Submission No 79

INQUIRY INTO HOMELESSNESS AMONGST OLDER PEOPLE AGED OVER 55 IN NEW SOUTH WALES

Organisation: AMA NSW

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From the President's Office
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Standing Committee on Social Issues
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Via email: Committee.SocialIssues@parliament.nsw.gov.au

Dear Standing Committee on Social Issues,

Thank you for the opportunity to provide input into the inquiry into homelessness amongst older people aged over 55 in New South Wales.

AMA (NSW) would like to address the Terms of Reference established by the Committee, in particular:

> (c) opportunities for early intervention to prevent homelessness,
> (i) the impact of homelessness on the health and wellbeing of older people and the related costs to the health system,
> (j) the specific impact of homelessness, including the matters raised above, on older women,
> (k) the impact of homelessness, including the increased risk of homelessness in the community, on older people in vulnerable groups, and
> (l) any other related matter.

Background
Homelessness is characterised as being without safe, secure accommodation. While there are many different forms of homelessness, three broad categories are widely used to capture the diversity of homeless experiences.[1]

1. **Primary homelessness**: This is defined as being without conventional accommodation, such as sleeping rough, in an improvised dwelling, or sleeping in a car.
2. **Secondary homelessness**: This is defined as moving from one temporary shelter to another, for example, moving from emergency accommodation to a refuge. This also includes 'couch surfing' – a term used when someone stays at the home of a friend or relative.
3. **Tertiary homelessness**: This is defined as accommodation that is below minimum standards, for example, a boarding house or caravan park, or an overcrowded household.

There is reciprocal causation between health and homelessness. Ill health (both physical and mental) can increase an individual's risk of homelessness. Similarly, homelessness can trigger poor health and/or exacerbate an already existing condition. In this submission, we will address both aspects.

Ill health and risk of homelessness
Homelessness can be the result of many factors, including poor health (mental and physical), disability, trauma, family and domestic violence, and substance abuse. A 2021 study found that

people were considered at risk of homelessness if they lived in rental accommodation and were experiencing at least two of the following:

- Low income
- Vulnerability to discrimination in the housing or job markets
- Low social resources and supports
- Needing support to access of maintain a living situation due to significant ill health, disability, mental health issues or problematic alcohol and/or drug use
- Rental stress (when lower-income households put more than 30% of income towards housing costs)[2]

In the last decade, the rate of homelessness has increased in Australia, with COVID-19 exacerbating an already alarming trend. The prevalence of homelessness in NSW is particularly acute.

Homelessness in NSW increased by 37% in NSW from 2011 to 2016 – significantly higher than the national increase of 14%.[3]

Demand for homelessness services has also increased. In 2019-2020 homelessness services across NSW assisted 70,000 clients – 26% more than homelessness services are funded to support.[4]

IMPACT OF COVID-19 ON HOMELESSNESS RISK FACTORS

There is additional evidence that finds COVID-19 has increased rates of domestic violence, mental distress, housing stress, and negatively impacted people's physical health.[5,6,7,8]

Increase in domestic violence

The pandemic worsened many of the underlying stressors that contribute to family and domestic violence. While an increase of financial stress, alcohol use, psychological distress, social isolation, and reduced source of support during the pandemic are not causes of family or domestic violence, they are situational stressors that can exacerbate the underlying drivers of violence and increase the likelihood, complexity, and severity of violence.[9]

A survey of 15,000 Australian women in May 2020 found that for some women the pandemic coincided with the onset or escalation of violence and abuse. The survey found 4.6% of respondents—and 8.8% of women in a cohabiting domestic relationship—experienced physical or sexual violence from a current or former partner in the three months prior to the survey.[10]

For 33% of the respondents, this was the first time they had experienced physical or sexual violence within their relationship. And more than half (53%) of respondents who had experienced family or domestic violence said the violence had become more frequent or severe since the start of the pandemic.[11]

Increase in mental ill health

A 2021 survey on the impact of COVID-19 on the health and wellbeing of NSW residents and those with lived experience of mental health issues, found negative impacts on mental health were felt by most NSW residents across the State. However, older residents and those living in Regional NSW experienced a greater burden during 2021 compared to 2020, identifying more personal, psychological, and emotional challenges than they did in 2020.[12]

The report found that 61% of NSW residents reported that their mental health was negatively impacted by COVID-19 in 2021, an increase from 55% in 2020. The research also revealed one in eight NSW residents experienced a new mental health issue since the pandemic began and 95% of people with lived experience of mental health issues experienced challenges in 2021, such as loneliness, decreased physical health, and feeling unable to cope with life in general.[13]

Increase in physical ill health

COVID-19 had both a direct and in-direct impact on people's health. People who contracted the virus experienced a range of symptoms from mild to severe illness and death. The rollout of the COVID-19 vaccine and high rates of immunisation in Australia curtailed severe illness and death; however, infection of a fully vaccinated person is still possible. While vaccines reduce the likelihood of hospitalisation and death, people who are immunocompromised are still at greater risk of severe infection.

In addition to the direct impacts of the virus, the pandemic had other in-direct impacts on people's health.

A study on the impact of COVID-19 on health found around half (48%) of all participants had delayed a medical appointment, test, or procedure because of COVID and most (57%) of these people have skipped at least some of the delayed appointments rather than rescheduling them.[14]

In addition, repeated shutdowns of elective surgery have resulted in longer wait times. In the fourth quarter of 2021, there were 94,807 patients on the waiting list, with 10,770 patients who had waited longer than clinically recommended – the highest of any quarter since 2010. The majority of these patients were waiting for semi-urgent (31.6%) and non-urgent (68.3%) surgeries.[15]

Increased physical pain and poorer health outcomes are associated with longer wait times for elective surgery patients.[16]

Lack of affordable housing

Lack of affordable housing in NSW is a significant driver in homelessness in NSW. There are 50,000 households on the social housing waiting list.[17]

Affordable housing remains a critical issue in NSW. Contrary to expectations that COVID would dampen the property market, house prices have continued to climb, which has resulted in a rental crisis. Homelessness is expected to increase across Australia by 9% and housing stress could increase 24%.[18]

Less than 1% of all private rentals are affordable for people on income support. The priority housing list increased by 800 applicants in 2020.[19]

Increased risk of homelessness

It is evident from the research that the factors that increase the risk of an individual becoming homeless have intensified during the pandemic. The impact of COVID-19 on people's mental and physical health combined with a significant lack of affordable housing and an increase in domestic violence, has created a 'perfect storm' for those at risk of homelessness.

VULNERABLE GROUPS AT RISK OF HOMELESSNESS

People at most risk of homelessness include women, Indigenous Australians, individuals in a single person household or single-parent household, those on low income or unemployed, and people receiving income support payments.[20]

There is an acute need to invest in housing solutions for women and children escaping domestic and family violence. There has been a 6% increase in women who had experienced domestic violence seeking specialist homelessness services in March 2021 compared to the year before. Lack of long-term housing is forcing 7,690 women a year to return to violent partners and 9,120 women a year to become homeless.[21]

Women over the age of 55 are at greater risk of financial hardship and housing insecurity due to systemic factors, including lack of superannuation, the gender pay gap, age discrimination in the job market, part time employment status, and employment history gaps due to childbearing and raising a family. Life events such as the death of a spouse, illness and divorce can trigger homelessness for this vulnerable group. This demographic is the fastest growing group of homeless people in Australia.[22] Research published in 2020 found 240,000 women aged 55 or older and another 165,000 women aged 45-54 are at risk of homelessness.[23]

Policies that address the current housing crisis are needed to adequately stem the rapid increase of women over 55 becoming homeless.

THE IMPACT OF HOMELESSNESS ON THE HEALTH AND WELLBEING OF OLDER PEOPLE AND THE RELATED COSTS TO THE HEALTH SYSTEM

There is a 30-year gap in life expectancy between people experiencing homelessness and those in stable housing.[24] International evidence finds that in addition to increased mortality rates, people who are homeless experience much higher rates of physical and mental health conditions, including complex multimorbidities.[25,26]

It is clear from the evidence that homelessness has a significant impact on an individual's health. Being homeless can exacerbate an already existing condition or put an individual at risk of developing a new condition, including poor oral health, chronic disease, skin and foot problems, infectious diseases such as tuberculosis, hepatitis C and HIV infection, substance abuse,[27] and mental illness.[28]

People experiencing homelessness present frequently to hospitals,[29,30,31] which places a significant burden on the public health system.

While hospitals are able to deal with acute health issues, it is expensive care that does not address the other factors that can contribute to homelessness.

Furthermore, It is a preventable cost to the health system that could be avoided if barriers to healthcare access for people experiencing homelessness were to be improved.

Barriers to healthcare access for people experiencing homelessness

People experiencing homelessness often face barriers in accessing healthcare services.[32]

Davies and Wood examine the barriers that prevent people from accessing primary care in their paper "Homeless health care: meeting the challenges of providing primary care."[33]

The narrative review describes three main barriers to health care access for people who are homeless as: personal, practical and relationships.

According to the research, personal barriers include competing needs such as securement of food, water, and a place to sleep, which are often higher priorities than looking after one's health needs.

Mental health can also be a personal barrier to accessing care, with people experiencing both mental health and homelessness feeling depressed and unmotivated seek healthcare, anxious, or suspicious of others.[34]

The paper finds practical barriers to include financial barriers – not only to medical services, but transport to medical services. Patients without mobile phones or a means of accessing an appointment reminder are also at risk of missing out on care. Lack of identification is seen as another barrier.[35]

Finally, the paper examines relationship barriers that prevent care, including stigma of seeking help for mental illness or poor mental health, and/or drug and alcohol problems, fear of being judged, and feelings of inadequacy.[36]

Provision of specialised care

Research has found services that specialise in providing patients with a medical service that can manage complex multi-morbidities, mental illness and drug and alcohol issues, as well as trauma-informed care can be particularly effective.[37]

Combining these medical services with case managers who can help people secure social housing, or support for NDIS packages is an important part of that service. These specialised services address some of the personal and relationship barriers previously examined that can prevent individuals from accessing traditional health sector service models.

There are many examples of specialised services that have track record of success in assisting patients experiencing homelessness.

St Vincent's Homeless Health Service is a multi-specialty service that supports people experiencing or at risk of homelessness. It supports healthcare access to mainstream and specialist services, and partners with local services to provide assessment, treatment, education, support and referral. St Vincent's Homeless Health Service provides an integrated health and homelessness service response.

Lou's Place, a daytime women's refuge, provides a safe place for women and offers services to assist with women's basic needs (home cooked meals, shower and laundry facilities, emergency clothing), as well as crisis intervention, referrals, trauma-informed programs, free legal advice and support with court appearances or medical appointments and case management. It also offers healing programs and health workshops.

Other widely recognised services include Newtown Neighbourhood Centre and the Matthew Talbot Hostel. These services have been effective at providing assistance to people who are most vulnerable in the community; however, there is a need to ensure funding is sufficient for all of these services, and other specialised services, to meet the growing need in communities.

Certain forms of homelessness attract greater empathy and receive higher donations from the community. As such, there is a need to provide balanced funding to all of these services.

OPPORTUNITIES FOR EARLY INTERVENTION TO PREVENT HOMELESSNESS

While specialised services, such as St Vincent's Homeless Health Service, have proven to be effective at providing healthcare access to people experiencing homelessness, there is additional need to adequately support general practice.

General practitioners are often the first port of call when people experience physical and/or mental ill health. As a result, GPs are well positioned to provide early intervention to patients who are at risk of homelessness.

However, several barriers exist which limit access to general practice and primary care. People who are at risk of homelessness are typically financially disadvantaged and unable to access medical services that are not bulk billed.

Bulk billing

The MBS rebate has not kept pace with the costs of providing services. As a result, many practices have been forced to adopt a private billing model resulting in out-of-pocket costs for patients.

The Productivity Commission's Report on Government Services 2022, shows in 2020–21 just 67.6% of patients had all GP services bulk billed.[38]
Recent figures found the bulk billing rate is down 1.2% in the December quarter of 2021 from the previous quarter (89.6%). Further to that, the average patient contribution per GP service peaked in Q3 of 2020–21, at $42.79.

The Commonwealth Government must close the gap between the indexation of Medicare schedule fees and the indices for CPI, average weekly earnings, and the AMA fees.

Workforce
Australia's GP shortage also contributes to reduced access to healthcare services. Fewer doctors-in-training are choosing general practice as a specialty. Applications for GP training dropped by 22% between 2015 and 2020. Meanwhile, unfilled rural training places increased from 10% (65 places) in 2018 to 30% (201 places) in 2020.[39]

Almost 40% of the GP workforce is over 55.[40] As older general practitioners retire over the next five years the situation is expected to worsen.

A lack of available medical services has put pressure on appointment availability. A two to three week wait for an appointment is not uncommon, particularly in rural and regional areas.[41]

Government action to improve the appeal of a career in general practice is needed, including adjustments to remuneration for registrars and improvements in entitlements. Policies to accelerate recruitment into areas of need, particularly rural and regional NSW must also be implemented.

Aligning health and social care via general practice
Addressing homelessness is part of healthcare. As outlined in the paper from Stanford and Wood: "Addressing homelessness is, itself, an important form of healthcare, not a separate "non-health" issue."[42]

For those experiencing homelessness, or at risk of homelessness, a general practice is a safe place and if it is also a place where there is consistency of practitioner and practice health staff. This allows for better outcomes and care that is comprehensive.

We have identified four principles underpinning the successful provision of care to individuals experiencing homelessness, or at risk or homelessness,

1. Encourage/support patients to register with a usual general practice
2. Support general practices to provide appropriate care
3. Support the use of broader practice teams
4. Minimise fragmentation through better care coordination and communication

Medicare and block funding to support general practice in provision of care
In addition to experiencing a physical or mental health condition, people at risk of homelessness who present to general practice may also be experiencing a drug and alcohol problem, mental ill health, trauma, and/or family violence as well as housing instability. They may also experience lower levels of literacy and therefore require support in filling in forms for Government financial assistance and housing assistance.

Solving these complex conditions is time consuming and requires a team-based approach to healthcare. Remunerating practice health staff to assist with health assessments for patients at risk or, or experiencing homelessness, would allow for tailored care that encompasses the patient's whole-of-health needs.

The criteria for health assessment item numbers currently does not cover homelessness as a reason for initiating a health assessment. Health assessments allow practice nurses to be engaged as part of the MBS rules. Creating a health assessment item number that could be used be utilised by the general practice team, including but not limited to practice nurses, would give general practices greater flexibility in providing care to this cohort.

Alternatively, we recommend funding practices to provide enhanced services through block funding which can be applied to the practice team as appropriate (eg. For phone outreach, emails, texts).

Building capacity and capability in general practice

Coordinating social and health services from mainstream general practice can be challenging. Equipping general practitioners with the tools and education to better meet the needs of these complex patients will increase the system's capacity to assist people experiencing homelessness.

The continued use and expansion of HealthPathways is valuable in supporting this capacity building. This is valuable resource for GP teams that are less familiar with, or have less exposure to, assisting people experiencing homelessness.

Access to specialised drug and alcohol advice also gives greater confidence to general practitioners who feel under-equipped to deal with the complexity of issues that people experiencing homelessness can present with.

In addition to ensuring referrals services are easily accessible, there is a need to adequately resource these services so that they are more responsive.

Models for provision of complex care

There currently exists models where GPs can refer families with complex care needs for assistance by linking to appropriate services. The Western Sydney Kids Early Years (KEYS) Network is a new approach that aligns health and social goals and is designed to deliver cohesive, coordinated services. It relies on multi-sector collaboration. While KEYS was developed to assist children aged five and under and their families, the model could be adapted to serve patients experiencing homelessness.

A second model that currently exists is the Neighbourhood Health Hub, which links patients to many of the same services but for a broader cohort. These service structures serve as vehicles to achieve an objective rather than being service providers in their own right, but all start from the fundamental premise that patients should be linked with a usual practice.

RECOMMENDATIONS

AMA (NSW) recommends:

1. That referral services and specialised services be adequately funded to better meet the needs of increasing numbers of people experiencing homelessness, or at risk or homelessness.
2. That a balanced funding approach be applied to specialised services.
3. That the State and Commonwealth Government introduce policy measures that address the current housing crisis by securing affordable housing options for groups over 55, particularly

vulnerable Australians including women and Indigenous Australians, and those experiencing domestic violence.

4. That the Commonwealth Government address barriers to healthcare access by increasing the MBS rebate to reflect the rising costs of running a practice, which in turn will allow general practices to continue bulk billing practices.
5. That the Commonwealth Government address the shortage of general practitioners by introducing measures that attract more doctors-in-training to the specialty of general practice.
6. That linking patients with a usual general practice is prioritised.
7. That the capacity and capability of general practice is increased through improved education of available referral services and specialised care services.
8. That both state and Commonwealth Governments make appropriate investments to allow general practice to better support people experiencing homelessness or people at risk of homelessness. This should be in the form of both supplementing Medicare based funding structures and more open funding options to build services and capacity.
9. That funding is applied to regional health hubs which relate to and support practices. This may be best done through collaborative commissioning models, or regional pooled funding.
10. That future solutions adopt a genuine co-design approach that considers the preferences of people experiencing the various levels of homelessness.

Yours sincerely,

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President, AMA (NSW)

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