National Heart Foundation of Australia submission to the Senate Community Affairs References Committee

Inquiry into the

Extent and Nature of Poverty in Australia

14 February 2023

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About the Heart Foundation

For more than 60 years the National Heart Foundation of Australia (Heart Foundation) has led the battle to save lives and improve the heart health of all people living in Australia. Through the generosity of our donors the Heart Foundation makes a difference in the fight against heart disease by:

- funding high-impact research, supporting emerging and leading heart health researchers
- working to improve heart disease prevention, detection, care and support
- advocating to governments and industry for increased funding and resources for heart health
- building community awareness about living a heart-healthy lifestyle through public health awareness campaigns, accessible information and resources
- supporting health professionals in their work to prevent, diagnose, treat and manage heart disease.

Scope of this submission

The Heart Foundation welcomes the Senate Community Affairs References Committee Inquiry into the extent and nature of poverty in Australia. The Heart Foundation would like to comment on the following terms of reference:

(C) the impact of poverty on individuals in relation to (iii) health outcomes

Summary of submission recommendations

- **Affordable access to healthcare**
  - **The Australian Government should continue to provide timely and affordable access to Heart Health Checks by extending MBS items 699 and 177.**
- **Reducing the impact of poverty on obesity and cardiovascular disease**
  - **Honest and transparent labelling of food, a mandatory Health Star Rating system, and stronger reformulation targets achieved through the Healthy Food Partnership.**
  - **The Australian Dietary Guidelines are routinely updated, and national nutrition surveys are undertaken at regular intervals.**
  - **A National Nutrition Strategy is developed and implemented, focusing on equitable access to fresh, healthy and sustainable foods.**
  - **Policies developed to ensure that everybody, irrespective of their economic circumstances and where they live, has access to healthy food.**
- **Reducing the impact of poverty on physical inactivity and cardiovascular disease**
  - **Incorporate active living in our built environment (such as the initiatives outlined in the Heart Foundation's Healthy Active by Design program).**
  - **Continued government investment in low-cost and no-cost physical exercise activities (such as the Heart Foundation's Walking Program), particularly in areas of high need and poverty.**
  - **Continued support and expansion of the Heart Foundation's Active Australia Challenge to support more community-led programs in areas of poverty support increased physical activity.**
- **Reducing the impact of poverty on smoking and cardiovascular disease**
  - **Continue Australia's anti-tobacco initiatives.**
  - **Provide additional assistance to those from lower socioeconomic groups to quit smoking.**
- **Reducing the impact of poverty on rheumatic heart disease**

- **Continue policies to eliminate RHD in Australia, with a particularly focus on ending poverty amongst First Nations Communities**
- **Increased funding and commitment to implement the Rheumatic Heart Disease Endgame Strategy including those directly related to the socioeconomic outcomes and targets established under the new National Agreement on Closing the Gap.**
- **Support the ongoing delivery and expansion of community led peer support programs such as the Heart Foundation's Champions4Change program that prioritise Aboriginal voices and leadership, decision making at all levels of the health system, the importance of developing community capacity, acknowledge the value of lived expertise and are locally responsive**
- **Support the prevention, control and management of Rheumatic Heart Disease by making a notifiable disease in every State and Territory.**

The impact of cardiovascular disease

Cardiovascular disease continues to be one of the leading causes of morbidity and mortality across Australia. Each year more than:

- 42,000 people die from cardiovascular disease, which is 117 people each day
- Almost 600,000 000 people are hospitalised with cardiovascular disease
- Over four million people are living with a cardiovascular condition.

Cardiovascular disease burden puts immense strain on people, their families, the health service, and costs the nation more than $11.8 billion in direct health expenditure.

Clear links between poverty and cardiovascular health

The medical research literature shows that there are clear links between poverty and health outcomes[1] [2] [3]and across a range of different areas including food security, energy affordability, indigenous status, and the health impacts of climate change[4] [5] [6] [7]. People living in poverty are more likely to have adverse cardiovascular health outcomes[8], and this relationship is bidirectional, as those living with cardiovascular health conditions are more likely to be living in poverty[9]. The Heart Foundation contends that addressing the causes of poverty has the potential to improve the cardiovascular health of millions of Australians, and that by helping people to improve their cardiovascular health they are less likely to find themselves trapped in poverty.

The evidence shows there is a strong overlap between the more than 4 million Australians currently living with cardiovascular disease and the one in eight Australians living in poverty. Therefore, tackling both poverty and cardiovascular disease needs to be seen as two tasks that must be taken together, hand-in-hand. Every effort taken to reduce poverty will help reduce cardiovascular disease burden, and every effort taken to reduce cardiovascular disease will in turn reduce poverty.

Priority areas for action

In this submission the Heart Foundation would like to draw the Committee's attention to five priority areas:

1. Poverty, access to healthcare and cardiovascular disease
2. Poverty, obesity and cardiovascular disease
3. Poverty, physical inactivity and cardiovascular disease
4. Poverty, smoking and cardiovascular disease
5. Poverty and rheumatic heart disease

Access to healthcare and cardiovascular disease – extending Medicare subsidised Heart Health Check items 699 and 177

For those living in poverty it is more difficult to find timely and affordable access to primary healthcare. A recent report by the Grattan Institute for the Consumers Health Forum of Australia found that high out-of-pocket healthcare costs are deterring people from seeking treatment[10]. When patients are unable to afford routine healthcare appointments they are at risk adverse health conditions, including cardiovascular disease, going undetected.

To help improve patient access to routine heart health checks the Heart Foundation successfully campaigned for the Australian Government to introduce Medicare items for comprehensive Heart Health Checks (MBS items 699 and 177). At a cost of just $11.5 million per year these Heart Health Checks are one of the most vital tools we have to reduce cardiovascular disease across the population. However, without action these Medicare items are set to lapse in June 2023, which will make it more difficult, especially for those living in poverty, to receive a heart health examination. This situation would lead to cardiovascular disease going undetected, particularly among those living in poverty who would be less able to afford a non-subsidised heart health check.

Recommendation: The Australian Government should continue to provide timely and affordable access to Heart Health Checks by extending MBS items 699 and 177.

Poverty, obesity and cardiovascular disease

An unhealthy diet can lead to being overweight or being obese. Excess body fat contributes to the development of increased blood pressure, abnormal lipids, and the increased risk of type 2 diabetes. According to the 2017-18 National Health Survey, an estimated 2 in 3 Australians aged 18 and over were overweight or obese, with around 31% being obese[11]. The link to obesity and poverty is clear with adults living in the lowest socioeconomic areas being more likely to be overweight than those in the highest socioeconomic areas[12].

There are multiple reasons why those living in poverty are more likely to be overweight or obese. Many people have limited access to healthy food in their diet either because their economic circumstances mean such food is unaffordable, or simply not available where they live. In addition to the difficulties of accessing and affording healthy food, kitchen preparation facilities and nutritional education can be hard to access for many people living in poverty[13] [14].

The Heart Foundation supports policies that incentivises and makes healthy food choices easier, affordable and accessible.

Recommendations:

- **Honest and transparent labelling of food, a mandatory Health Star Rating system, and stronger reformulation targets achieved through the Healthy Food Partnership.**

- **The Australian Dietary Guidelines are routinely updated, and national nutrition surveys are undertaken at regular intervals.**
- **A National Nutrition Strategy is developed and implemented, focusing on equitable access to fresh, healthy and sustainable foods.**
- **Policies developed to ensure that everybody, irrespective of their economic circumstances and where they live, has access to healthy food.**

Poverty, physical inactivity and cardiovascular disease

There is a clear link between cardiovascular disease and physical inactivity. The It is estimated that over 16% of chronic heart disease in Australia occurs because of a lack of physical activity[15]. The AIHW also found that 63% of those from the lowest socioeconomic groups (and therefore more likely to be living in poverty) undertake insufficient physical activity compared to 48% in the highest socioeconomic areas[16].

According to a VicHealth report there are three main social determinants that drive physical activity, and these include the socioeconomic, political and cultural context of people's lives; people's daily living conditions; and an individual's motivation[17]. The Heart Foundation, through its Healthy Active by Design program[18], has undertaken substantial work looking at how our daily environment impacts on our health, particularly with respect to physical activity.

Better designed spaces can lead to more physical activity as people are motivated to move between places using active transport. Conversely, poorly designed spaces that put barriers in the way of active living result in decreased physical activity as people often have to use non-active forms of transport such as cars. In many areas, particularly those where poverty levels are higher, there can be fewer options to engage in physical activity either through a lack of safe open space and parks, or through poor design.

An individual's motivation to be physically active can be heavily influenced by poverty as some forms of physical exercise can be costly, such as fees for children's sports participation, and suitable clothing and equipment. This makes access to physical activity harder for those living in poverty and can have lifelong impacts on engaging in physical activity and sports. The Heart Foundation's walking program (which has recently received supported from the Australian Government) aims to address this access problem and provides people with the ability to create their own individual Personal Walking Plan, as well as details on how to join one of 1,200 Heart Foundation walking groups across the country[19]. Promoting a simple, low-cost activity like walking, and walking groups, has proven benefits on both increasing physical activity, but also mental and social wellbeing. We know these Heart Foundation walking groups are reaching those in highest need, and those on low incomes, and 60% of participants are overweight and obese and the majority (57-81%) have one or more chronic disease risk factors[20].

Recommendations:

- **Incorporate active living in our built environment (such as the initiatives outlined in the Heart Foundation's Healthy Active by Design program).**
- **Continued government investment in low-cost and no-cost physical exercise activities (such as the Heart Foundation's Walking Program), particularly in areas of high need and poverty.**
- **Continued support and expansion of the Heart Foundation's Active Australia Challenge to support more community-led programs in areas of poverty support increased physical activity.**

Poverty, smoking and cardiovascular disease

Smoking is the number one modifiable risk factor contributing to disease burden and deaths.[21] Overall age groups, 15% of all cardiovascular deaths in Australia can be attributed to smoking. For those aged 45 to 54, 38.2% of cardiovascular mortality for men and 33.7% for women is attributable to smoking[22]. Those from low socioeconomic groups, and therefore those most likely to be living in poverty, have substantially higher smoking rates than the overall population[23]. While there is a clear relationship between prevalence of smoking and poverty, the driving factors behind it are complex and involve cumulative and multiple effects across the life course[24].

Measures to discourage people from taking up smoking and measures to assist people to quit smoking must continue to be prioritised. The most effective actions to discourage smoking such as pricing mechanisms and taxation, plain packaging, warnings, and the removal of smoking from indoor environments all continue to be important. However, extra targeted efforts need to be directed towards providing assistance to those from lower socioeconomic groups to quit smoking, given their relative higher levels of smoking.

Recommendations:

- **Continue Australia's anti-tobacco initiatives.**
- **Provide additional assistance to those from lower socioeconomic groups to quit smoking.**

Poverty and rheumatic heart disease

Rheumatic heart disease (RHD) starts with a Strep A infection of the throat and skin. When left untreated, the infection can lead to acute rheumatic fever (ARF) which causes sore joints, rash, fevers and heart inflammation. While the other symptoms of ARF go away, heart damage may remain – and this is known as rheumatic heart disease. RHD is a chronic, disabling condition that can significantly reduce life expectancy and quality of life. It can also be fatal. RHD, has been eliminated in most wealthy countries. RHD is entirely preventable and is essentially a disease caused by poverty.

First Nations communities in remote areas of Australia live with some of the highest rates of RHD in the world[25]. While there are direct biological causes of ARF and RHD, it is the political, economic, social and environmental conditions in which people live which puts First Nations communities at risk and continues to drive the inequitable burden of disease. Healthy housing and health infrastructure, reducing household crowding, access to culturally safe health care services and access to employment and education are known to reduce rates of ARF and RHD in the population[26]. The same social and environmental factors also contribute to other health conditions which disproportionately affect First Nations communities (e.g. ear disease, kidney disease, and respiratory infections).

Improving the socio-economic circumstances will reduce the high rates of ARF and RHD among First Nations peoples. With children and adults most at risk from ARF and RHD, reduced burden of disease will lead to increased participation in education and the workforce[27]. Prevention strategies for RHD, as articulated in the RHD Endgame Strategy[28], directly relate to the socioeconomic outcomes and targets established under the new National Agreement on Closing the Gap.

Community led peer support programs are an important component of a comprehensive strategy in addressing the social, economic and cultural determinants of health. Peer led support programs have demonstrated a wide range of benefits including high levels of satisfaction by participants, increased health knowledge, improved social support and social

connectedness, emotional wellbeing and reductions in patient care time required by health professionals.[29] [30] [31]

Among Aboriginal people in the Northern Territory, where language diversity is amongst the highest in the world, there is a real need to provide accessible information and more support for ARF and RHD. [32] [33].

Champions4Change is a culturally safe program led by Aboriginal and Torres Strait Islander peoples and communities and designed to be run by people from across Australia with the lived experience of Acute Rheumatic Fever (ARF) and Rheumatic Heart Disease (RHD). The 'Champions' work through a peer support model to support each other, advocate for ending RHD and health system reform, design education and awareness programs responsive to local community needs and priorities and inform resource and program development with their lived experiences and expertise. Such community led approaches that acknowledge and understand the challenging, complex and cultural environments in which ARF/RHD exist are necessary to effectively eliminate RHD and improve care for those living with ARF/RHD.

The Heart Foundation joins the voices of Aboriginal and/or Torres Strait Islander leaders and our colleagues across the country in calling for an additional and urgent funding injection to implement the Rheumatic Heart Disease Endgame Strategy. We acknowledge and support the vital work being undertaken by NACCHO, Telethon Kids Institute and the END RHD Centre for Research Excellence, amongst many others. The Heart Foundation fully supports their calls for ongoing and additional funding as part of a comprehensive evidence-based strategy to eliminate rheumatic heart disease from this country.

Recommendation:

- **Continue policies to eliminate RHD in Australia, with a particularly focus on ending poverty amongst First Nations Communities**
- **Increased funding and commitment to implement the Rheumatic Heart Disease Endgame Strategy including those directly related to the socioeconomic outcomes and targets established under the new National Agreement on Closing the Gap.**
- **Support the ongoing delivery and expansion of community led peer support programs such as the Heart Foundation's Champions4Change program that prioritise Aboriginal voices and leadership, decision making at all levels of the health system, the importance of developing community capacity, acknowledge the value of lived expertise and are locally responsive**
- **Support the prevention, control and management of Rheumatic Heart Disease by making a notifiable disease in every State and Territory.**

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