New South Wales

Special Commission of Inquiry into Healthcare Funding

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Public Health Association
AUSTRALIA

Submission to the New South Wales Special Commission of Inquiry into Healthcare Funding

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The **Public Health Association of Australia** (PHAA) is Australia's peak body on public health. We advocate for the health and well-being of all individuals in Australia.

We believe that health is a human right, a vital resource for everyday life, and a key factor in sustainability. The health status of all people is impacted by the social, commercial, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the root causes of poor health and disease. These determinants underpin the strategic direction of PHAA. Our focus is not just on Australian residents and citizens, but extends to our regional neighbours. We see our well-being as connected to the global community, including those people fleeing violence and poverty, and seeking refuge and asylum in Australia.

Our mission is to promote better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

Our vision is for a healthy population, a healthy nation and a healthy world, with all people living in an equitable society, underpinned by a well-functioning ecosystem and a healthy environment.

Traditional custodians - we acknowledge the traditional custodians of the lands on which we live and work. We pay respect to Aboriginal and Torres Strait Islander elders past, present and emerging and extend that respect to all other Aboriginal and Torres Strait Islander people.

Introduction

PHAA welcomes the opportunity to provide this input to the Special Commission's work.

This inquiry is a rare opportunity to pause and take stock of fundamentals about how the entirety of an Australian state health 'system' functions, and the financial implications of that functionality. However, we urge the Commissioner not to assume that the task is simply how to ensure continued *funding* for current activity under current system design. We urge the Commissioner to review the fundamentals of the system itself, including not merely the institutions, workforces and mechanisms that we deploy for *treating* chronic diseases, injury and illness, but by investigating the reasons why health problems arise in the first place, and ***how health problems – chronic disease in particular – might best be prevented***.

Our particular contribution will be to urge the Commissioner to grasp the logic of "prevention", the expression universally used by the public health community to refer to all measures which prevent people from being affected by disease (or other health harms) in the first place.

It is estimated that around one third of all prevalence of chronic disease in the population is preventable by modifiable risk factors. Recasting the health system so that prevention is given dramatically more attention is likely to be one of the strongest approaches available to NSW to making the health system more financially sustainable. Indeed, it might be the only way to do so.

Since most preventive health interventions happen at the primary care level of the health system, or indeed even before primary care is accessed, we also offer some observations on how to strengthen the primary care component of the system.

We also offer observations about the crucial role of the workforce needed to deliver public health programs. Note that we do not use the term 'public health' in its very broad usage, including all entities and workforces involved in the non-private part of the health system. We mean 'public health' in its more specific meaning, namely those engaged in the science of population health and the programs and services which deliver public health measures of a protective and preventive nature. The COVID pandemic has re-introduced our community to this more specific term, as infectious disease control and other public health functions, including the work of the chief health officers, became prominent in the public's consciousness.

We also offer comments on alternative models of care of a more preventive character.

Finally, we emphasise that revenue measures, as well as spending, can simultaneously serve public health outcomes while also contributing to the 'funding' of our health system. Revenue options which make long-term contributions to reducing the prevalence of chronic diseases obviously make two contributions to the financial sustainability of the health system, firstly by raising revenue, and in the longer term by reducing expenditure. We note that many of the larger revenue options take the form of product excises, and are thus constitutionally the responsibility of the Commonwealth level of government, but in those cases we urge the NSW government to work cooperatively with other governments to see sound health-maximising revenue policies introduced nationwide. Meanwhile, with state legislative power in mind, we offer below an example of a licencing scheme for the tobacco retail sector which happens to coincide with regulatory reform needs currently relevant to NSW. Other state-based revenue options could no doubt be proposed.

At this early stage we do not present a log of specific recommendations, although some will appear in the body of this submission. Rather, we earnestly hope that the Commissioner will perceive the big picture, and adopt a preventive health framing throughout his deliberations.

We would be very willing on request to provide further written advice, or appear at hearings, as would best assist the Commissioner.

Funding of health services

This section is broadly addressed to Term of Reference 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.

The financial significance of a preventive approach to health

One of the greatest challenges facing all Australian health systems, and driving their ever-growing funding needs, is the growth in chronic disease prevalence in the population. The most logical solution to this challenge is not to find ever-more burdensome ways to fund treatment services, but to prevent the growth in chronic disease prevalence in the first place. The Australian Institute of Health and Welfare (AIHW) has estimated that around one third of all prevalence of chronic disease in the population is preventable by modifiable risk factors.[1]

The economic case for public health investment is simple and powerful: prevention (or minimisation) of disease in the community saves governments – as well as the private economy – very significant costs in financial and labour resources. Redesigning the health system so that prevention is given significantly more attention would likely to be one of the strongest approaches to making the health system more financially sustainable. Indeed, it might be the only way to do so.

Years spent in ill health present two major forms of economic loss: the opportunity cost of lost productivity during working years, and the direct cost (often increasingly expensive) of treatment and care. The reality is that we will inevitably expend resources on 'health'. Our choice lies in whether we decide to spend efficiently on *preventing* disease and maintaining wellbeing, or find our governments forced to expend more each year, expensively and less efficiently, on *treating* illness once it manifests.

The degree of wellbeing and health – or alternatively, the extent of disease – across the population is also a major driver of its economic vitality, to say nothing of the social importance of wellbeing. The state of population health significantly influences the inflow and outflow of government revenue and expenditure.

According to the Productivity Commission, on average, Australians live 13.2% of their lives in ill health – one of the highest proportions of any OECD nation, exceeded only by people in Turkey and the United States.[2] The economic cost of the rate of prevalence of chronic disease is so great that significant shifts upward – or downward – in chronic disease rates present major economic and financial challenges (or opportunities) for governments.

Many studies have demonstrated the economic significance of disease burdens in our population. A 2019 study of the economic cost of preventable disease found that "*estimates of the annual productivity loss that could be attributed to individual risk factors were between $840 million and $14.9 billion for obesity; up to $10.5 billion due to tobacco; between $1.1 billion and $6.8 billion for excess alcohol consumption; up to $15.6 billion due to physical inactivity and $561 million for individual dietary risk factors*."[3]

The OECD's *Heavy Burden of Obesity: The Economics of Prevention* report (2019), examined 52 developed member nations.[4] This study calculated the economic impact of overweight and obesity, which is one of modern society's most common forms of ill-health, and a driver of several major disease conditions. The report put the estimated economic cost to Australia at an astonishing 3.1% of GDP, including lowered labour market outputs equivalent to the productive output of 371,000 full-time workers, as well as an average reduction in lifespan by 2.7 years per person.

These costs clearly form some of the largest economic and financial burdens facing Australia's governments. They are drivers of continual pressure on national and state/territory governments to make our health systems (or more accurately, our *illness treatment* systems) more financially 'sustainable'.

However, the concept of fiscal sustainability should be understood not merely as a justification for *expenditure constraint*, but rather as making a case for a holistic approach to ensuring that higher socio-economic policy goals can be delivered in a manner which can be reliably maintained over many years. In fact, too much constraint on investing in disease prevention can be financially counter-productive in the long term, by increasing the extent of chronic disease and other illness and injury in the population.

The evidence clearly supports the case for public health investment have clear benefit-cost value, and have a powerfully positive impact on Budget sustainability into the future. A decade ago, the *Assessing Cost Effectiveness in Prevention* (ACE) study provided a comprehensive analysis of the comparative cost-effectiveness of preventive intervention options addressing the non-communicable disease burden in Australia, with a specific focus on Indigenous Australians.[5] The study evaluated the cost-effectiveness of 150 preventive health interventions, addressing areas such as mental health, diabetes, tobacco use, alcohol use, nutrition, body weight, physical activity, blood pressure, blood cholesterol and bone mineral density.

Across these areas of preventive intervention, the ACE study identified 23 'dominant' program interventions that both improve health and achieve net cost savings, as well as over 50 further interventions in 'very cost-effective' and 'cost-effective' categories. The study remains a policy road-map for budgetary investments in preventive health.

More recently, a report on *The Health of Queenslanders 2020* found that: "There is growing evidence that public health interventions are cost-effective with up to 75% of UK public health interventions from 2005 to 2018 meeting this criterion.[6] It was estimated that a $1 investment in public health generated $14 in return,[7] in addition to the return of the original investment, back to the wider health and social economy."[8]

In making these observations, we acknowledge that NSW Health is a leader in the development of high-level preventive health strategies, including Healthy Eating Active Living, the Hepatitis B Strategy and the Hepatitis C strategy, which are all designed to improve health and reduce the burden of chronic disease. We also acknowledge that NSW, together with other jurisdictions, has contributed to developing national strategic direction statements including the National Alcohol Strategy, National Obesity Strategy, National Tobacco Strategy, and the over-arching National Preventive Health Strategy. As a nation we are not lacking in evidence-based guidance about health policy directions. What is needed is political commitment to preventive health investment.

The social value and cost-effectiveness of NSW investing in prevention

This Special Commission is tasked with examining the funding of the NSW Health system, but it should not ignore the vital *social* significance of the outcomes of the system's overall design.

Investing in chronic illness prevention and control, through affordable, cost effective, high-impact policies and legislative measures will deliver the greatest possible health impact in reducing illness, disability, and premature death. Chronic diseases such as cancer, diabetes, heart disease, chronic respiratory diseases and cardiovascular disease have a major impact on health and wellbeing and are responsible for around 89% of deaths every year.[9] These diseases and the major risk factors that contribute to them (tobacco use, alcohol use, unhealthy diet and lack of physical activity) also have significant negative consequences on economic productivity and financial stability for individual, households and society, as a whole.

The present pandemic will also trigger significant additional health problems, both directly from COVID infection but also from the indirect impact of many delayed preventive treatments for other forms of disease, including the often-unseen impact of chronic diseases. Diabetes, heart disease and hypertension,

cancer, lung diseases, and obesity all significantly worsen the effects of COVID-19, increasing the risk of serious illness or death.[10]

Cost estimates of chronic disease in Australia continue to mount. As noted above, estimates of the annual productivity loss that could be attributed to individual risk factors relating to obesity, tobacco, alcohol, physical inactivity and dietary risks totalled in aggregate up to $47 billion.[11]

To deliver on the National Preventive Health Strategy, the roll-out of public health measures by all governments should accelerate rapidly, with commitments to programs including:

- Cessation of tobacco use, and reduction in uptake by new users
- Reduction of alcohol consumption, especially for those consuming alcohol at risky levels
- Reduction of sugar-added beverage consumption
- Reduction of junk food consumption
- Reduction of harm associated with gambling
- Promotion of healthy diets and dietary patterns
- Better maternal and childhood health.

The NSW Government should also address practices used by the private sector to promote products and choices that are detrimental to health. In 2020, the WHO-UNICEF-*Lancet* Commission on Child Health noted that commercial marketing of products that are harmful to children is one of the most underappreciated risks to their health and wellbeing. It concluded that industry self-regulation does not work, and the existing global frameworks are not sufficient. Industries selling unhealthy products are highly active in trying to shape individual behaviours towards the consumption of these unhealthy but often highly profitable products.[12] Such marketing practices do not affirm individual choice, but instead deliberately manipulate and undermine real personal choice. Arguments about commercial 'freedom' are often simply justifications for unhealthy product suppliers to be free to manipulate consumers and dominate marketplaces.

A far stronger and more comprehensive approach to regulation is required to protect people, and most especially children, from the marketing of tobacco, alcohol, sugar-sweetened beverages, and gambling. Safety from the potentially damaging impacts of use of social media, and the inappropriate use of personal data captures through online activity, are also a key concern.[13]

Sustained programs to help people make healthy consumption choices have proven effective in many domains in the past. Effective and sustained social marketing campaigns and related programs have helped people to achieve reductions in harmful consumption habits (tobacco, alcohol, sugar-added beverages, junk food, etc), and increase healthy activities (physical activity and promoting healthy eating).

The inequity trend of worsening chronic disease prevalence

In addition to the growing *scale* of chronic disease, their *spread* is becoming more socially uneven. As a society we face a steadily growing problem of economic inequality and inequity, including specifically inequity of health status and outcomes. While this is true of the population as a whole, the greatest challenges are witnessed in the conditions faced by Aboriginal and Torres Strait Islander peoples, Australians of lower socio-economic status and resources, and Australians living in rural and regional areas. Socio-economic determinants such as housing, education, justice matters, and cultural security also powerfully affect equality in Australia.

Inequality also has a compounding effect, perpetuating and worsening conditions for those least well off. Socio-economic disadvantage results in persistent inability to take healthy actions, resulting in poorer health outcomes and inability to access services to deal with illness perpetuating a vicious cycle of ill health and poverty.[14]

The financial question facing the NSW Government

There is immense strain on NSW's health and hospital system given almost half of all Australians have a chronic disease, with rates of these diseases rapidly increasing in recent decades. The financial benefits to the Australian economy of realistic reductions in chronic disease risk factors have been conservatively estimated to be $2.3 billion over the lifetime of the 2008 population.[15] It has been found that for every $1 invested in chronic disease prevention intervention, there is a median return of $14 plus the original investment back to the wider health and social care economy.[16] This type of investment leads to less reliance on costly ambulance, emergency and hospital services, where 38% of illness, disease and early deaths and 1 in 10 hospital admission days can be prevented.

In line with the national goal expressed in the National Preventive Health Strategy, we urges the NSW Government to put in place increase and sustained focus and investment in public health, and chronic disease in particular, with underlying prevention funding (exclusive of emergency spending such as that associated with the pandemic) rising to at least 5% of the total health expenditure by 2030. Priorities for the implementation of this recommendation should include transparent annual public reporting and benchmarking of investment in public health, specifically investment based on clear evidence and evaluation of costs, benefits and impacts

Broadly speaking, there are established principles of healthcare of spending that should be considered:

- *Supporting preventive Measures*: preventive and community health programs often require sustained funding to be effective. These programs can help address health issues at the root, ultimately reducing the burden on the healthcare system and improving public health. Examples of such programs include VicHealth's Community Activation program and Walk to School Campaign, which serve to robustly address specific health outcomes utilising preventives and therefore, cost effective measures.
- *Reducing Health Disparities*: Adequate funding can be allocated to regions or populations with the greatest health disparities, ensuring that everyone, regardless of their socio-economic status or geographic location, has access to quality healthcare services. Initiatives including the VicHealth "Supporting the health of Indigenous Australians" address this key target of the UN's Sustainable Development Goals 3 and 10, ensuring that Government Health Agencies are reducing the negative effects of Social Determinants on health outcomes are reduced.
- *Enhancing Quality of Care*: Additional funding can be used to hire more healthcare professionals, invest in advanced medical technologies, and improve infrastructure. This directly translates into better quality healthcare, which is vital for achieving optimal health outcomes. Healthway WA's Referral Directory is an example of an inexpensive and effective tool to improve health infrastructural pathways, enabling a more streamlined and user-friendly mechanism to connect health services with vulnerable communities and individuals.

Transparency and reporting of preventive health investment

Progress made towards the implementation of a 5%-for-prevention commitment should be reported annually, including a breakdown of preventive health expenditure, with the scope of prevention being public health activities funded by key jurisdictional health departments that deal with issues related to populations rather than individuals comprising of selected health promotion; cancer screening; prevention of hazardous and harmful drug use; public health research.

Finally, in regard to data collection, we recommend that the extent of preventive health spending in NSW should be monitored through increased collaboration between NSW Treasury and preventive health decision-makers within the NSW Ministry of Health, so to increase use of economic evidence available to inform preventive health spending.[17]

Access to preventive and community health initiatives

This section is addressed to Term of Reference 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 preventive and community health initiatives and overall optimal health outcomes for all people across NSW.

Local Health Districts as preventive health service providers

Local Health Districts (LHDs) deliver services and programs to facilitate implementation of preventive health strategies, with the NSW Health Performance Framework outlining the performance expected of LHDs to achieve desired outcomes in population health status. The Performance Framework enables LHDs to deliver a coordinated, high quality health service to the communities it serves and to support its teaching, training and research roles, with some programs mandated for implementation by LHDs under service agreements (a central component of the Performance Framework).

Population Health services within each LHD deliver prevention and health promotion programs that are part of the Service Agreement to achieve the State strategies, such as Healthy Eating Active Living in their communities. However, programs may need to be more targeted among certain communities, as there are certain groups across NSW who experience social inequality and disadvantage resulting in health inequity. An important part of delivery of preventive health programmes is assessing the needs of such groups and tailoring activities accordingly to address differences in risk factors.[18] Programs therefore also need to be developed locally to meet an identified need in a particular population sub-group or to implement a wider initiative aimed at impacting one or more social determinants that shape health.

Currently, funding to Population Health services is generally low, changeable, is of uncertain efficacy year-to-year, and can be short-term in reliability (even merely annual). The time needed to plan, design, develop, pilot and revise, implement, evaluate and report a new program's outcomes and impacts can require a multi-year sustained resourcing.

Some population health services may have the research-focused expertise and resources to secure additional program funding through pathways such as National Health and Medical Research Council (NHMRC) grants and NSW Health Translational Research Grants, but this pathway may not be feasible for every LHD as a means of providing bespoke preventive health initiatives that meet their local community needs.

To help remove obstructions to preventive and community health initiatives, we recommend that funding is both increased and also assured over a longer cycle to align with the timeline of program implementation more realistically in communities, and to improve certainty and flexibility for population health services.

Aboriginal Community-Controlled Health Services

PHAA notes that the Productivity Commissions' 2023 *National Agreement on Closing the Gap - Draft Report* outlines a lack of progress, commitment, and accountability across all governments towards implementation of the National Agreement.[19] The apparent business-as-usual approach to implementing policies and programs that affect the lives of Aboriginal and Torres Strait Islander peoples is not acceptable. Without a fundamental shift in ways of working, the scale of structural change required to deliver on the National Agreement's goals and targets cannot be achieved and, at best, the status quo will remain.

PHAA would also like to draw attention to the work by Equity Economics, commissioned by the National Aboriginal Community-Controlled Health Organisation (NACCHO) in 2022, which estimated the total gap in health expenditure *needed to achieve equivalent health outcomes* for Aboriginal and Torres Strait Islander health is in the order of $4.4 billion per year, of which $2.6 billion is the Commonwealth's share, and the remaining $1.8 billion shared across the state and territory governments.[20] This equates to a funding 'gap' of just over $5,000 per Aboriginal and Torres Strait Islander person. The health gap will not close if this extensive funding gap continues.

PHAA urges all governments to close this alarming gap for Aboriginal and Torres Strait Islander peoples. To do so, PHAA strongly supports the shifting of service delivery to Aboriginal Community-Controlled Health Services (ACCHSs) as a mechanism of self-determination. Community-controlled services have been shown to achieve better results for Aboriginal and Torres Strait Islander peoples.[21, 22] In the case of health services, this is because the ACCHS model provides comprehensive primary healthcare that incorporates disease prevention and health promotion, is strongly informed about social determinants of health relevant to clients, and is uniquely placed to embed cultural matters within health services.[23]

However, shifting service delivery to ACCHSs is no easy feat, as evidenced by the process undertaken by the Gurriny Yealamucka Health Service in Yarrabah, Queensland, which took almost 30 years. An evaluation of their transition provides an outline of the processes and strategies undertaken, forming a framework for governments and ACCHSs to inform future transitions.[24] It also highlights the level of planning and resourcing required to make such a transition successful, and the ongoing power issues that form a major barrier to shifting service delivery.[25]

Various implementation challenges, including resourcing, have also been reflected in a recent Evaluation of the Pathways to Community Control program in the Northern Territory. In particular, the level of funding for both the transition process and ongoing operations, was identified as the major barrier, not just for service provision but also for the change process. The evaluation report provides a series of recommendations for improving transition processes to overcome the identified challenges.

While PHAA supports the transition of service delivery to community control, we urge governments to sufficiently provision any transition processes, particularly where complex funding pools are required as a result of the shared responsibility across government jurisdictions for Aboriginal and Torres Strait Islander health in Australia,[26] to better enable the ACCHSs to design and deliver services that best meet the priorities and needs of their communities.

Non-Government Organisation-provided community services

NSW Health has long recognized the valuable role played by NGOs in the planning, management and delivery of health services in NSW. NGOs have repeatedly demonstrated their capacity to work well with local GPs, community groups and services, private businesses, hospital services, community health services and other health and welfare providers to deliver an integrated range of services to their clients.

NSW Health has shown commitment to partnering with the non-government sector to deliver important community-based services that support the health and wellbeing of the public, especially vulnerable or hard to reach populations. NSW Health committed approximately $172 million in MAG funding to NGOs across the state during 2021-22.[27] However, the funding allocated to agencies is subject to maintenance of funding to NSW Health as part of the State Budget appropriation, and in many cases agencies can only guarantee one year of funding to grantees.

If funds are available, it is possible to establish triennial funding arrangements. This means that the base grant awarded to the grantee for the first financial year can be provided for two further financial years without the requirement for a new application.[28]

Health promotion specialist agencies

NSW has fallen behind other states in establishing dedicated health promotion institutions. Healthway (the WA Health Promotion Foundation) in WA and Victoria's VicHealth agency are examples of entities that have played a pivotal role in reducing healthcare costs in their respective states through effective health promotion and prevention strategies, in partnership with local communities.

A compelling case study in the utility of dedicated state health promotion agencies is the role played by VicHealth in smoking prevention. According to research published on Tobacco in Australia, the economic evaluation of tobacco control interventions reveals that for every dollar invested in such programs, there is a significant return on investment. VicHealth has been actively involved in tobacco prevention efforts over many years through multiple initiatives.[29] The reduction in tobacco use leads to fewer smokers developing tobacco-related illnesses, which directly alleviates the burden on the healthcare system. Not only does this result in a healthier population, but it also leads to substantial cost savings by preventing costly treatments and hospitalisations, as highlighted in a study published in the National Library of Medicine.[30] For instance, a study featured on Tobacco in Australia demonstrates the significant financial burden of smoking on healthcare, making it clear that preventive efforts can be a cost-effective strategy.

The cost-effectiveness of health promotion and prevention measures, like those advocated by Healthway in WA and VicHealth in Victoria, is always positive, and are crucial in curbing the escalating costs of healthcare.[31] By promoting healthier lifestyles and habits, these state entities help people avoid the need for expensive medical treatments and hospitalisations, ultimately reducing the strain on the healthcare system.

We therefore recommend that these models be considered for adoption into the NSW health system. We do note that these models work best when they feature strong partnership with community-level preventive and primary health providers, not by relying on a central state agency alone.

Capacity and capability of the public health workforce

This section is addressed to Term of Reference 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 …

An examination of existing skills shortages – ToR F(ii)

As noted in the introduction to this submission, we use the term 'public health' – specifically in the sense of 'public health workforce' – in its more specific meaning, namely those engaged in the science of population health and the programs and services which deliver public health measures or a protective and preventive nature. Our comments in this section are not framed to refer to a broader definition of 'health workforce'.

The public health workforce has historically been difficult to define and enumerate as the professions that contribute to this workforce are not consistently regulated in Australia. Nor are international classifications of the public health workforce currently available. Assessing the distribution of the workforce is therefore difficult.

However, the World Health Organization (WHO) has recently been undertaking a large piece of work to build the capacity and capability of the public health and emergency workforce to rectify this situation on a global scale[32]. As part of this project, the public health workforce has conceptually been defined according to the following three categories:

1. The core public health workforce that is formally trained in and contributes to the delivery of the essential public health functions, which is the primary focus of their role (e.g. public health physicians, epidemiologists, public health policy and program officers or managers, environmental health officers);
2. The health and care workforce whose role is to deliver health and care services, but whose role includes delivery of the essential public health functions as part of the health and care services they provide such as health promotion (e.g. doctors, nurses, allied health professions, social workers);
3. Other affiliated professions who contribute to delivery of the essential public health functions but who would not consider themselves as part of the public health workforce (e.g. water and sanitation personnel, food supply chain personnel, lawyers, teachers).

The WHO has developed a set of toolkits and guidelines to enable all countries across the globe "to identify their health system needs, develop competency-based education curricula for pre-service and in-service education of their public health workforce, and measure the quantity and quality of this workforce using a standardized measurement approach," which it is anticipated will be publicly available by the end of 2023[33]. We recommend that the Australian and jurisdictional governments utilise these WHO resources to benchmark their public health and emergency workforce as part of this global effort. PHAA has representatives on the WHO Taskforce leading this work, and we would be happy to be consulted by the Commissioner on recommended ways forward.

PHAA is aware that NSW Health is in the process of mapping the current staff and teams that are involved in public health functions, but that this is focused mainly on specific health protection functions.

Furthermore, in response to the recommendations arising from the Public Health – NSW COVID-19 Response report, NSW Health is in the process of developing a Public Health Workforce Plan, and has been consulting with the PHAA representatives involved in the WHO as part of this process. However, this process is being confined to the Local Health Districts within the NSW Health system and does not extend

to the broader public health workforce that would also be employed by other healthcare service providers such as the Aboriginal Community Controlled Health Organisations, nor in other sectors, so this exercise will not provide a full picture of the public health workforce across the state.

Of the professions within the public health workforce, the public health physicians (PHP) are currently regulated under the Australian Health Practitioner Regulation Agency. The Australasian Faculty of Public Health Medicine (AFPHM) recently undertook a labour market analysis of this workforce in Australia. It based its recommendations on an established practitioner to population ratio of 2.5 PHPs per 100,000 population, which did not account for those PHP employed in teaching and research[34]. This is compared to recommendations from the UK Faculty for Public Health, which recommend 3.0 full-time equivalent public health specialists per 100,000 population as being a 'feasible, desirable and affordable' benchmark for a world class public health system, and which does include both service and academic specialists[35].

Notably, the UK offers an integrated public health training program which includes both medical and non-medical graduates. Similarly, NSW has long had a world class Public Health Officer Training Program (PHOTP), which trains both medical and non-medical individuals. However, across Australia, non-medical public health specialists are unaccredited and not regulated, therefore estimates of this workforce are difficult to ascertain and are not included in the AFPHM workforce analysis.

Irrespective, based on population data from the ABS[36], the number of PHP per 100,000 population in NSW at resent appears to be 1.66, and this is well below the recommendations of 2.5-3.0 full time specialists per 100,000 of the population, even without inclusion of the non-medical graduates. It is unlikely that this will account for the entire public health specialist workforce gap, and there is a need to increase the capacity of the PHOTP to meet future demand. The need to regulate and thus enable enumeration of the non-medical public health workforce is also clear.

The role and scope of workforce accreditation and registration – ToR F(v)

Noting the above, our recommendations on the issue of accreditation are two-fold. First, we recommend urgent implementation of accreditation and regulation of non-medical graduates of the PHOTP to allow true measurement of the distribution of public health specialists working in NSW. This will facilitate identification of areas where shortfalls in staffing below the recommended 2.5-3.0 full time specialists per 100,000 population exist. Our second recommendation is to increase public health specialist staffing to this 2.5 – 3.0 uniformly across the state, to ensure equitable staffing levels per capita in all areas.

Developing public health surge capacity across the health system to manage future public health threats due to pandemics is also recommended due to a key skills shortage in the NSW health system. This skills shortage was highly apparent during the height of the COVID-19 pandemic, where the ability of public health to continue to respond was severely impacted by limited surge workforce capacity, particularly in regional areas. As one system: The NSW Health system's response to COVID-19 highlights the need to better shape emergency planning measures, such as surge workforce planning, in anticipation of more prolonged high impact health threats, including a focus on workforce for a successful pandemic response.

Specific to this, we recommend development and implementation of standardised surge training, which incorporates basic public health and disease outbreak management training, that all health students across NSW undertake as part of their degrees. First, this will rapidly lead to an additional pandemic ready workforce, who can be surged at short notice addressing capacity issues. Second, in the longer term, it will lead to upskilling of clinicians working across the NSW health system able to be surged in times of emergency response.

New models of care

This section is addressed to Term of Reference 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.

Service delivery opportunities for better prevention

Uniformly implementing and enhancing chronic disease primary and secondary prevention across State funded clinical settings could both improve quality of care and patient outcomes, as well as increase cost efficiency of the health system by creating capacity, and improved health equity.[37, 38]

We therefore recommend expansion of the existing Community Health Service Network both in scope to include chronic disease prevention and management (at all services vs select services), as well as in number to ensure broader coverage across the state's population.

We also recommend implementation of education strategies to ensure all staff working in the NSW system understand the complex nature of obesity to recognise it is not an individual choice.

Further, there are multiple opportunities to strengthen and integrate prevention as part of routine clinical care in the NSW health system. Queensland Health recently conducted work to better understand what works in prevention, and why, in their health system. They examined how the dynamics and key drivers within the health system could work better to strengthen prevention and embed sustainable system change. A key finding from this work was that prevention was seen as a priority, but a perception existed that prevention was not seen as part of Queensland Health's remit nor an integral part of their clinical service delivery. Key outcomes of this work were the identification of high value opportunities to expand and sustainably embed chronic disease prevention as a core function of quality clinical care in the Queensland public health system.

Creating an environment where this was feasible including local service agreements, financial incentives for staff and mandates on prevention being delivered uniformly. We recommend that NSW Health build on this work by identifying where additional opportunities lie to expand and sustainably embed chronic disease primary and secondary prevention across the NSW state funded health system through clinical innovation and new models of care. This will enable NSW Health to address their identified area of action which is to "embed routine and opportunistic physical health screening across the whole of health care."

Better approaches to obesity prevention and management

It is appropriate to mention the prevention and management of obesity specifically, due to its leading role in overall population health status. Australians are living longer, yet many of those individuals experience years of poor health due to preventable chronic diseases, with the top 5 chronic diseases (cancer, musculoskeletal conditions, cardiovascular diseases, mental health conditions/substance use disorders and neurological conditions) contributing 62% of the total fatal and non-fatal disease burden.[39] Overweight and obesity increases risk of these diseases, including 13 types of cancer (notably cancers with the highest incidence in Australia: breast cancer in women, prostate cancer in men and bowel cancer in all persons), cardiovascular disease, type 2 diabetes, sleep apnoea, psychological issues, some musculoskeletal conditions.[40] People with excess weight are also more at risk of developing age-related cognitive decline and dementia, as well as other neurodegenerative pathologies such as Parkinson's disease.[41, 42, 43]

Hospitalisations attributed to overweight and obesity have been steadily increasing, and in 2020-21 climbed to more than 75,000 hospitalisations (763 in every 100,000 NSW residents), equating to ~2.3% of all hospitalisations in the State. These rates have been consistently higher in the most disadvantaged compared to the least disadvantaged areas.[44] Excess weight is also a major risk factor for kidney disease.[45] Admissions for renal dialysis were among the leading cause of hospitalisations among all persons in NSW in 2020-21, equating to 15% of all hospitalisations, at significant cost to the healthcare system.[46, 47]

Recent research found that a prevailing paradigm within health services is that obesity is a matter of choice.[48] This perspective treats obesity as a matter of individual responsibility, a type framing which hinders health services from being effective in obesity prevention and increases stigma which in turn reduces access to health services. Such a framing is to be avoided in all state health policies.

NSW Health has an excellent new strategy planned to address overweight and obesity across the NSW population: The NSW Healthy Eating and Active Living Strategy 2022-2032. This strategy aims to deliver prevention programs and services to support healthy eating and active living as well as facilitate provision of routine advice on healthy lifestyles as part of clinical care. The State also delivers existing initiatives designed to prevent obesity, but these limited in scope as they tend to focus on individual responsibility through behavioural change. Given the rising rates of obesity, it is clear these approaches are not successful, with a large proportion of the population not accessing current initiatives, likely due to poor health literacy and other access barriers such as stigma (real or perceived).

Given these limitations, there is a clear need for innovation in community-based care to prevent and manage obesity, as well as other chronic disease risk factors, to reduce hospitalisations. Community-based services are particularly needed for those with low income who are unable to afford GP care, where more support is needed due to low health literacy, or where services are not accessed due to attitudes and stigmatising language around weight.

Other issues: health-focused revenue policies

Health-oriented revenue measures

As one part of a response to these health challenges, we recommend that the Government consider the introduction and expansion of health levies (as excise taxes and pricing policies on harmful products which are detrimental to health) that both improve public health, and also generate revenue to help fund investments in public health programs.

The multiple aims of health levies include: to raise awareness about unhealthy products, to reduce the consumption of unhealthy products, to reduce the associated negative health burdens and to create new revenue streams for public health investment. There is clear evidence that health levies are effective and efficient in reducing consumption of the relevant products.

Health levies on products that have a negative public health impact, such as tobacco, alcohol and sugar-sweetened beverages have multiple policy merits.[49] Health levies are a high-return investment which saves lives and prevent disease, while advancing health equity, averting healthcare expenditure, increase workforce participation, and boost revenue for the general budget.

We acknowledge that constitutional constraints relating to imposing excises on goods means that state governments face barriers to introducing many forms of health levies. However, that fact should not be a barrier to NSW adopting supporting policy positions and working with the Commonwealth and other jurisdictions to bring national policies into effect, delivered though Commonwealth legislation.

Proposal for tobacco licensing

We propose for consideration one specific early initiative which is within the constitutional competence of NSW. With the exception of NSW and Victoria, all state and territories across Australia presently require retailers to pay a licensing fee to sell tobacco. NSW merely has a Tobacco Retailer Notification Scheme which requires retailers to notify Service NSW of their intent to sell, with currently no fees attached. Attaching a fee to a retail notification or license scheme could reduce the number of outlets selling tobacco, helping to reduce tobacco availability. It would also support tobacco and vaping products law enforcement operations by both state and national agencies.

A tobacco retailer fee was introduced in South Australia in January 2007. This move saw the annual cost of retail tobacco licences rise 15-fold from $12.90 to $200. This initial fee increase led to an almost 24% decrease in the number of tobacco retailers within two years.[50] Tobacco licenses declined by 33% overall by 2020, by which time the fee was $303. The most reductions in licenses have been seen across food service venues (65.2%) and hotels (37.2%).

In NSW, there are estimated to be at least 10,000 tobacco retail outlets,[51] with access to tobacco retailers demonstrated as being high in the state.[52] Accessibility of tobacco outlets contributes to smoking behaviour.[53] A Tobacco Retailer Notification Scheme where an annual fee is required is an example of where meaningful revenue can be raised. Such a fee will not only prompt new business to reconsider entering the market and prompt existing businesses to reconsider selling tobacco, but would be a small a new source of revenue for the NSW Government. Tasmania currently sets an annual tobacco retailer fee of $1,219. If NSW were for example to introduce an annual fee of $5,000 per annum, it has the potential to generate ~$50M annually. This could help cover the growing costs for monitoring and compliance of existing tobacco control legislation, where law enforcement agencies are currently under pressure to significantly expand their activity.

Conclusion

PHAA hopes that this inquiry will lead to real reform of the NSW health system in the direction of disease prevention as a social, economic and fiscal priority.

We are particularly keen that the following points are highlighted:

- The critical role of **prevention** of chronic disease, both as a social outcome of great importance but also as a major contributor to stabilising the financial sustainability of the NSW health system
- The critical role of locally-delivered **community health initiatives** as a low-cost, high-impact means of keeping the NSW population healthy
- The critical need to maintain and grow the **public health workforce** needed to deliver on all the communities health system goals
- The available options for health-generating **revenue initiatives**.

PHAA appreciates the opportunity to make this submission. Please do not hesitate to contact us should you require additional information, have any queries in relation to this submission, or seek testimony at hearings.

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References

1 https://www.aihw.gov.au/news-media/media-releases/2021-1/august/one-third-of-disease-burden-caused-by-modifiable-r

2 Productivity Commission, Shifting the Dial: 5 year productivity review, 2017, supporting paper 4, Why a better health system matters, 11, at https://www.pc.gov.au/inquiries/completed/productivity-review/report

3 Crosland P, Ananthapavan J, Davison J, et al. The economic cost of preventable disease in Australia: a systematic review of estimates and methods. Australian and New Zealand Journal of Public Health 2019;43:484-495.

4 https://www.oecd.org/health/health-systems/Heavy-burden-of-obesity-Policy-Brief-2019.pdf

5 Assessing Cost Effectiveness (ACE) in Prevention Study - School of Public Health - University of Queensland: https://public- health.uq.edu.au/research/centres/past-centres/assessing-cost-effectiveness-ace-prevention-study

6 Owen L, Fischer A. The cost-effectiveness of public health interventions examined by the National Institute for Health and Care Excellence from 2005 to 2018. Public Health 2019;169:151-162.

7 Masters R, Anwar E, Collins B, et al. Return on investment of public health interventions: a systematic review. Journal of Epidemiology and Community Health 2017;71:827-834

8 Queensland Health. The health of Queenslanders 2020. Report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2020

9 World Health Organisation: https://www.who.int/nmh/countries/aus_en.pdf?ua=1

10 Council on Foreign Relations (2021) Noncommunicable Diseases Kill Slowly in Normal Times and quickly in COVID-19 times https://www.cfr.org/article/noncommunicablediseases-kill-slowly-normal-times-and-quickly-covid-19-times

11 Crosland P, Ananthapavan J, Davison J, et al. The economic cost of preventable disease in Australia: a systematic review of estimates and methods. Australian and New Zealand Journal of Public Health 2019;43:484-495.

12 For example, Cairns G, Angus K, Hastings G, Caraher M. Systematic reviews of the evidence on the nature, extent and effects of food marketing to children. A retrospective summary. Appetite. 2013;62:209-15

13 Clark, Helen, et al. "A future for the world's children? A WHO–UNICEF–Lancet Commission." The Lancet 395.10224 (2020): 605-658. Available from: https://www.thelancet.com/commissions/future-child

14 2021 Close the Gap Report, Lowitja Institute: https://www.lowitja.org.au/page/services/resources/Cultural-and-social- determinants/culture-for-health-and-wellbeing/close-the-gap-report-2021

15 VicHealth: Cadilhac DA, Magnus A, Cumming T, Sheppard L, Pearce D, Carter C. (2009) The health and economic benefits of reducing disease risk factors. VicHealth: Melbourne.

16 Masters R, Anwar E, Collins B, et al. (2017) Return on investment of public health interventions: a systematic review Journal of Epidemiology and Community Health 71:827-834.

17 Ananthapavan J, et al. (2022) Preventive health resource allocation decision-making processes and the use of economic evidence in an Australian state government-A mixed methods study. PLoS One. 17(9)

18 Barnett, K. (2012) Best practices for community health needs assessment and implementation strategy development: A review of scientific methods, current practices, and future potential. Report of proceedings from a public forum and interviews of experts. Oakland, CA: The Public Health Institute.

19 Productivity Commission 2023, Review of the National Agreement on Closing the Gap, Draft Report, Canberra, July.

20 Equity Economics 2022, Measuring the Gap in Health Expenditure: Aboriginal and Torres Strait Islander Australians. NACCHO: https://www.naccho.org.au/app/uploads/2022/05/NACCHO-and-Equity-Economics-Report-Measuring-the-Gap-in-Health-Expenditure_FINAL.pdf

21 Panaretto, K.S., Wenitong, M., Button, S. and Ring, I.T. 2014, 'Aboriginal community controlled health services: leading the way in primary care', Medical Journal of Australia, vol. 200, no. 11, pp. 649–652.

22 Pearson, O., et. al. 2020, 'Aboriginal community controlled health organisations address health equity through action on the social determinants of health of Aboriginal and Torres Strait Islander peoples in Australia', BMC Public Health, vol. 20, no. 1, p. 1859.

23 Harfield, S. G., Davy, C., McArthur, A., Munn, Z., Brown, A., & Brown, N. (2018). Characteristics of Indigenous primary health care service delivery models: a systematic scoping review. Globalization and health, 14(1), 12. https://doi.org/10.1186/s12992-018-0332-2

24 Jongen, C., Campbell, S., McCalman, J. et al. (2020). Transitioning to Aboriginal community control of primary health care: the process and strategies of one community-controlled health organisation in Queensland. BMC Fam Pract 21, 230. https://doi.org/10.1186/s12875-020-01300-z

25 McCalman, J., Jongen, C. S., Campbell, S., Fagan, R., Pearson, K., & Andrews, S. (2021). The Barriers and Enablers of Primary Healthcare Service Transition from Government to Community Control in Yarrabah: A Grounded Theory Study. Frontiers in public health, 9, 616742. https://doi.org/10.3389/fpubh.2021.616742

26 Lavoie, J. & Dwyer, J. (2016). Implementing Indigenous community control in health care: lessons from Canada. Australian Health Review, 40, 453–458. https://www.publish.csiro.au/ZO/pdf/AH14101

27 Partners (nsw.gov.au) Communications - Partners (nsw.gov.au)

28 https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2019_013.pdf

29 https://www.vichealth.vic.gov.au/our-health/preventing-tobacco-use

30 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC390220/).

31 https://www.health.gov.au/topics/preventive-health/about

32 WHO (2022) National workforce capacity to implement the essential public health functions including a focus on emergency preparedness and response. Geneva (Switzerland). https://www.who.int/publications/i/item/9789240050402

33 WHO (2023) Public health and emergency workforce: A roadmap. Geneva (Switzerland). https://www.who.int/teams/health-workforce/PHEworkforce/1

34 Ridoutt L, Cowles C, Madden L, Stewart G. (2017) Planned and Unplanned Futures for the Public Health Physician Workforce in Australia. Sydney (Australia): Australasian Faculty of Public Health Medicine. https://www.racp.edu.au/docs/default-source/default-document-library/AFPHM-public-health-physician-workforce-futures-report.pdf

35 UK Faculty of Public Health. (2019) Functions and standards of a Public Health System. London (United Kingdom). https://www.fph.org.uk/media/3031/fph_systems_and_function-final-v2.pdf

36 Australian Bureau of Statistics (2019) *3101.0 - Australian Demographic Statistics*, June. https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3101.0Main+Features1Jun%202019

37 https://www.wslhd.health.nsw.gov.au/Community-Health-Services/The-Hills-Community-Health-Centre

38 https://www.health.nsw.gov.au/healthone/Pages/healthone-nsw-service-locations.aspx

39 https://www.aihw.gov.au/reports/burden-of-disease/australian-burden-of-disease-study-2022/contents/summary#Chronic%20diseases

40 https://www.aihw.gov.au/reports/risk-factors/risk-factors-to-health/contents/overweight-and-obesity

41 Abbott R.D., Ross G.W., White L.R., Nelson J.S., Masaki K.H., Tanner C.M., Curb J.D., Blanchette P.L., Popper J.S., Petrovitch H. Midlife adiposity and the future risk of Parkinson's disease. Neurology. 2002;59:1051–1057. doi: 10.1212/WNL.59.7.1051.

42 Procaccini C., Santopaolo M., Faicchia D., Colamatteo A., Formisano L., De Candia P., Galgani M., De Rosa V., Matarese G. Role of metabolism in neurodegenerative disorders. Metabolism. 2016;65:1376–1390. doi: 10.1016/j.metabol.2016.05.018

43 Forny-Germano L., De Felice F.G., Do Nascimento Vieira M.N. The Role of Leptin and Adiponectin in Obesity-Associated Cognitive Decline and Alzheimer's Disease. Front. Neurosci. 2019;12:1027. doi: 10.3389/fnins.2018.01027.

44 https://www.healthstats.nsw.gov.au/#/indicator?name=-beh-bmi-paf-hos&location=NSW&view=Trend&measure=DSTRate&groups=

45 Kovesdy CP, Furth SL, Zoccali C; World Kidney Day Steering Committee. Obesity and Kidney Disease: Hidden Consequences of the Epidemic. Can J Kidney Health Dis. 2017 Mar 8;4:2054358117698669. doi: 10.1177/2054358117698669. PMID: 28540059; PMCID: PMC5433675.

46 https://www.healthstats.nsw.gov.au/#/indicator?name=-beh-bmi-paf-hos&location=NSW&view=Trend&measure=DSTRate&groups=

47 NSW Combined Admitted Patient Epidemiology Data and ABS population estimates (SAPHaRI). Centre for Epidemiology and Evidence, NSW Ministry of Health.

48 Pearce, C., Rychetnik, L. & Wilson, A. The obesity paradigm and the role of health services in obesity prevention: a grounded theory approach. BMC Health Serv Res 21, 111 (2021). https://doi.org/10.1186/s12913-021-06089-w

49 World Health Organisation, Health Taxes: https://www.who.int/health-topics/health-taxes#tab=tab_1

50 Ziesing S, et al. 2023) Is it time to increase the cost of tobacco licences after 10 years of stagnation? Australian and New Zealand Journal of Public Health 47(5).

51 Watts C, et al. (2020) Understanding why some Australian retailers have stopped selling tobacco, some might and some are unlikely. Tobacco Control. 29(e1)

52 Watts C, et al. (2020) Accessing the most lethal product on the market: community perceptions of tobacco accessibility in NSW, Australia. Public Health Research Practice 30(3).

53 Lee JGL, et al. (2022) Associations of tobacco retailer density and proximity with adult tobacco use behaviours and health outcomes: a meta-analysis. Tobacco Control. 31(e2)