New South Wales

Special Commission of Inquiry into Healthcare Funding

Submission Number: 79

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Date Received: 31/10/2023

1. Introduction

I make this submission, with a due sense of gravity, in response to the New South Wales (NSW) Royal Commission of Inquiry into Healthcare Funding, 2023.

As an epidemiologist, Distinguished Research Professor in the University of WA's School of Paediatrics and Child Health and as the author of more than 350 published papers in scientific journals, I support the commission of this inquiry and call on the Commissioner and his officers, with support of submissions such as this one, to undertake this critically important task with the energy and openness required to live up to the moment with which they have been entrusted.

This brief submission is made up of General Comments in response to the intent of the Commission, rather than direct responses to specific areas of inquiry as articulated in the Letters Patent. Further to this submission I would greatly appreciate the opportunity to engage further and speak directly to the Commissioner.

2. General Comments

The major challenge for all developed nations' health services (developing countries even more so) is that tertiary health care is becoming increasingly expensive. There are several reasons for this – the two most important being:

- The frightening rise in lifestyle diseases (50% of Australians are overweight or obese and the percentage is not much less for 12-year-olds, and mental health problems a major issue). This increase is much more in low socioeconomic populations than those who are well off.
- Medical practitioners are making huge amounts of money – both from Medicare items which are not needed (not quite fraud but close to it) and by overcharging privately for services they provide (N.B. orthopaedic surgeons earn in the order of $2million per annum in this country, while our health system struggles to meet basic demand).

As well there is a dramatic increase in inequity in health care – between city and regional and between the wealthy and the poor. This is most obvious in our First nations people where the gap in most health outcomes, compared with non-Indigenous populations is increasing (see the Productivity Commission report 2023). I have excellent data which could guide a major change in outcomes in Indigenous populations, evidence which I have gathered working in collaboration with Aboriginal Health scholars for more than 40 years. The solution to this major inequity lies with giving more power to Aboriginal people which is why the no vote is so devastating.

In response to this problem at the heart of our health system I submit the following recommendations:

1. <u>We must increase investment in prevention.</u>

   No modern health system can be sustained at a level that meets the needs of its community, and particularly those in disadvantaged populations, without fundamentally shifting the balance of funding between tertiary care and prevention.

To this end the Commissioner and his officers must not limit their inquiry to the mechanisms and governance of funding into existing models of care provision, but rather investigate and consider alternative funding models with a focus on stemming the burden of care through prevention.

Far too much focus is currently given to disease diagnosis and management and far too little to the preventions we know work, such as investing in healthy pregnancies, healthy environments, and early childhood services and supports.

More than 20 years ago, we (a large group of child and youth health researchers and practitioners) were alarmed by the rapid increases in the new morbidity in Australian children. This was a 'wicked' problem, with multiple causes.

More children had developmental disorders and a range of mental health issues. The suicide rate in males aged 15-19 rose 4-fold between 1980s and 2000 and 2-fold for girls. Other than for self-harm and suicide, the health divide between populations in wealthy and poorer areas was increasing and disturbing.

Today that trend continues and sits alongside the frightening rise in lifestyle diseases already mentioned.

Until these early pathways to poor health are seriously addressed, our Health System will continue to fail in its effort to treat of 'end-of-pathway' disease and its funding requirements will continue to expand beyond the means of our society.

There must be a real understanding by those in power, that early pathway investment is **far** more cost-effective, humane and sensible than the huge costly ineffective spending at the ends of pathways.

The costs of not implementing effective early interventions, reducing risk and increasing preventive strategies are now enormous in many wealthy countries. The significant increases in poor outcomes mentioned earlier have been estimated at $15.2 billion[1] per annum with costly (and mostly ineffective) services in health, mental health, education, child protection, disability, and justice. As well we have more young people unable to participate in society because of ill health, developmental disorders, behaviour problems, school failure and mental health issues. This is hugely costly beyond the health system but contributes to the excessive spending on education, child protection, disability, police and justice.

2. <u>We need a national strategy for prevention.</u>

Given Australia's fragmented health funding system, we need a national prevention strategy that crosses jurisdictions and links State and Federal health remits. We know what to do. The solutions to the health funding crisis will only come from an evidence-based and properly funded public health program, with a strong focus on maternal and child health.

We need to stop having health policy swayed by special interest lobbying (including the Australian Medical Association and medical specialists) and stop paying so much for the medical profession to do so little for population health, and make the investments that research tells us will provide the greatest health returns over time.

[1] How Australian can invest in children and return more; A new look at the $15b cost of late action. https://www.minderoo.org/thrive-by-five/#resources

3. We must address the privatisation of our health system.

I submit to you that commercialisation results in failed care. This fact was exposed during COVID with private provision of childcare, aged care and medical care such as private pathology testing unable to meet surges in demand and seriously overcharging the government.

The private medical system in Australia controls a huge amount of the budget and much of it, I submit, is either:

a) Unnecessary, or even harmful, and
b) focused on making money rather than providing care.

This investment in privatised and end-of-pathway care does little to improve health outcomes, but it costs us all dearly. Increasing renal dialysis in remote communities is important for end of life treatment for Aboriginal people, but it will just increase renal disease not prevent it.

4. We should cease fee for service in Medicare and salary all doctors (with good remuneration of course) to reduce the huge waste in the system.

I acknowledge that this may appear to be a left-field recommendation. but it is one in which I sincerely believe and that is well supported by data – including the recent review of Medicare by Gratton health economist Professor Stephen Duckett. Prof Duckett made clear that fee for service is a huge problem within Medicare.

I would highly recommend that the Commission seek the input of Prof Duckett into this inquiry.

3. Next steps

Further to this submission, I would greatly appreciate the opportunity to engage further with this Commission of Inquiry.

WHY GIVING FIRST NATIONS A VOICE IS ECONOMIC BEST PRACTICE
21/11/2022

When the Uluru Statement from the Heart emerged from the challenging consultations all around the country in 2017, I along with many non-First Nations people, felt that at last Australia would start on the journey for constitutional recognition and improved circumstances for our First Nations people. The statement gives the emotional, historical and spiritual reasons why Australians should support this statement. When the Turnbull government ignored and then rejected the Uluru statement, I was gutted. I tried to imagine what I would feel like as a First Nations person. How would a Noongar or Wiradjuri leader feel? Perhaps they had become cynical with so many proposals, royal commissions, social justice reports and carefully crafted legal documents demanding social justice over so many years being ignored. But this was different surely? This process had been requested by the Federal Government. The national consultations were led by highly skilled and committed First Nations leaders. Would not this process produce a document that, this time, would get there? Following an appalling silence for months, a press release was leaked, rejecting the request to ask Australians to vote for (or against) an "Aboriginal voice", legitimised in the Constitution, because i) it would not get up and ii) it was recommending an undemocratic third chamber of parliament because only First Nations could vote for it. Polling from various sources suggested that nearly 70% of Australians would vote yes for a voice and I can't see anything in the statement recommending a third chamber of parliament. In fact, the proposal, beautifully crafted, was quite measured in its demands. It put clearly what was needed: 1 a voice so that FN could have a say on what is done to them, 2. A Marrakata or treaty process and 3. A truth telling. It did not detail how that voice would work in a constitutional or political sense. That could be worked out later.

As a health researcher, my over 40 year career has been committed to getting the best data and evidence to improve the health, development and wellbeing of children and youth in Australia. With an outstanding group of First Nation researchers, we have worked closely together to identify the most important pathways to improve health in First Nations families over their whole lives. The data are clear and important for our response to the Uluru Statement calling for a voice. There is international evidence now that the pathways in to poor health in FN populations world-wide commence early and emerge from social disadvantage (no surprises there) and include forced removals of children from families and land, resulting in ongoing inter-generational trauma. These circumstances and history also influence almost EVERY OTHER PATHWAY ie to poor educational outcomes, substance abuse, gambling, child maltreatment, FASD, criminal behaviours, incarceration and suicides. This may sound depressing (and it is), but it also opens up fantastic opportunities for First Nations improvements. If we can influence these early pathways, then ALL outcomes will improve.

There is ample research from Canada, NZ and Australia, that describe and measure outcomes in communities which have Aboriginal control, in which Aboriginal culture is strong (as measured by language, attendance at cultural events) and which have attachment to country. The results are staggering. In such communities, use of services (which are of course tailored to the specific and variable contexts of First Nations lives) is very high, and health conditions better diagnosed and treated. But the fascinating thing is that the whole population wellbeing is improved. In the Nunavit community in Northern Ontario, the results of bringing back Aboriginal birthing included better birth outcomes (as predicted) but also increased self-esteem, reduced domestic violence, substance abuse and more children were ready for and attending school! These outcomes were not predicted by those funding these services (Health Canada). In British Columbia, a study of youth suicide in all the Aboriginal tribal tracts across the province over 20 years showed some communities with very high rates and some with no suicides at all. Those with no suicides had strong Aboriginal councils, language and Aboriginal controlled services (health, education, other). A major report from a study done by our First Nations researchers in the Kimberley in 2012 (Hear our Voices)

confirmed the need to empower First Nations people, focus on youth, provide jobs and futures and listen to Aboriginal solutions. However, it is now clear with yet another WA Coroners report on the causes and prevention of very young suicides, that governments have failed to listen and this has had devastating impacts. There are real human, economic and social costs of not promoting and resourcing First Nations solutions. The economic costs of lost culture and the potential of enriched life pathways has been calculated using ABS data by the ANU Centre for Aboriginal Economic Policy Research. The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project "Solutions that Work; what the evidence and our people tell us" published in 2016, summarises the evidence base for Indigenous community led suicide prevention. It focuses on the upstream risk and protective factors for suicide and demonstrates the effective tools for improving all social outcomes. Giving First Nations people a voice is cost effective. It is economic best practice.

The other huge advantage is that these First Nations programs do not just focus on one issue such as policing to get children to school. They focus on the whole family and community, they know the local diverse circumstances in each community and in so doing they can effectively address the causal pathways referred to earlier. And they are powerful in enhancing self-esteem and mental health. The other exciting aspect is that there are so many highly trained and skilled First Nations people who are capable of running their own services. Of course we still need more - more Aboriginal teachers, midwives, nurses and so on. Over 3% of the intake to Australian medical schools is now Aboriginal, which mirrors their proportion in the population, a great success story. Surely if it can be done for future doctors, it can be done for all professional and other training positions. Aboriginal jobs don't all have to be in mining.

The expensive failure of most Federal and State/Territory government programs for Aboriginal and Torres Strait Islander people in Australia is a tragedy. It is not only a huge waste of money but in some circumstances is causing more trauma, more illnesses, more suicides and more incarcerations. Whilst most Aboriginal services and activities that are government funded have to provide evaluations of effectiveness, few government run programs do, in spite of it being obvious that they are often useless.

The clearly demonstrated advantages of First Nations running their own services means that this needs to be front and centre of government policy. It means that instead of evaluating them to death, we should enabling them to succeed by partnering to give them capacity and strength. A First Nations voice to advise and guide decisions made for them is both historically and economically best practice.

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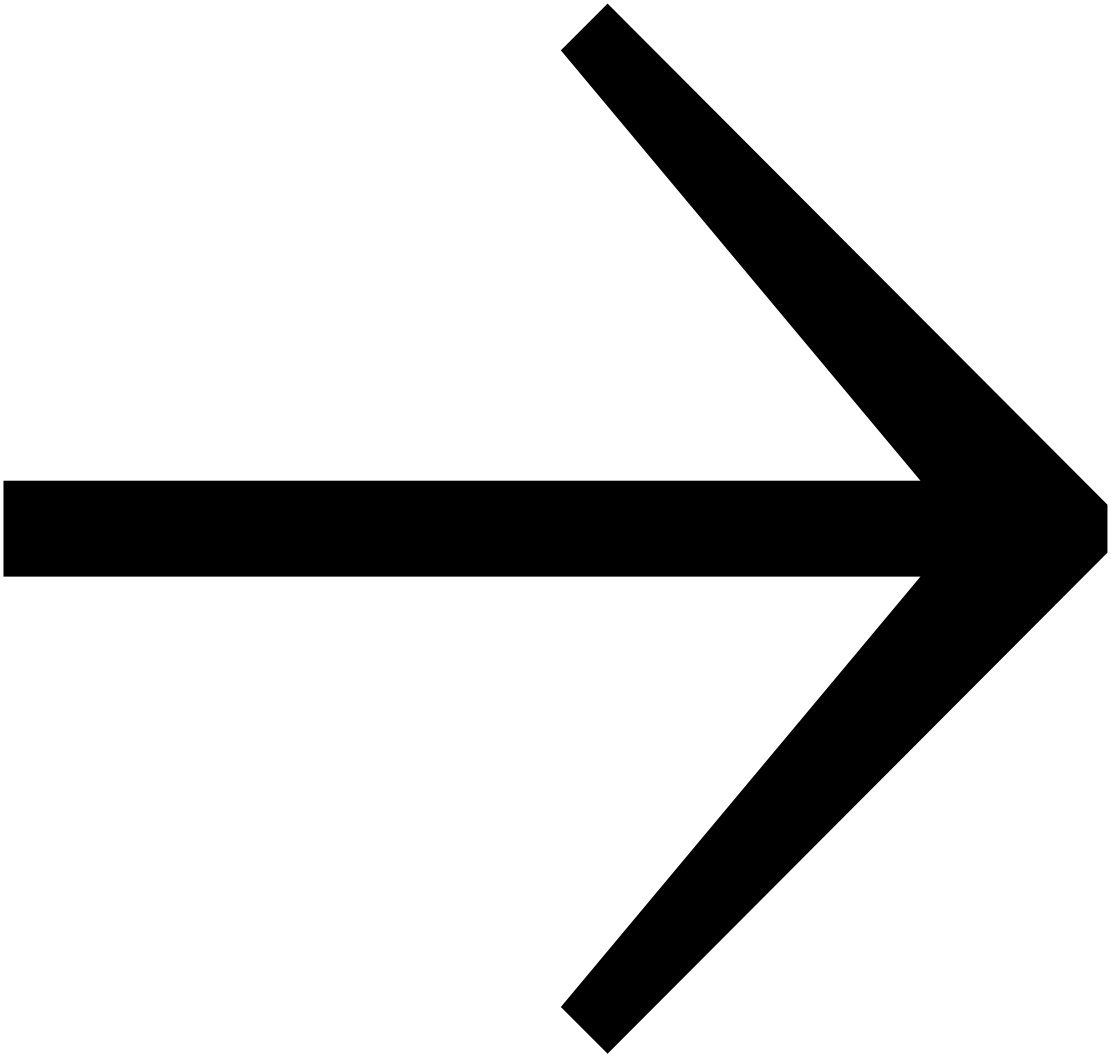

Opinion

In the early days of Covid-19, Indigenous leaders used their voice and averted a

catastrophe

Fiona Stanley and Marcia Langton

Despite underfunded services, early Aboriginal and Torres Strait Islander leadership saved hundreds of lives – this is what is possible when we are listened to

Fri 31 Mar 2023 12.06 AEDT

Consultation is not a new concept. Neither is the wisdom and insight that comes from listening. Lived experience counts. Most people would agree. Yet when it comes to a simple request from Aboriginal and Torres Strait Islander people to have a voice, suddenly these things are open to debate.

"Show us the evidence," critics say. "Will it do anything to close our nation's disgraceful gap in outcomes?"

You bet it will. And here's a recent example.

Minister for Indigenous Australians Linda Burney
Government puts social media giants

As epidemiologists and medical anthropologists, we were concerned about how coronavirus would impact on the Aboriginal and Torres Strait Islander populations in Australia. Based on the known risks and previous serious flu epidemics

on notice over misinformation and hate speech during voice referendum

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such as H1N1, we knew that many more Aboriginal and Torres Strait Islander people were likely to become infected and to have more serious disease. And Covid-19 was even more contagious, with high illness and death rates.

Aboriginal-controlled medical services and other important services for Aboriginal and Torres Strait Islander populations have been chronically underfunded for many years. Now they were needed to provide rapidly for, potentially, a very sick group of people.

Indigenous health leaders swung into action. In North Queensland, Dr Mark Wenitong brought in the measures that started the national response for Aboriginal and Torres Strait Islander people. The National Aboriginal Community Controlled Health Organisation, with CEO Pat Turner, successfully lobbied federal and state governments to implement the National Biosecurity Act to close all remote communities, with support organised for their living needs.

Aboriginal-controlled health organisations all around the nation banded together and lobbied for personal protective equipment, increased staff for testing and contract tracing. They set up taskforces with government departments such as health, families and communities and housing to manage social distancing, food deliveries, special care for elders, telehealth and help to house homeless people.

Most of this activity was done within Indigenous groups themselves, with government departments and relevant NGOs responding to their requests as to what their needs were. The result is a model of how, with Aboriginal and Torres Strait Islander leadership, an expected disastrous pandemic result was prevented.

Up until January 2021, there were only 148 cases of Covid among Indigenous people nationwide, 15% hospitalisations, 1 case in ICU and no deaths. There were no cases in remote communities and no cases associated with the Black Lives Matter marches in major capital cities. As Indigenous people make up 3% of the population, it was expected that at least 3% (850+) of Australia's 27,701 cases would be in these groups.

The rate of infection in the non-Indigenous population was 1.12/1000 people while that for First Nations was 0.19/1000 people. Thus, the rate for non-Indigenous Australians was 5.9 times the rate in Indigenous Australians, a dramatic reversal of the gap. Not only did Indigenous health leaders save hundreds lives, but they also avoided significant healthcare costs. This response was the best of any in the world, with many Indigenous populations in other countries having much worse outcomes.

Compare that with when vaccines became available throughout 2021/22. There should have been a clear line of provision of these to all Indigenous populations in regional and urban centres who were at higher risk. This did not happen. And the decision to open remote communities came too soon. Then the numbers of cases and death increased.

This happened despite Aboriginal leaders warning of the adverse effects. They had lost their voice.

The initial Indigenous-led response to a major health threat that has impacted so negatively on so many populations around the world is a major achievement and clear evidence for a voice. We should applaud these leaders. They moved quickly and averted a catastrophe.

They prevented serious illness and death, avoided costly care and anguish. And they did so in spite of their health and welfare services being underfunded for decades, with inappropriate, unwelcome or unavailable mainstream services.

If ever there was a time to implement the Uluru Statement from the Heart, particularly the voice to parliament, it is now. What more proof do we need?

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