New South Wales

Special Commission of Inquiry into Healthcare Funding

Submission Number: 30

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Submission from the Charles Perkins Centre, University of Sydney.

Thank you for the opportunity to make a submission to the Special Commission of Inquiry into Healthcare Funding.

This submission focusses on the need to improve health care systems and for people with chronic conditions which have a major health and economic impact on the individual, their families and society. This need is illustrated by focussing on overweight and obesity, the most prevalent chronic condition affecting our community.

While we acknowledge that a comprehensive health system must have efficient and accessible acute health care services, this should not be to the detriment of people with chronic conditions, which is unfortunately the case at present. We also acknowledge that public health care funding in Australia is complex and relies on Commonwealth and State funding, but we believe that more could be achieved at a State level to improve services for chronic conditions, which would ultimately lead to individual and population health benefits and efficiencies and savings for the health system.

The National Strategic Framework for Chronic Conditions and the National Obesity Strategy provide frameworks to guide reform in services and funding chronic conditions and obesity.

The **Charles Perkins Centre** is a multidisciplinary centre at the University of Sydney with a focus on easing the burden of diabetes, obesity and cardiovascular disease, and their related conditions, through innovative research collaborations, research partnerships and teaching.

The **Obesity Collective** is the peak body for obesity in Australia. It is a national umbrella coalition with a vision to reduce the health and wellbeing impacts of obesity in Australia. The Collective is working together to raise awareness of the science and reality of obesity and promote evidence-based action on prevention, treatment and stigma reduction through a strong, cooperative and inclusive network. Our Board, Collective Advisers, Stigma Expert Group and staff are listed here.

This submission has been prepared by the following members of the Charles Perkins Centre:
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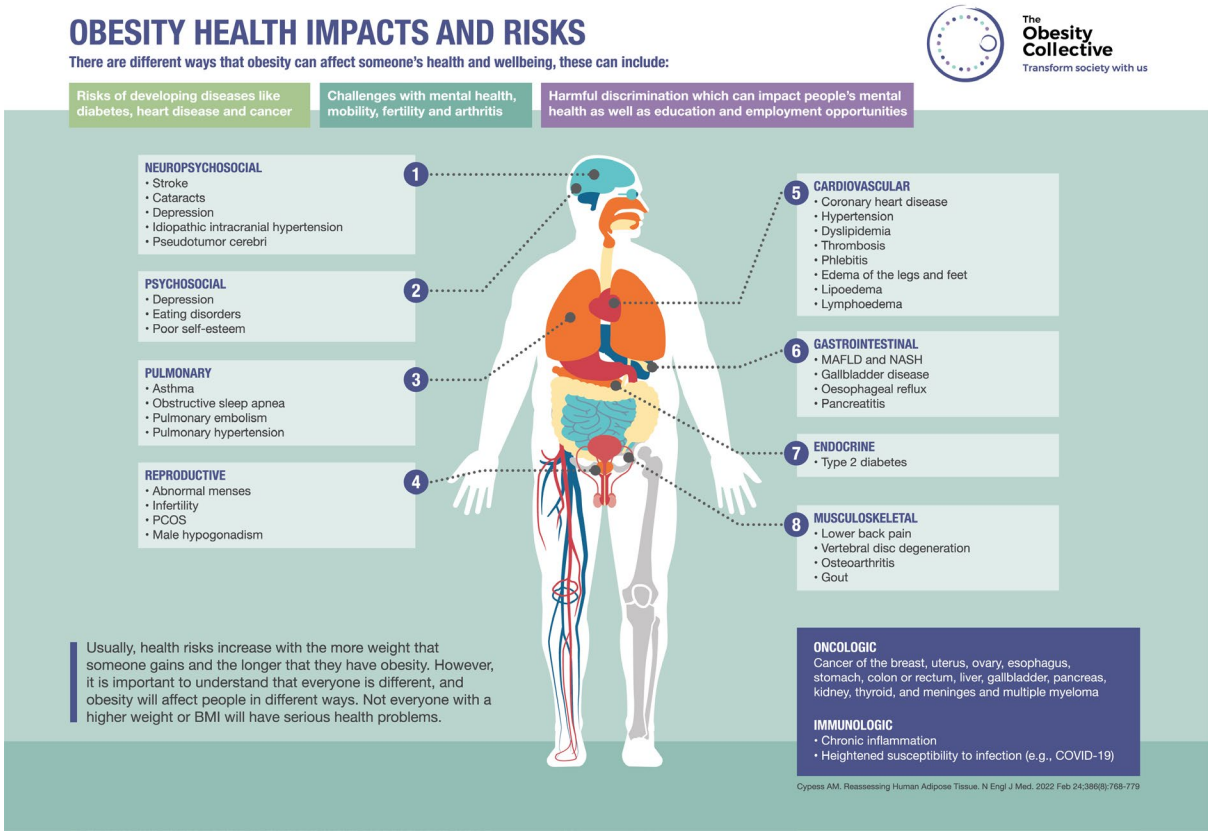
About overweight and obesity

Overweight and obesity are the most common chronic conditions in Australia. Data from the Australian Bureau of Statistics show that two in three adults (67%) are living with overweight or obesity (12.5 million adults) with 36% living with overweight and 31% with obesity. Overweight and obesity affect 75% of men and 60% of women. In the ten years to 2017-18, the number of adults living with obesity has more than doubled.

These statistics hide the disproportionate distribution of obesity rates across LHDs in NSW, with the highest rates of obesity occurring in outer regional and remote areas and areas with the highest socioeconomic disadvantage (Nepean Blue Mountains 29.3% Murrumbidgee 32.5%, Western 32.3%, Far Western 47.4%).

One in 4 (25%) children and adolescents aged 2–17 is living with overweight or obesity (1.2 million children and adolescents), with 17% living with overweight and 8.2% with obesity. Children with obesity are five times more likely to also experience obesity as adults.

Overweight and obesity have significant detrimental effects on physical health, including premature mortality and a wide range of complications, as illustrated in the following diagram.



In addition, there are significant mental health challenges and social consequences, driven by widespread community stigmatisation and health system bias towards people living with obesity.

Overweight and obesity have significant financial impacts on the individual, their family, the community, governments and the health system. In 2018, obesity cost the Australian community $11.8 billion and is projected to increase to $87.7 billion by 2032.

The cost to the health system is grossly underestimated. A study of acute hospital settings in NSW between 2012 and 2021 showed that only 30.8% of people with obesity were coded as having

obesity. This deficiency in obesity coding means that obesity-related costs, which are used for health service allocation and prioritisation, are a gross under-representation of the real cost of obesity in NSW health care settings.

The higher service use by people with overweight and obesity is well documented. NSW studies show that adults, children and adolescents with overweight and obesity present much more frequently to primary, secondary and tertiary care services than would be expected from the background prevalence of the health issue.

Benefits of intervention

The health benefits of interventions to treat overweight and obesity are well established and include:

- Reduced premature mortality and increased life expectancy
- Lower risk of new-onset heart failure, heart attack, and stroke
- Lower risk of new-onset diabetes, and remission of diabetes
- Reversal of liver inflammation and liver failure
- Reduced risk of obesity-associated cancers (especially gastrointestinal, genitourinary and gynaecological)

Systemic barriers to healthcare for obesity in the NSW public health system

- obesity services are very patchy and under-resourced around NSW, with the vast number of LHDs having no formalised services available. For example, in 2019 only 5 of 17 LHDs/specialty networks in NSW had some form of multidisciplinary service for children or adolescents with obesity but all were extremely under-resourced. There are only 8 adult obesity services in NSW, all located in Sydney.
- lack of services for sub-groups such as Indigenous populations
- lack of access - severely restricted entry to services, long waiting times to receive care and limited to no pre-care or post-care interventions in the community for those who cannot afford a 'user-pays' system (the majority).
- lack of understanding about weight, its drivers and its management
- weight stigma at an individual and structural/institutional level leading to significant health inequity.
- Due to the focus on personal responsibility, very limited system/community responsibility is taken to assist individuals who are very unwell, have significant disability and very limited capacity to improve their health without proper support
- lack of integration between health facilities and health professional disciplines

Detailed submission to the Terms of the Inquiry

The following addresses the issues around current models of care and funding for chronic conditions, and potential solutions, under the specific headings and terms of the Inquiry.

> A. The funding of health services provided in NSW and how the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services to the people of NSW, now and into the future;

We submit that current funding and provision of health services for chronic conditions using obesity as model, do not provide a high quality of safe, effective, equitable and accessible care and the system is not patient-centred as detailed below. This particularly applies to those with high-risk social determinants of health who are most at risk for severe and complicated obesity and are most reliant on public obesity services. The increasing availability of effective treatments for obesity which

are not funded through the public system threatens to widen the health and social divide between those who can or can't afford obesity care.

The current system is designed for care of the downstream sequelae of chronic conditions without supporting effective upstream interventions which prevent these sequelae.

The current funding model fails to recognise and take into account the impact of chronic conditions / obesity on health care costs in NSW and the drain on overall resources which could be rectified by a coordinated state-wide approach. The cost of providing such a service would result in significant health improvements and cost-savings.

B. The existing governance and accountability structure of NSW Health, including:

i. the balance between central oversight and locally devolved decision making (including the current operating model of Local Health Districts);

ii. the engagement and involvement of local communities in health service development and delivery;

iii. how governance structures can support efficient implementation of state-wide reform programs and a balance of system and local level needs and priorities;

iv. the impact of privatisation and outsourcing on the delivery of health services and health outcomes to the people of NSW;

v. how governance structures can support a sustainable workforce and delivery of high quality, timely, equitable and accessible patient-centered care to improve the health of the NSW population;

i] Chronic conditions / obesity are not suited to a health funding system with devolved priority decision making, especially one where funding is based on KPIs which focus on acute care eg emergency waiting times etc. Funding pressures invariably result in downgrading of chronic disease services in favour of acute care. A State-wide co-ordinated model with a dedicated budget is required to begin to address obesity in an equitable, safe and effective manner.

This has been recognised by previous recommendations for a state-wide service for obesity in NSW.

- In 2009 the old Greater Metropolitan Clinical Taskforce (the forerunner of ACI) released an Obesity Plan and proposed a model of care for delivery of services in each then Area Health Services, across adults, adolescents and children. The plan was never implemented because it was not resourced and was not seen as a priority by senior leadership within most Area Health Services/ LHDs.

- "Tackling Childhood Obesity" was a major NSW Premier's Priority from 2016-2019. Childhood obesity remains a NSW Health Priority under the Population Health Division which is effectively overseeing the public health/ health promotion aspects. However, it is not possible nor appropriate for that Division to oversee the provision of *clinical services* and key health service restructuring is not progressing.

These examples underscore the need for a high-level commitment from Government and the section of NSW Health responsible for providing health services to implement an adequately funded state-wide model to address the care of people living with chronic conditions / obesity.

Central decision making is required to progress this with devolved responsibility for appropriately funded implementation.

The model itself is generally agreed based on a hub and spoke model with:

- an integrated system of primary, secondary and tertiary care, including virtual care
- specialised tertiary obesity services
- integrated clinical outreach services provided by secondary services with support and capacity building from tertiary obesity services
- a stepped care model with services based on health needs and individual circumstances
- access to subsidised obesity-related pharmacotherapy
- access to public bariatric surgery
- improve access to mental health, social services and disability support
- consistent guidance to manage weight in clinical settings and support for health professionals to understand and reduce weight bias
- treatment through multi-disciplinary care, a non-stigmatising approach, and whole-of-family engagement and long-term maintenance weight control strategies

ii] Engaging lived experience experts in the design of care models will help ensure they are fit for purpose and person-centred. 'Customers' of services can help identify important potential barriers to care and progress that healthcare professionals would not be aware of. There is increasing global recognition of the value of engaging patients in the design of appropriate care. The WHO released a framework for meaningful engagement of people living with noncommunicable diseases, and mental health and neurological conditions. (https://www.who.int/publications/i/item/9789240073074), The Weight Issues Network is a charity based in NSW and they represent the lived experience and support conversations around better patient care and options nationally. (https://weightissuesnetwork.org/)

iii] Addressing obesity requires a formalised governance structure specifically for obesity, similar to the Mental Health program. Within the current health structure this should be located in the Health System Strategy and Patient Experience section. In addition to the overview of the model described above in B i), there is National Framework for Clinical Obesity Services (https://www.nacos.org.au/wp-content/uploads/2023/04/NACOS-Framework-combined-25022020.pdf).

The program should also include tailored and appropriate evaluation and reporting against specific obesity service relevant KPIs.

Bariatric surgery is an integral component of treating people living with obesity. However, apart from the limited access, appropriate governance structures for public bariatric surgery are lacking and are not consistent with the National Public Bariatric Surgery Framework (https://anzmoss.com.au/wp-content/uploads/Public-Bariatric-Surgery-Framework_full-report.pdf). At present there is no impetus for LHDs to ensure that obesity services (if they exist) comply with the minimum standards described in these documents

iv] The current approach to limiting public health bariatric surgery services highlights the false economy of relying on private bariatric surgery and serves as an example of de-facto outsourcing.

While bariatric surgery has significant benefits, there are risks and potential post-operative complications. Data from the Bariatric Surgery Registry indicate that at least one third of public bariatric surgery is devoted to correcting surgery performed in private hospitals.

v] A formal Ministry of Health Obesity group could implement a program to develop and support a sustainable workforce to care for people living with obesity. Strategies could include breaking down silos at a local level (e.g. community health working with medical teams), and more state based virtual interventions that are not LHD dependent. This would also allow for better adjustment for social needs, over and above SIEFA.

C. The way NSW Health funds health services delivered in public hospitals and community settings, and the extent to which this allocation of resources supports or obstructs access to preventative and community health initiatives and overall optimal health outcomes for all people across NSW;

The current Ministry of Health structure is not well equipped to deal with and fund a complex societal health problem such as obesity which require integration of prevention and care. The challenge for chronic conditions is that "it is everywhere but nowhere" and is not "owned" within NSW Health. The priorities of the ACI do not align with the challenges of complex health problems such as obesity. The low priority on the ACI agenda is disproportionate to the prevalence and impact of obesity on individual and population health.

Addressing this will require a dedicated obesity group and program with the Ministry of Health (see above). This should include a refocus of KPIs onto chronic condition management and accountability of senior LHD executives to meet these KPIs.

This could include NSW Health requesting Commonwealth activity-based funding to provide care to people with severe obesity with the objective of reduced social welfare reliance and reduced medication usage.

D. Strategies available to NSW Health to address escalating costs, limit wastage, minimise overservicing and identify gaps or areas of improvement in financial management and proposed recommendations to enhance accountability and efficiency;

A single patient electronic medical record (EMR) would facilitate integrated and co-ordinated care. Data linkage is critical for a more efficiency and cost-effective health system e.g. ensuring all outpatient services are using the EMR, prioritising the integration of private pathology and radiology services with the single patient EMR, ensuring all outpatient correspondence is visible on the EMR. This would also facilitate evaluation and implementation of services to document impact.

Services should be incentivised to work together which could include improved physical co-location of related services and sharing of staff across related services.

E. Opportunities to improve NSW Health procurement process and practice, to enhance support for operational decision-making, service planning and delivery of quality and timely health care, including consideration of supply chain disruptions;

There are opportunities for waste minimisation related to in-patient and ambulatory care of people living with obesity. These individuals, especially if living with severe obesity, require special equipment - chairs, beds, weighing facilities. At present purchasing this equipment is devolved. This requires services to research appropriate equipment individually. Centralised assistance with relevant information would be beneficial. Appropriate equipment for obesity is not an optional extra but is essential for occupation health of staff, safety of individuals living with obesity and their careers in the community.

Hospitals should be required to understand the numbers of people with bariatric needs attending their services and supply appropriate facilities to accommodate them. Currently, responsibility is often passed down by executive to clinical teams who have to order and pay for the equipment. This requirement to pay, sometimes from trust funds, is a disincentive to adequately furnish clinical spaces. There are outpatient facilities with no provision for patients requiring bariatric equipment - they can't even sit down, let alone have their blood pressure measured.

F. The current capacity and capability of the NSW Health workforce to meet the current needs of patients and staff, and its sustainability to meet future demands and deliver efficient, equitable and effective health services, including:

i. the distribution of health workers in NSW;

ii. an examination of existing skills shortages;

iii. evaluating financial and non-financial factors impacting on the retention and attraction of staff;

iv. existing employment standards;

v. the role and scope of workforce accreditation and registration;

vi. the skill mix, distribution and scope of practice of the health workforce;

vii. the use of locums, Visiting Medical Officers, agency staff and other temporary staff arrangements;

viii. the relationship between NSW Health agencies and medical practitioners;

ix. opportunities for an expanded scope of practice for paramedics, community and allied health workers, nurses and/or midwives;

x. the role of multi-disciplinary community health services in meeting current and future demand and reducing pressure on the hospital system;

xi. opportunities and quality of care outcomes in maintaining direct employment arrangements with health workers;

The chronic condition/ obesity workforce is very limited and insufficient to provide a high quality, equitable and safe service. Addressing this should be part of planning and implementing a state-wide integrated chronic condition/ obesity service. The Ministry of Health should place more emphasis on the outcomes of the larger services they are funding. This should specifically pertain to their impact, rather than their activity and other indirect KPIs.

i] The distribution of the workforce across the state is inequitable. This could be partly addressed by upskilling in obesity care and improved access to virtual care.

Incentivisation should be considered. Currently central LHDs tend to have higher grade awards on offer than do regional and remote centres. Perhaps this could be the other way around? Another consideration is addressing the reduced opportunity for staff working in rural, regional and remote services to have academic appointments.

ii] a state-wide obesity plan should examine and address skills shortages and strategies on how to upskill the primary care workforce. This should include extended scope of practice and increasing engagement and expanding the role of nurse practitioners in obesity management.

There should also be equity adjustment in LHDs for the services available to people in the community and the needs of the population.

G. Current education and training programs for specialist clinicians and their sustainability to meet future needs, including:

i. placements;

ii. the way training is offered and overseen (including for internationally trained specialists);

iii. how colleges support and respond to escalating community demand for services;

iv. the engagement between medical colleges and local health districts and speciality health networks;

v. how barriers to workforce expansion can be addressed to increase the supply, accessibility and affordability of specialist clinical services in healthcare workers in NSW;

Previous comments are relevant to this issue.

There should be increased resources for training within specialised units. This training should be for undergraduates, early career clinicians and community clinicians (e.g. GP, practice nurses). There should be a specific nurse practitioner and clinical psychology training program, supported with scholarships to encourage participation by rural/regional staff.

Unlike in United States where there is a board certification in obesity management (https://www.abom.org/) there is no pathway in Australia for specialist training in obesity medicine. Although obesity is a major risk factor for most chronic conditions, training in obesity management is not included in the curriculum for most professional fellowships. The inclusion of obesity management training in undergraduate curriculums is insufficient due to a lack of time or a lack of academics with sufficient obesity management training and/or experience to provide the education. A key component of obesity education is addressing obesity stigma.

This could be addressed by implementing mandatory training on obesity stigma for all NSW Health staff; incorporating obesity management in the undergraduate curriculum for medical and allied health professionals; providing opportunities for specialist obesity management training for NSW Health doctors-in-training (e.g. SCOPE certification); encouraging NSW Health Staff Specialists to utilise TESL for additional training in obesity management; incentivising obesity training through provision of additional resources to staff/units who have undertaken additional obesity management training.

H. New models of care and technical and clinical innovations to improve health outcomes for the people of NSW, including but not limited to technical and clinical innovation, changes to scope of practice, workforce innovation, and funding innovation; and

The suggested model of care for chronic conditions / obesity has been detailed above.

I. Any other matter reasonably incidental to a matter referred to in paragraphs A to H, or which the Commissioner believes is reasonably relevant to the inquiry.

No additional comment