New South Wales

Special Commission of Inquiry into Healthcare Funding

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Submission to the NSW Government *Special Commission of Inquiry into healthcare funding*

Dr Edward Jegasothy, 31 October 2023

1. I thank the NSW Government for the opportunity to provide evidence and recommendations with respect to the health of the population of NSW and the funding of health services within the state. I write as a public health professional, specifically an epidemiologist and biostatistician. While I am employed at the University of Sydney School of Public Health as a lecturer, I make this submission in a personal capacity. I am an experienced public health researcher, educator, and have previously worked in NSW Ministry of Health as an analyst. The views expressed in this document are mine alone and do not necessarily represent those of The University of Sydney, nor the Sydney School of Public Health.

2. In this submission, I will focus particularly on the issue of equity as it relates to the state of health within the population of NSW and access to services. Equity is a key principle public health which ought to guide the implementation of policy and services delivered to the public. Equity encapsulates both the aim of closing gaps and the recognition of differing needs within the population. Inequities in society provide a moral imperative for Governments to act and prioritise resource allocation accordingly. To this end, I welcome the explicit reference to the delivery of equitable and patient-centred health services in NSW.

3. The points made in this submission speak across the terms of reference of the Commission.

Health is a primary responsibility of governments

4. The COVID-19 pandemic highlighted the importance of health to the population, economy and Governments. Swift, severe, and expensive action was taken in NSW to minimise the impact of that health crisis. This action was highly successful by international standards in terms of minimising the impact of severe disease on the population. The pandemic did, however, highlight the ongoing disparities in health across different social strata in the population. The disparities were evident from the impact of the virus as well as the impact of control measures and mirrored and exacerbated existing inequalities.

5. Fundamentally, health services aim to improve the quality of life of people in the community. That means focusing on the outcomes of equity, dignity, and self-determination for those the health system seeks to help.

The health burden in Australia is driven by inequalities – *the social gradient of health*

6. In NSW, there exist inequalities in health outcomes across different social strata. These include socioeconomic status, Aboriginal and Torres Strait Island peoples, remoteness, LGBTIQ+, people with disabilities, refugees and people seeking asylum, and other marginalised communities.

7. Inequalities in health are exemplified in observed differences in rates of disease prevalence, mortality rates, and health service usage.

8. I retrieved the following publicly available data from HealthStats NSW (www.healthstats.nsw.gov.au) and the Australian Institute of Health and Welfare (www.aihw.gov.au).

9. The following comparisons seek to demonstrate the inequitable burden of disease in NSW. The percentage differences could be interpreted as the health burden which could be avoided if inequality were to be completely removed for those populations.

10. In NSW, in 2021, the age-standardised mortality rate for people in the most disadvantaged quintile (609 deaths per 100,000 population) of areas was 53% higher than that of the least disadvantaged quintile (399 deaths per 100,000 population). While mortality rates have declined slightly over the past 10 years, the difference in rates between these quintiles has grown. In 2021, the mortality rate was 38% higher in the most disadvantaged quintile (464 deaths per 100,000 population) compared to the least disadvantaged quintile (638 deaths per 100,000 population). The gap in health between the least and most disadvantaged groups in NSW is widening.

11. Mortality rates in “Remote” and “Very remote” areas in NSW were 75% and 200% higher than in “Major cities”, respectively, in 2021.

12. The mortality rate among Aboriginal people was 71% higher than non-Aboriginal people in NSW in 2021.

13. Potentially avoidable deaths are defined as deaths of people under 75 from conditions that are potentially preventable through individualised care and/or treatable through existing primary or hospital care. The rate of potentially avoidable deaths in the most disadvantaged quintile is over twice as high as that of (or 100% higher than) the least disadvantaged quintile for all of Australia. If all of Australia had the same rate of potentially avoidable deaths as the least disadvantaged quintile, 36% of these potentially avoidable deaths would have been prevented. This suggests that there are important systemic causes for these avoidable deaths.

Inequalities in health inform *needs* and *opportunities*

14. Inequalities in disease prevalence and health outcomes between social groups and geographic areas provide indication of the distribution of need for services to treat, manage and support patients.

15. Comparison between the distribution of deaths and hospital admissions provide a crude insight into potential unmet need in healthcare services.

16. Figure 1 shows the distribution of rates of coronary heart disease (CHD) deaths and hospital admissions by quintile of socioeconomic status in NSW in 2020-21. CHD is the leading cause of death in Australia. The presence of a clear gradient in deaths by socioeconomic status at the same time as an absence of the same gradient in hospital admissions for that condition indicate that there is likely unmet need for health services.

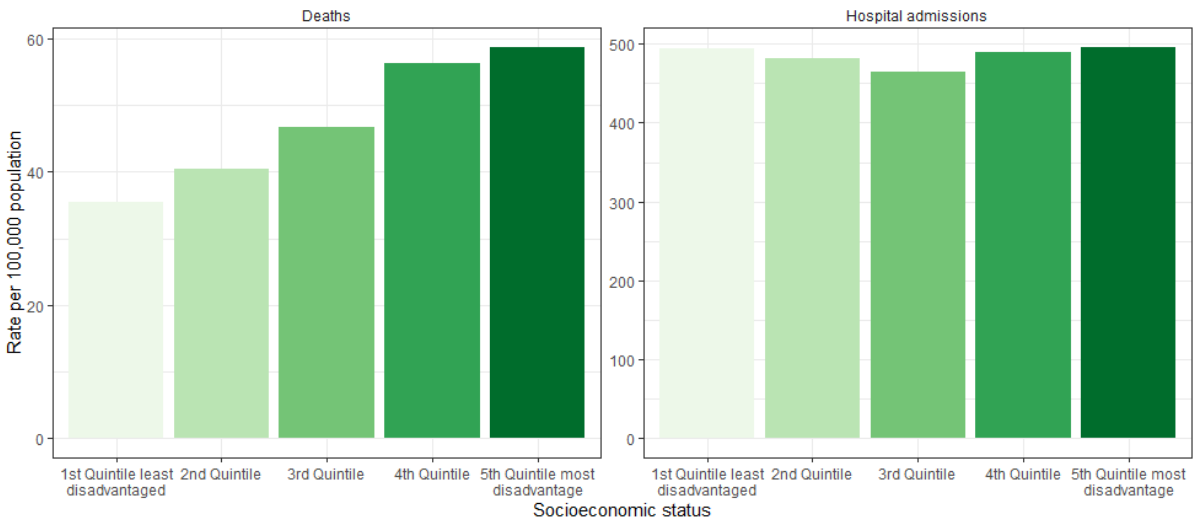

Figure 1. Coronary Heart Disease deaths and hospital admission rates in NSW, 2020-21.

17. This potential unmet need would indicate that health services are not performing adequately nor equitably. This would mean that in order to address this need, health service expenditure may need to increase.

18. This submission does not speak to policies to reduce current health expenditure, however, there are opportunities to do this through reforms to reduce "low value care".

19. Health inequalities across these strata also indicate the potential future benefits to closing the gap on socioeconomic and environmental inequities which contribute to health and broader quality of life.

20. Spending now to meet current needs and spending now on various orders of prevention measures for a healthier public in the future which will ultimately save resources downstream, and into the future.

Prevention is a long-term investment

21. The pattern of increasing health burden in the population with increasing disadvantage is a result of structural determinants of health. While access to adequate health care is an important component, there are many other causes outside the health system which lead to these disparities. These root causes include poverty and material deprivation, poor housing, employment, education, discrimination and marginalisation, and environmental factors.

22. Ultimately, a whole-of-government approach is required to meaningfully address the inequalities that underpin the health burden across the population. Government investment in income support, public and social housing, housing quality, public education, workers' rights, and a healthy built environment will go a long way in improving the health of the people of NSW for future generations.

23. Many of the intermediate risk factors which lead to poor health have been traditionally characterised as "lifestyle" factors. These include diet, exercise, and smoking. There is a clear socioeconomic gradient in both the health outcomes and these risk factors themselves. This indicates that the root causes of these lie further upstream and outside the control of the individual, and are due to structural inequality in our society. While efforts to address these risk factors through support services and policy is important and should continue, these

need to be centred around equity and the dignity and needs of individuals and communities. This means making sure that the policies aimed at addressing these risk factors are supported by evidence that they are effective in disadvantaged groups and do not stigmatise or isolate people.

24. Currently, disease prevention and health promotion services are funded by Local Health Districts out of their health care budget. This means that trade-offs need to be made between health care services and preventative services. There needs to be dedicated funding for prevention, especially in Districts with higher healthcare needs.

Affordable, accessible and appropriate primary care is the cornerstone of an equitable health system

25. The two weakest points of Australia's health system are its fragmentation and lack of universality. The split of responsibilities for different levels of care between state and Commonwealth Government result in a greater, unnecessary burden on the hospital system.

26. The fee-for-service model has seen growing increasing out of pocket costs for attendance at General Practice services. This has introduced a barrier to affordable, care with continuity. General Practitioners provide an crucial service to support individuals and families in the community. They help to manage health risks as well as support people with complex healthcare needs.

27. Patients with complex needs are more likely to be from disadvantaged circumstances. The fee-for-service model for both GPs and specialists means that those who are disadvantaged are inequitably served by the health system.

28. There are updated models of care which can provide more equitable service. This could include state-run primary care clinics which employ salaried clinicians, rather than a fee-for-service model. Such primary care clinics could be initially targeted at areas of high need like regional areas and low-socioeconomic status areas.

29. Ideally, the entire health system for Australia should be run consistently with a universal single-payer system to remove inequitable distribution of services. There are currently incentives for patients with higher means to invest in private care rather than the public system, and incentives for clinicians to move to private care. This is inherently inequitable as it results in a two-tiered system with timelier, and potentially higher quality, care for those who can afford to pay themselves. Opportunities to deliver such a model of healthcare funding without making an amendment to the constitution ought to be investigated.

An equitable and patient-centred health system needs to focus on dignity and self-determination

30. The health system exists as a service to the public and must be centred around the patient.

31. Services need to be funded based on needs, both current and future, to ensure that equitable care is provided.

32. Inequitable health care has been misattributed to a lack of health literacy in certain communities. Taking a dignity-based approach to healthcare means that the system and services need to be modified to meet the needs of the community they serve.

33. Consultative development of services, especially with First Nations communities, is crucial to ensuring high quality, equitable care.

Recommendations

I seek to make the following recommendations:

1. The NSW and Commonwealth government should prioritise investment in policies to address socioeconomic inequalities including:
    a. Raising income support payments above the Henderson poverty line
    b. Investing in public and social housing
    c. Investing in public education
2. The NSW and Commonwealth governments should develop large reforms to deliver equitable, adequate and patient-centred care:
    a. State-run primary care clinics with salaried clinicians to remove barriers to care, remove out of pocket costs, and improve continuity of care.
    b. Move to a single-payer universal healthcare system which delivers equitable care with complete funding through tax revenue.
    c. Ensure funding and service allocation is determined using needs assessments in consultation with communities being served.
    d. Ensure funding for preventative health services is guaranteed independently of other health service responsibilities of Local Health Districts.