New South Wales

Special Commission of Inquiry into Healthcare Funding

Submission Number: 192

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Date Received: 19/12/2023

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Submission from the School of Population Health, UNSW Faculty of Medicine and Health

About the UNSW School of Population Health

As the oldest and largest health management program in Australia and ranked in the top 50 globally for public health research, the School of Population Health is a pioneer in population health, global health, health leadership and management. Work ranges from responding to emerging public health crises to training the future health workforce, with a common focus to achieve social justice and better health for all.

More than 1000 undergraduate and postgraduate coursework students and more than 120 research candidates are enrolled at the School of Population Health. The School holds teaching and research collaborations with national and international partners, has an extensive alumni network in Australia, the Asia-Pacific region and beyond.

The School of Population Health is located on the unceded territory of the Bidjigal people (UNSW Kensington campus). The School of Population Health acknowledges the Bidjigal people as traditional custodians of the unceded lands on which UNSW Sydney stands, pays respects to Elders both past and present.

Introduction

The School of Population Health welcomes the opportunity to provide a submission to the Inquiry into Healthcare Funding. This submission is underpinned by the understanding that the purpose of a health system is to ensure good health by 1) providing equitable, high quality, affordable health care, and 2) by preventing disease and ill health. Both aspects of this are germane to this inquiry.

Response to inquiry

PREVENTION

The burden of disease has changed. The health system must now grapple with health issues related to ageing, poor mental health, and a continuing rise in chronic diseases. As a result, the health system is

under pressure – hospitals are overwhelmed, there have been failures in primary care, aged and disability care, and a decline in rural medicine.

Keeping people healthy and out of hospital is key to saving health care costs and stronger focus on prevention is needed to ensure this. Prevention is key to good community health and wellbeing, and prioritising prevention is crucial to addressing this changing landscape, to ensure good health for all (Chamberlain et al., 2017; Harris et al., 2019; Stockings et al., 2016). Prevention initiatives saves health care dollars; return on investment for prevention programs is strong. Cost-effectiveness is particularly strong for regulatory approaches such as restrictions on advertising unhealthy food to children and tobacco control restrictions, or taxation of unhealthy products like alcohol, tobacco and sugary drinks (Ananthapavan et al., 2020).

However, much of the burden of disease is driven by the social determinants of health, that is, factors such as where people live work and play, their access to education and employment, socioeconomic disadvantage, and the social and physical environment. Addressing the social determinants will therefore have a significant impact on health of the community. In order to do this, the health system needs to collaborate on prevention with agencies outside of the health sector, including education, employment, justice, welfare, infrastructure and planning.

This means prevention is best delivered via a systems approach – that is, addressing the underlying root causes via an array of coordinated approaches, including those that target the regulatory environment, the physical environment, and individuals.

With the unfolding climate crises, provisions also need to be made to address the environmental determinants of health. The water quality crisis in Walgett demonstrates how climate change has compromised access to safe drinking water, in a community that was already experiencing disproportionate levels of disadvantage (Earle et al., 2023).

Strategic reform to resource allocation is needed. NSW Health needs to put a greater focus on population health and health equity. More sustained investment in **prevention strategies** that target the social determinants of health at the personal, relational, and community levels, is essential to improve the health and wellbeing of all Australians, and to relieve pressure on public hospitals and emergency departments. NSW Local Health Districts (LHDs) should be provided with funding for prevention initiatives, that extend beyond delivery of prevention programs in clinical care. There should also be significant and sustained funding for primary prevention – including to non-government organisations (NGOs), community services and sporting organisations. Many organisations implementing prevention programs struggle to implement long term sustainable programs because of short and inconsistent funding cycles.

HEALTH INEQUITIES

Existing health inequities point to a need to focus on variation in care, particularly in rural/remote, Indigenous, culturally and linguistically diverse (CALD) communities and persons experiencing socioeconomic disadvantage. Sustained funding and investment in prevention, early intervention, and wellbeing in communities experiencing disadvantage is required to ensure optimal health outcomes for all people across NSW. Engaging communities experiencing disadvantage (outreach programs etc) in health care can be more costly and must be funded appropriately. Specially, greater funding should be allocated to Aboriginal Community Controlled Health Organisations (ACCHOs) to address health inequities in Aboriginal and Torres Strait Islander communities.

GOVERNANCE AND FUNDING MODELS

The health system is disconnected. Local decision making and greater coordination between primary care and LHDs is needed. Collectively, Primary Health Networks (PHNs) and LHDs should be enabled to establish community services to respond to local needs.

Aboriginal and Torres Strait Islander Health is a priority for many working in NSW Health. ACCHOs must be involved in decision making to ensure cultural safety in LHDs, and in other parts of the health system.

Current funding models do not support interconnection and collaboration, and are not fit to address health inequities. Activity Based Funding (ABF) is designed for the general population. LHDs with CALD populations face high demands and costs due to low heath literacy, and prevalence of chronic diseases, especially diabetes. ABF does not adequately recognise the demands of addressing the needs of diverse populations and means that health agencies working with such populations are not appropriately funded.

Innovative, coordinated models of care to essential to ensuring good health for all. The governance and funding structures in place in NSW do not enable innovation and coordination. There are alternative measures that can be considered, including value-base care funding models, funding models that promote patient centred care, and outcomes-based funding using Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs).

Funding for implementation

Further there is a need for funding for formal support for implementation in health care. Currently, Health Technology Assessments (HTAs) for Medicare Benefits Schedule (MBS)/ Pharmaceutical Benefits Scheme (PBS) item numbers are primarily concerned with effectiveness of services, technology, and new drugs, but do not provide formal assessment of *how* health systems and the people working within it need to change to accommodate new practices and procedures. MBS items are approved but often not used or used incorrectly. This leads to variation in practice, confusion amongst healthcare professionals, and increased inequities.

Allocated funding, and formal integration of implementation assessment, planning, and initial support – similar to that of HTA infrastructure – could optimise the impact of new services, technologies, and drugs.

PRIMARY CARE AND THE PREVENTION WORKFORCE

Comparatively low investment in prevention health programs in the community has led to more spending on treatments and hospitalisation for conditions that could have been prevented, or managed in primary care. However, cost and availability deter the use of general practitioners for many people. This leads to more hospital presentations and emergency department attendances, resulting in greater pressure on public hospitals and emergency departments. To deliver prevention, the public health and primary care workforce needs to be funded and developed. Priority should be given to these areas:

- Developing a multidisciplinary workforce, including training for clinicians and funding models that reward multidisciplinary teams.

- Identifying and better supporting the public health workforce, including health promotion practitioners, the multicultural community workforce and communication experts. Although NSW has a well-developed public health officer and biostatistics training programs there remain little formal opportunities for career pathways for others in the public health workforce. Similarly, there is an important need for broader and more easily accessible training pathways for data analysts and epidemiologists to ensure sufficient supply.
- Improving the recruitment and retention of Aboriginal Health Workers. Fostering cultural safety in health organisations is imperative to achieving this.
- Implementing community health worker programs for chronic disease and aging. The National Health Service (NHS) in the UK has implemented community health services. UNSW has piloted a community health navigator platform – there is scope to evaluate and adapt this for greater community needs (Mistry et al., 2023).
- Developing and funding the Nurse Practitioner workforce.
- Continuing to fund Urgent Care Services and after hours services (for patients presenting outside of general practice clinic times).
- Continuing funding for Assistant in Medicine (AiM) roles to enable senior medical students to boost workforce capacity in NSW hospitals.

DATA GOVERNANCE AND INFRASTRUCTURE

The NSW health system generates ever-increasing volumes of data, but access to these for analysis and research remains slow (at least one year from initial request to receipt of data) and costly. Although linked data are available through the NSW Centre for Health Record Linkage (CHeReL) and Lumos (including general practice data) there is lack of clarity about governance and approvals processes for hospital electronic medical records (EMRs), which increasingly will support the development of AI-driven approaches to personalised patient care. International experience demonstrates that enabling secure access to de-identified health system datasets by pre-approved external teams, with appropriate governance and controls in place, amplifies research and innovation, and improves patient well-being, productivity and the efficient use of resources. Long-term large-scale partnerships between government, universities and medical research institutes are a highly efficient way to support data-driven health system innovation, as exemplified by international initiatives such as Health Data Research UK.

To drive innovation, it is important that NSW Health establishes a clear governance mechanism and unified infrastructure to streamline and simplify access to statewide, linkable de-identified health-related data, including hospital EMRs, for a broad community of potential users, including external scientists and analysts.

Investment in disease and population-specific data repositories and registries is also insufficient in NSW, with no clear strategy regarding how these will be prioritised or supported. By contrast, Sweden puts a quarter of its health budget into funding disease registries and quotes at tenfold return.

Furthermore, meeting the growing need within the health system for people with skills in data science and AI, requires an investment in workforce development in these capability areas across NSW Health in its entirety, in particular the LHDs.

Contact for the School of Population Health submission

To discuss this submission further, the Inquiry Team are welcome to contact Scientia Professor Rebecca Ivers AM FAHMS FRSN, Head of School, School of Population Health, Faculty of Medicine and Health, Chair and Director, [redacted]

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