group. If, however, the rate of burden experienced by all Australians was the same as in Major cities, there would be a 4.4% reduction in burden.[29]

Chronic diseases such as diabetes, cardiovascular disease (CVD) and chronic kidney disease (CKD), are leading causes of ill health, death and disability. It is well known that, on average, people who are socioeconomically disadvantaged have a higher burden of disease. Further, people in rural areas experience these conditions at a higher rate than their metropolitan counterparts.[8]

The burden of chronic disease is not shared equally and there is a social gradient to these three diseases.[30]

> If all Australians had the same type 2 diabetes prevalence as people in the highest socioeconomic areas in 2016, the total type 2 diabetes prevalence would have declined by 46%, and there would have been 416,000 fewer people with type 2 diabetes.[30] AIHW 2019

People with chronic disease not only have shorter lives lived with more years of ill health, they also have lower earnings. The effects of chronic disease are worst for poorer Australians, who are twice as likely to experience multiple chronic diseases compared to wealthy Australians.[24]

Access to health care in rural areas

Access to high-quality, affordable primary (and other level) health care, regardless of where you live, is important to reducing poverty and improving the health, wellbeing and broader social and economic goals of rural communities.

Despite a higher burden of ill health and premature death, rural Australians have reduced access to health care and also experience more potentially avoidable hospitalisations. The latest Australian Burden of Disease Study (2018) indicates that the total burden of disease continues to increase with remoteness from 173.7 disability adjusted life years (DALY) in major cities to 243.9 DALY in remote and very remote areas combined.[29] Challenges in recruiting and retaining the full spectrum of health professionals in rural Australia is an integral piece of the puzzle when it comes to access to health services.

The Alliance does not consider that poor access to services, poor health or premature death should be an accepted outcome of living in rural Australia.

Even within the public hospital system, services can be concentrated in larger towns and regional centres, if not in major cities (for example, hospital outpatient clinics for surgical treatment). Reduced local access to health services in or close to rural communities means longer travel times, resulting in financial costs due to the travel itself, as well as the need for accommodation, time off work and additional childcare. Local services that do exist are often more expensive in rural areas, due to thin markets making the provision of low-cost services in private practice (such as private Medicare funded surgical consultations) unsustainable. For people experiencing poverty, the costs associated with travel or health services themselves present additional challenges which can influence decisions about seeking health care in a timely manner, if at all. Patient experience survey data indicates that people living in outer regional, remote or very remote areas are more likely to delay or not use some health services due to cost.[38]

It is critical that there are well-funded programs that provide financial reimbursement for the costs incurred in travelling to receive health services, to assist rural people who do not have services close by and are therefore forced to access them in regional and metropolitan centres. These programs must be widely publicised, and easy to navigate and utilise.

Medicare funding for the provision of outpatient services by non-GP medical specialists in rural areas must take into account the accessibility (or not) of other affordable options (such as public hospital outpatient clinics) and the ability of private businesses to be sustainable while offering bulk-billed consultations. Where free or low-cost options are not available within a reasonable travel time, rebates must be adjusted accordingly to make bulk billing more sustainable for those who need it most.

In addition, new models of funding for primary health services are needed in rural areas where markets are thin. This is even more critical given the recent changes to Distribution Priority Areas. Changes to funding are critical to enable the provision of high-quality, sustainable and affordable local services to those who need them most and to recruit and retain the required health workforce.

Recent independent analysis by the Grattan Institute, summarising information from a range of sources, is pertinent to understanding city–rural differences and issues of affordable access.

> There are big gaps in some rural GP services. Rural areas have greater need but fewer GPs.
>
> Compared with people in major cities, people in small rural towns have about 35 per cent fewer GPs, see their GP about half as often, and are 30 per cent more likely to report waiting too long for an appointment.
>
> GPs without much local competition are likely to charge higher prices and bulk-bill fewer of their patients. As a result, rural patients pay higher out-of-pocket costs to see their GP. There is no evidence that GPs charging out-of-pocket costs provide better or longer services. But these costs can be a barrier to care for poorer people, and increase their financial stresses.
>
> Grattan Institute (for evidence cited refer to section 1.3.1 of the report)[24]

The Alliance is advocating for a novel place-based approach to primary health care, referred to as Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS), which aims to improve access to high-quality, affordable primary health care in the parts of rural Australia that need it most.

Recommendation:

- Ensure patient assisted travel schemes are well funded, widely publicised, and easy to navigate and utilise.
- Increase the amount of Medicare funding for outpatient services provided by non-GP medical specialists in rural areas where local low-cost options (such as public hospital outpatient clinics) are not available within a reasonable travel time, to make bulk billing more sustainable and enable the provision of free or low-cost services to those who need them most, in private practice.

What are PRIM-HS, advocated by the National Rural Health Alliance?

PRIM-HS will be community-based organisations that offer a comprehensive and affordable range of primary healthcare services. They should be not-for-profit organisations funded by government, designed and established by local communities to meet their primary healthcare needs in flexible and responsive ways.

PRIM-HS will employ a range of primary healthcare providers including general practitioners, nurses and midwives, dentists and allied health professionals (such as physiotherapists, podiatrists and psychologists, paramedics and pharmacists). The mix of practitioners employed will depend on the needs and circumstances of individual communities, with consideration of existing healthcare providers. Health practitioners will be supported by administrative staff (including practice managers), to ensure that clinical staff can focus on clinical practice. The PRIM-HS paradigm supports medical and allied health rural generalist models and pathways, including opportunities for structured supervision and support.

PRIM-HS overcome the barriers to attracting and retaining a rural health workforce, outlined above, by providing secure, ongoing employment with a single or primary employer, attractive conditions including leave provisions (holiday, personal, parental and long service leave), and certainty of employment and income.

PRIM-HS do not rely on health practitioners committing to establish their own practice, with the attendant responsibilities of operating a financially viable, standalone business (managing staff, administration and compliance), in what are generally thin markets. This employment model makes it easier for health practitioners to take up a rural position, knowing they can focus on their professional practice without the stress of establishing, purchasing or running a practice in a thin market. They can also easily change their minds if their circumstances change.

PRIM-HS support work–life balance, minimising social and professional isolation through peer support from a multidisciplinary team and overcoming related negative perceptions of rural practice. Employment conditions recognise and support continuous professional development and specific accreditation requirements and can provide the opportunity for training and research collaborations. PRIM-HS provide ready connection to the local community, with support and advice available regarding accommodation, employment opportunities for partners, education options for children, and social and recreational activities.

The health workforce shortage in rural Australia often means that older people or people with disabilities cannot access the support and interventions they need and are eligible for, including medical, nursing, allied health, dental and pharmacy, across a range of settings: residential aged care facilities (RACF); National Disability Insurance Scheme (NDIS) benefits; and support through the Department of Veteran's Affairs (DVA). PRIM-HS has the potential to provide in-reach services for RACF, NDIS and DVA recipients, as well as for rural people with chronic disease, including those with chronic disease management or other similar care plans.

PRIM-HS are not intended to compete with Aboriginal Community Controlled Health Organisations (ACCHOs). Where appropriate, PRIM-HS will work collaboratively to ensure that all primary healthcare services, serving the full spectrum of community members, can thrive. PRIM-HS acknowledge the holistic, comprehensive and culturally appropriate health services provided by these distinct organisations.

PRIM-HS are also not intended to compete with existing health professionals in a community or threaten the viability of existing services. PRIM-HS are aimed at supporting communities where there is a lack of primary health care and would be implemented to ensure existing services are enhanced. Hence, PRIM-HS will be co-designed with local health consumers, providers and organisations to address local needs, offering a range of services that are better integrated across all sectors.

Recommendation:

- Introduce and fund PRIM-HS. This is a model of comprehensive, multidisciplinary primary health care for rural Australia proposed by the Alliance that would address the barriers to recruitment and retention of a rural health workforce, in order to increase its size and improve its distribution, therefore enabling improved access to high-quality, culturally safe health care in rural Australia. This model requires block funding, enables a flexible employment model, creates a multidisciplinary team and is locally designed and led, ensuring close links between the service and the community it serves. The PRIM-HS model has the potential to be a key mechanism in the provision of universal primary health care to people experiencing disadvantage in rural Australia.

A preventive health lens

The National Preventive Health Strategy 2021–2030 provides direction for preventive health action across the course of life and an opportunity to build sustainable systems, address increasing burden of disease and reduce health inequities, and improve preparedness for emerging health threats.[28]

The NPHS principles, are important when operationalising primary care or general wellbeing and socials services. These include:

- multisector collaboration (within and without of health)
- enabling the workforce (including in health promotion and through multidisciplinary health care and health professionals working at their full scope of practice)
- community participation (including place-based and co-designed approaches)
- an equity lens (promoting self-determination and self-care for people from all socioeconomic and cultural backgrounds, focusing on structural and environmental factors impacting autonomy).

Preventive health actions can build on strengths and risks. The focus on providing the best start in life and across the life course, and its potential to influence actions outside of the health sector given the crossover in risks and protective factors, can provide a focus for community co-design. These principles align with the PRIM-HS model proposed by the Alliance.

Food Insecurity

Food insecurity has adverse health and social effects from early childhood through all stages of life. The human health impact includes higher rates of chronic diseases. While food insecurity exists in low-income communities across Australia, one of the groups at greatest risk are remote Aboriginal and Torres Strait Islander communities.

According to the Organisation for Economic Cooperation and Economic Development (OECD):

> A person is considered "food secure" when they have the physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life (as defined by the United Nations Committee on World Food Security).[31]

Research with consumers seeking emergency relief support through 15 Uniting services (across Tasmanian and Victoria) during August 2022 indicates cost-of-living pressures were impacting the purchasing of food and groceries the most, especially meat and vegetables. But many were cutting back in other domains too. Most surveyed were people experiencing unemployment. Almost one-third of those surveyed identified as a person with a disability.[32] For older people, energy costs were a major concern.

Pollard et al, in their study of geographic factors as determinants of food security: a Western Australian food pricing and quality study[33], analysed the cost of a Healthy Food Access Basket (HFAB) across a range of retail types and geographic areas. The HFAB cost 24 per cent more in very remote areas than in a major city, with fruit 32 per cent more expensive, vegetables 26 per cent more expensive and dairy 40 per cent more expensive. Further, higher prices did not correlate with higher quality with only 80 per cent of very remote stores meeting all criteria for fresh produce, compared to 93 per cent in Perth. With increasing geographic isolation, most foods cost more and the quality of fresh produce was lower.

Access to potable, clean and continuous water is also essential to support healthy dietary choices. Bottled water in many remote communities is very expensive and many reports highlight this aspect of food security and recommend access to free water dispensers in communities and subsidised bottled water.[3]

The Need for a National Rural Health Strategy

The Alliance is seeking an integrated National Rural Health Strategy and Implementation Plan to address enduring health workforce, access and affordability issues, food insecurity and with a preventive health lens. It should also include the rural health sector in responding to climate change and in local disaster planning and emergency management. Such a Strategy would also enable all the social determinants of health that affect people in rural Australia to form part of a concentrated effort to improve health and limit adverse impacts of poverty in rural communities.

The Government has an obligation to support the full spectrum of primary healthcare services throughout the country. The emergence of significant new health challenges in recent years gives added impetus for a new and current National Rural Health Strategy.

The health effects of climate change should be incorporated, recognising the increased frequency and intensity of bushfires, droughts and floods. This is particularly relevant for rural communities, which are disproportionately affected by these extreme weather events.

Further, since the development of previous strategies and frameworks, the impact of the COVID-19 pandemic has exposed the vulnerability of rural Australians due to the lack of capacity in the rural health system. It has also emphasised the social contract that 70 per cent of the population and the Government must make with rural Australians. Workforce shortages, the lack of appropriate facilities, and a higher proportion of older and vulnerable people, all contribute to this risk. The way forward is a comprehensive and integrated National Rural Health Strategy and Implementation Plan to drive necessary policy change and reform.

A commitment from all levels of government to support a National Rural Health Strategy will be critical to its success and capacity to drive reform and structural change. Support for the objectives of the Strategy, as well as collaboration and action across governments, will be key drivers required to achieve the aims of improved accessibility, equity and rural health outcomes. In particular, a commitment is required from governments to additional funding to support rural access to the full spectrum of health professionals, including medical, nursing, midwifery, allied health, dental, paramedicine and pharmacy.

Recommendation:

- That the Australian Government commit to developing an integrated National Rural Health Strategy and Implementation Plan to address (not limited to) workforce, access and affordability issues, as well as climate change, food insecurity and health promotion and prevention in rural locations.

4.2 Poverty and education outcomes in rural Australia

This section responds to **TOR (c)(iv) – the impact of poverty on individuals in relation to education outcomes**. It does this by adding the relevant issues highlighted above.

Poverty can limit educational outcomes, which is especially significant for children and young people and lifetime levels of advantage or disadvantage.

‘Female education, in particular, is strongly linked to improved health care for children, families and communities.’[34]

Overall, Australians have comparatively good educational outcomes, but at the same time:

- Australia is ranked in the bottom third of OECD countries on equitable access to education.[35]
- Those with the lowest level of education in 2016 had a life expectancy equivalent to the national average of 15–20 years ago.[36]
- Student groups likely to experience educational inequity include First Nations people, refugees or migrants from a non-English speaking background, people with a disability, or those who live in rural and regional areas. Being part of multiple groups only increases the chances of inequity – a refugee student living in a regional community is at a greater risk of poorer educational outcomes.[37]

Education is protective against, and critical to, addressing poverty. Completing school is a key step in reducing disadvantage, as it opens up opportunities for economic participation and enhances literacy, including health literacy and digital literacy.

Lack of access to computers and affordable, reliable internet disadvantages children experiencing poverty by limiting their ability to fully participate in education. Relative disadvantage may also be a point of embarrassment (or even ridicule and resulting shame) for individuals. This can impede help-seeking, contribute to poor health or affect confidence when considering a career or looking for work.

Those who grow up in a rural area are less than half as likely to gain a bachelor and above qualification by the time they are 35 years old compared to individuals from metropolitan areas. Further, compared to their metropolitan counterparts, rural students are less likely to complete secondary schooling, apply for higher education or complete tertiary education. They are also more likely to defer university offers.

Various factors can deter or prevent rural students from pursuing a tertiary education in any field. For example, fewer local study options can mean the need to relocate, at considerable financial and social cost, and this lack of options can affect the aspirations and choices of students.[38]

Low representation in higher education is an impediment to breaking cycles of disadvantage and reducing the risk of poverty. Further, it hampers efforts for growing the rural health professional workforce and therefore the services needed in rural Australia, including for those experiencing poverty, deprivation and disadvantage. It is important there are rurally located pathways from school, through vocational education and training (VET) and into university and later rural practice. Vocational and higher education institutions can engage with rural schools to show what options are available so that students can 'see' what they can 'be'.

The health sector is a large source of employment in rural areas. If educational opportunities were improved in rural areas it would assist rural residents (across the life course) to more easily train or retrain for health professional careers or other caring roles, including as disability support workers or aged care personal care workers.

Literacy, including health literacy and digital literacy

Education is central to good health literacy and digital literacy and using these skills for health and wellbeing, including a wide range of important activities such as obtaining work, ensuring quality use of medicines or engaging in cognitive behavioural therapy homework for good mental health.

As part of the NPHS, a National Health Literacy Framework is under development. This is a welcome development. There is a lot of stigma felt by people experiencing literacy concerns, and embarrassment and stigma can mean people hide these issues.

Health literacy initiatives should be supported by co-design, including for placed-based multidisciplinary approaches to helping people learn in a safe environment. The Alliance strongly supports tailored and co-designed health literacy and communication activities, including place-specific measures that draw on the health workforce available in rural areas (multidisciplinary, collaborative across settings), integrated with primary health care where possible.

Recommendation:

- Invest in tailored and co-designed health literacy and communication activities, including place-specific measures that draw on the health workforce available in rural areas (multidisciplinary, collaborative across settings) and is integrated with primary health care where possible.

4.3 Poverty among different demographics in rural communities

This section responds to **TOR (d) – the impacts of poverty among different demographics and communities.**

4.3.1 First Nations Australians

The proportion of Aboriginal and Torres Strait Islander people reporting positive indicators increases with remoteness, for example feeling calm and peaceful all/most of the time, experiencing happiness. Connection to Country and maintaining family networks are other factors that positively support wellbeing.[39]

On the flip side, Aboriginal and Torres Strait Islander peoples are especially vulnerable to poverty and comprise a significant proportion of the population in rural and remote areas. Of particularly high priority is improving the health and wellbeing of Aboriginal and Torres Strait Islander peoples living in remote Australia, including poverty and food insecurity. This should be done within a co-design process with First Nations peoples and build upon the work to date of ACCHOs, and contribute to implementing the *National Aboriginal and Torres Strait Islander Health Plan 2021–2031*.

> Closing the social determinant gap requires cross-sector approaches across all levels of government and the whole health system. The Aboriginal Community Controlled Health Service (ACCHS) holistic model of care provides a valuable example of how culturally safe and responsive primary health care can incorporate social determinants at the service level.[40]
> *National Aboriginal and Torres Strait Islander Health Plan 2021–2031*

Positive developments

There have been improvements in birth and pregnancy outcomes for Aboriginal and Torres Strait Islander mothers and babies nationally. There is evidence of:

- an increase in the proportion of mothers attending antenatal care in the first trimester
- a decrease in the rate of mothers smoking during pregnancy
- a decrease in the proportion of babies born small for gestational age.[39]

Income and remoteness over time

The Centre for Aboriginal Economic Policy Research (CAEPR) has analysed census data, over three censuses (2006, 2011 and 2016), to look at the distribution of income within the Indigenous population. Importantly, analysis by geography/variation by remoteness was a strong focus, with insights well communicated using maps showing relative circumstances across regions. On the good news side, CAEPR noted that Indigenous incomes are growing and at a faster rate than non-Indigenous incomes (analysed in aggregate).[41]

While steady growth in Indigenous incomes is occurring in urban areas of Australia, the paper shows a 'great divergence in the material circumstances of the Indigenous population across Australia. Urgent policy action is required to ameliorate the growing prevalence of poverty among Indigenous people in very remote Australia.'[41] Similarly, when considering differences between Indigenous and non-Indigenous populations, a divergence is shown – the gap in income is narrowing in urban areas, yet growing rapidly in very remote areas.[41]

Concerningly, CAEPR note in their analysis that:

> For the first time that we are aware of, more than half of the Indigenous population in very remote Australia was in income poverty, with rates in most very remote regions well above 50% in 2016. Indigenous incomes in very remote areas fell further behind non-Indigenous incomes, with the median Indigenous income in these areas averaging just 44% of the median non-Indigenous income. The structural causes of this increase in poverty require urgent action. [41]

Access to affordable nutritious food for Aboriginal and Torres Strait Islander people

The current poor nutritional health of many Aboriginal and Torres Strait Islander people is in marked contrast to the situation prior to European settlement in Australia, when Aboriginal and Torres Strait Islander people were generally healthy and enjoyed a varied traditional diet low in energy density and rich in nutrients.[41]

It is important to ensure that consideration of strategies to improve food security in remote Indigenous communities takes into account the historical and cultural context of the community and the particular circumstances and individual needs of the community. This can only be achieved by community engagement, consultation and ownership of strategies.

The *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* is designed to achieve the Closing the Gap targets. Strategies within this plan include improving access to nutritious foods through a National Nutrition Policy.

Strategies need to recognise that food is central to individual and collective Aboriginal identity. Aboriginal and Torres Strait Islander people living in remote communities in Australia experience a disproportionate burden of chronic disease. There is clear evidence of the significant detrimental health effects of poor nutrition linking to a range of chronic diseases that affect life expectancy and overall community wellbeing.

The key food security issue for remote Indigenous communities relates to access to affordable, high-quality, nutritious food. There are many factors that influence food security, however, the high cost of fresh food relative to the low level of incomes in remote communities emerges as a significant factor.

It is clear that market forces alone cannot be relied on to address food security issues in remote communities, and there is a role for government at the national, state or territory and local level to intervene in the market to ensure both demand- and supply-side issues are addressed. Fundamentally, locally based solutions must be the result of outcomes designed and supported by communities in response to specific community circumstances and needs.

4.3.2 People experiencing sustained periods of poverty or multidimensional disadvantage

Providing support and opportunities is key to ensuring poverty and complex disadvantage do not become entrenched. Chronic disease is rising, however much is preventable or lower burden can be achieved through good management and primary care.

> Persistent and recurrent poverty affects a small, but significant proportion of the population. About three per cent of Australians (roughly 700,000 people) have been in income poverty continuously for at least the last four years. People living in single-parent families, unemployed people, people with disabilities and Indigenous Australians are particularly likely to experience income poverty, deprivation and social exclusion. For people in these circumstances, there is an elevated risk of economic disadvantage becoming entrenched, limiting their potential to seize economic opportunities or develop the skills with which to overcome these conditions.[42]
> Productivity Commission, 2018.

The following tables provide a summary of the differences in remoteness categories for single parent families and people receiving long-term unemployment benefits.

Table 1: Single parent families with children under 15 years, 2021

Remoteness category	Single parent families with children under 15 years	Total families with children under 15 years	% single parent families
Major cities	354,254	1,876,260	18.9
Inner regional	109,276	438,115	24.9
Outer regional	48,161	189,572	25.4
Remote	6,515	28,240	23.1
Very remote	5,162	17,514	29.5

Public Health Information Development Unit (PHIDU)[43]

Table 2: People receiving an unemployment benefit long term, June 2021

Remoteness category	People receiving Newstart Allowance or Youth Allowance (other) for longer than 6 months	Persons aged 16 to 64 years	% people receiving Newstart Allowance or Youth Allowance (other) long-term
Major cities	651,381	12,136,008	5.4
Inner regional	206,012	2,703,271	7.6
Outer regional	105,623	1,250,003	8.4
Remote	18,001	183,304	9.8
Very remote	20,150	130,745	15.4

Public Health Information Development Unit (PHIDU)[43]

Supports and opportunities that help prevent people ending up long-term unemployed or provide pathways out of unemployment are also important for health outcomes. However, the multidimensional nature of disadvantage means this this a complex area.

> The elevated risk of falling into income and multidimensional poverty has been an overlooked cost of poor mental health.[44]

In rural and remote Australia, limited availability of mental health professionals means less options for addressing psychological distress early, with a view to avoiding such a fall into poverty. For example, the psychology workforce is most prevalent in major cities (MM1) and least prevalent in small rural towns (MM5). The prevalence of psychologists as a full-time equivalent per 100,000 population is reduced in all rural areas when compared to major cities.[45,c]

People experiencing multiple challenges may not be able to address all the barriers or issues at once – it is important that those working with them are aware of other supports and their priorities for action. For example, if housing is insecure then that may be the first issue that needs addressing, or they may be open to working on their physical health, such as increasing their walking, as part of addressing a chronic disease concern or risk factor. People are unlikely to be able to change everything at once, so person-centred approaches are critical. In rural areas, the PRIM-HS model would be an excellent model for people on low incomes who have complex health needs or are at risk of chronic disease. The location-specific nature also provides focus for targeting services to maximise inclusion.

4.4 Other related matters

In response to **TOR (g), any related matters**, the Alliance includes digital inclusion as an issue for consideration.

Digital inclusion

Digital inclusion increases with education, employment and income. Health literacy, health systems literacy and digital literacy are all important for overall wellbeing, and core to understanding health messages and written information as part of early intervention in chronic disease.

[c] Calculations by the National Rural Health Alliance based on the National Health Workforce Dataset and population figures provided by the Australian Government Department of Health and Aged Care.

Digital inclusion means people can access and use digital technology to participate in life, such as participating in learning or working from home and accessing telehealth. The Australian Digital Inclusion Index (ADII) uses data from the Australian Internet Usage Survey to measure digital inclusion across three dimensions of access, affordability and digital ability.

Digital inclusion at the national level is improving, but improvements are not equally shared. People who have not completed secondary school, are in the lowest income bracket, or are social housing renters are much more digitally excluded. The divide between metropolitan and regional areas has narrowed but remains marked. In 2021, regional areas recorded an ADII score of 67.4, which is 3.6 points below the national average (71.1) and 5.5 points less than metropolitan Australia (72.9).[10]

Broadband and mobile connectivity is an enduring concern across many communities and increasingly crucial to the economic and social wellbeing of Australian regions. As highlighted by Infrastructure Australia, many parts of rural Australia have no, or poor, mobile phone voice and data reception, affecting quality and reliability of services. While Australia's mobile phone networks cover most individuals at home, there is limited service in many regional and remote areas (known as mobile blackspots), reducing mobile phone access for individuals when they travel and for some regional and remote communities. The lack of connectivity disadvantages Australians in these areas, who rely on mobile connections for social inclusion and access to services such as health (for example, telehealth), education (for example, online distance education) and other welfare services, as physical services are often not cost effective to provide in these areas.[46]

Recommendation:

- Prioritise ongoing investment in communications infrastructure in rural Australia, in order to improve coverage, reliability and speed and reduce cost, to reduce inequity in digital inclusion by geography.

Conclusion

Access to high-quality, affordable primary health care, regardless of where you live, is important to reducing poverty as well as improving health, wellbeing and broader social and economic goals for rural communities.

Responses to poverty and disadvantage, geographically targeted at rural areas and implemented concurrently with new models of community-driven rural primary health care services, are needed.

Measures that include strong preventive health and community-wellbeing-focused activities should be considered for funding by governments (whether local, state, territory or federal) in collaboration with communities, private business, industry, and social and charitable stakeholders. It is an important investment in human capital and associated positive economic, health and wellbeing outcomes.

The Alliance argues that this would be especially useful in areas of relative disadvantage as measured by evidence-based data and research that reflects the complex interplay between income, education, health, employment and other key social indicators.

The Alliance would be pleased to elaborate on any of the issues referred to in this submission.

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