Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At Level 2, 121 Macquarie Street,
Sydney, New South Wales

Wednesday, 11 December 2024 at 2.00pm

(Day 068)

Mr Ed Muston SC	**(Senior Counsel Assisting)**
Mr Ross Glover	**(Counsel Assisting)**
Dr Tamsin Waterhouse	**(Counsel Assisting)**
Mr Ian Fraser	**(Counsel Assisting)**
Mr Daniel Fuller	**(Counsel Assisting)**

Also present:

Mr Richard Cheney SC with Mr Hilbert Chiu SC for NSW Health

THE COMMISSIONER: Good afternoon.

MR MUSTON: Thank you, Commissioner.

This afternoon we have four witnesses in a panel, Dr Jo Mitchell, Ms Nadia Mastersson, Professor Andrew Wilson and Dr Martin McNamara, who are the authors of a document entitled, "Expert report 2: Strengthening the focus on the prevention of chronic disease through applying evidence based insights." I call those four individuals.

THE COMMISSIONER: Yes. Would any of you like to give an oath - all affirmation? We can do it all at once, then.

<JO MITCHELL, affirmed: **[2.02pm]**

<NADIA MASTERSSON, affirmed:

<ANDREW WILSON, affirmed:

<MARTIN MCNAMARA, affirmed:

THE COMMISSIONER: Go ahead.

MR MUSTON: I might start by asking each of you to just tell us who you are and the organisation you represent when you are not contributing to reports such as this one. Perhaps starting with you, Dr Mitchell, moving along the desk.

DR MITCHELL: Yes, my name is Jo Mitchell. I've worked in the prevention space for more than 35 years. That included working in local health districts and then in the Ministry of Health, which I left five years ago, and I'm now pursuing a - I have a small consultancy business, but I have also been a senior adviser to the Australian Prevention Partnership Centre and it is through that connection that I was brought on to this project.

MS MASTERSSON: Nadia Mastersson. I'm the head of prevention at the Sax Institute and I lead the Australian Prevention Partnership Centre.

PROFESSOR WILSON: Thank you. I'm Professor Andrew Wilson. I'm the co-director of the Leeder Centre for Health Policy, Economics and Data. I'm also - was the co-director of the Australian Prevention Partnership

Centre. I've worked in the - I'm a public health physician by background. I've worked in the area of prevention for, I don't know, about 40 years.

I also just note, for the record, that I have had many roles with NSW Health as well, including chief health officer in the past, and I currently chair the board of the Clinical Excellence Commission and just note that any comments that I'm making today I'm making in my role as one of the authors of this paper and not for NSW Health.

MR MUSTON: Dr McNamara I think you introduced yourself yesterday --

DR McNAMARA: Yes, correct.

MR MUSTON: -- so unless anything's changed within the last 24 hours, we can take that as a given.

I might start with you, Ms Mastersson. Could you explain to us what the prevention partnership is and how it operates?

MS MASTERSSON: Absolutely. So the prevention centre, the Australian Prevention Partnership Centre, is Australia's leading collaboration of policymakers, researchers and practitioners who are focused on prevention. So coming together to bring best evidence into practice and policy to ensure that we best use resources to make change to improve health and wellbeing of Australians.

MR MUSTON: You've each contributed to the report, "Strengthening the focus on prevention of chronic disease through applying evidence based insights", dated 29 November 2024?

MS MASTERSSON: Yes.

PROFESSOR WILSON: Yes.

MR MUSTON: The views expressed in that document remain views that each of you hold as you sit here now.

(All participants nod)

MR MUSTON: Thank you. Commissioner, that is document [SCI.0011.0608.0001].

Do you each have a copy of that available? Excellent.

You tell us in the first 18 to 20-odd paragraphs of the significance of prevention and the burden of chronic disease that can be potentially avoided by prevention. I think, unless there is anything in particular that you think you would be able to assist us on in relation to a nuanced understanding of that, I think we can take it as a given that the evidence that has been received by the Commission overwhelmingly supports the proposition that there is an increasing burden of chronic disease which needs to be addressed through preventative measures.

In terms of the impact, though, of doing so, there has been some debate amongst submissions that we've received about the extent to which focusing on prevention has the capacity to result in savings within the health sector as opposed to potentially deferring those health costs to a later point and having them manifest themselves in a different way.

Is there a comment that any of you would like to make in relation to that? Perhaps starting with you, Professor Wilson? I notice you're nodding knowingly.

PROFESSOR WILSON: Look, I think we've got to just be clear that, first and foremost, prevention is not about saving costs in the healthcare system. It's about improving and extending the quality and length of human life, which we've done very, very successfully for the last 150 years, about improving wellbeing and about reducing inequities.

A side benefit of that, from my perspective, is that we may reduce the load in certain areas within the health system, within the healthcare system, but the demand for care is such that anything that is saved is rapidly filled by other needs, and also, in that extending life, it is almost inevitable that there will be some increase in burden of chronic disease. That's because every age cohort carries with it the exposures that they've had from their life experiences. You can't necessarily remove that, so some disease burden associated with that is inevitable. We can do a lot to prevent some complications from that and, obviously, also to treat it, and that, therefore, then generates costs.

THE COMMISSIONER: When you say - when you talk about the "side benefit", that you just talked of, reducing "the load in certain areas within the health system". By "reduce the load", do you mean the need to provide certain services or reducing costs in certain areas or both?

PROFESSOR WILSON: It could be both, because you may actually reduce the incidence of disease; you may reduce, therefore, presentations with new cases. So, for example, between about the end of the 1960s and 1990, life expectancy in Australia grew about seven years. It's a phenomenal observation in human history. It's what got me interested in prevention. And what was the main reason for that? It was the reduction in smoking and an increase in better blood pressure control during that period of time.

THE COMMISSIONER: I was going to say, and I'm introducing this in the most general of terms, but another co-benefit of some prevention, interventions and tobacco - reduced rates of tobacco smoking is one area where there's really clear economic evidence that there's economic gains either with increased productivity, et cetera, as well as reductions to healthcare costs, as one example where there's been a lot of evidence of other co-benefits to just keeping people healthier.

PROFESSOR WILSON: As I say, it is a benefit. It's just that it isn't the primary reason that we prevent disease in the first instance, in relation to that.

Yes, there is clear evidence that prevention does improve productivity. That's actually been accepted by the Productivity Commission in a report looking at chronic disease in relation to that, and so I think, you know, we are increasingly seeing the benefits of that increased life expectancy and what's happening --

THE COMMISSIONER: Very general also, there's plenty of peer-reviewed evidence concerning - let me just call it the money benefits. Of course, there's a different primary aim, as you say, of, as an example, reducing obesity in children - is another area?

PROFESSOR WILSON: If you don't reduce obesity in children, you're probably never going to deal with the

epidemic that we have of obesity. We've got some new drugs becoming available which clearly, for the first time, demonstrate that they can reduce this. And so I think it will become a bit like blood pressure, that for that cohort of people who already, like myself, have obesity, it will be a control measure that we will have for that.

But as a society, if we don't want to live with that epidemic forever, then we have to address the determinants of obesity, and to do that we have to act early because we know this is a pattern which is set in childhood.

THE COMMISSIONER: Sure, yes.

MR MUSTON: You touch on that as an example in paragraph 24, as an emerging health issue that will require a prevention response. I gather in the second bullet point there at the foot of page 7, the emerging health issue is the development of Ozempic and drugs like it.

I gather what you're telling us is it's an emerging issue because, to the extent that a drug like that becomes available and it's able to treat or assist people with obesity, it's a cost burden which will be borne by the health system if we are to utilise it as part of our preventative or public health response to the epidemic of obesity?

PROFESSOR WILSON: So the point the paper is making is that we have to think about two aspects of this. I'll simplify it to some extent.

We need to think about the population prevention - that is, preventing the onset of this condition in the first place - and addressing the determinants that lead to people becoming obese; but we also need to recognise that we can do something about it once somebody is there and we can prevent subsequent complications of obesity, such as diabetes, osteoarthritis and a range of other conditions that we know are associated with obesity.

MR MUSTON: So Ozempic as a treatment is very much in that tertiary category of preventative --

PROFESSOR WILSON: Well, I guess there's a bit of an argument about that in terms of where you would see that happening, you know, how you would think about it. If you

think about it in my terms of thinking about it like blood pressure, like high cholesterol, then it is what I would call a clinical intervention. It's something we do to people, to individuals, to reduce their risk.

But we know that we need to address the other determinants like diet and like the dietary environment, like physical activity, as well as have available those treatments that will help people with this condition.

DR MITCHELL: I would also make the point as well that, with the drug treatment, there is also the requirement for also clinical support in terms of advice around diet, et cetera, as well. So it's not just a set and forget, that there's also counselling that happens with that, in the same way that should also happen for bariatric surgery as well. So not on its own is it a magic pill.

MR MUSTON: So is it the point that some of these sort of primordial and primary, and perhaps secondary, to the extent that Ozempic is not a secondary preventative measure, all of those primordial, primary and secondary also contribute to the prevention strategy that might be applied, even in the case of someone who has tipped into that debatably tertiary category of taking the Ozempic to get their weight under control - all of those other factors will continue to operate to the benefit of someone who has progressed to a level of disease in exactly the same way as they might be of benefit to someone who has not yet encountered that disease or is in the very early phases of it and potentially able to have their condition adjusted through those sorts of measures.

PROFESSOR WILSON: Yes. I mean, one of the points we make in the paper, in a more general sense, is that you need to think about your whole portfolio of prevention around a particular problem, and what you're describing really is that portfolio: what's the investment in activities across that portfolio that is likely to be able to address it and what's the balance in trying to achieve that in that regard?

At the moment, things are very weighted towards later interventions in relation to most of these problems, and if you actually take a more formal look at that, you would probably reinvest differently if that was your objective and you could - now, of course, you can't just freely move

money around the system - around the healthcare system, it's tied up in all sorts of different ways. But what we are saying here is that it's important to look at what investment you're making and say, "What's the best bang for buck here? What gives us the best quality outcomes for what we're trying to achieve with what we're prepared to put in?"

MS MASTERSSON: And what I would add to that is if you think about the upstream, or what you were saying is primordial and primary prevention, that is your best bet, because not only will it help shift those who are already requiring secondary or tertiary prevention, that will shift the entire population. So that is your population approach and that is why Andrew's referring to "best bang for buck", because it benefits everyone.

But more importantly, it has an equity benefit, so it will reduce the gap between those who are well off and those who are less able to control circumstances in their life. And when we talk about the later burden and we're talking about just moving people's disease status until later, well, in fact, if you work at the primordial level, you are changing the way they generationally will experience their health. So it's more than shifting it, it's actually changing. And so that has your best effectiveness, best sustainability and most equitable.

MR MUSTON: And potentially a multi-generational effect?

MS MASTERSSON: That's exactly right and that's why it has that strong equity benefit.

MR MUSTON: But one of the challenges with --

THE COMMISSIONER: Sorry, does that mean increased rates of healthy elderly people as well?

MS MASTERSSON: Absolutely. So it will stretch: it will benefit people across their lifetime by engaging early in the social determinants of health - so education, good employment, safe housing. So it will have longer-term benefits for that person, but it will have generational benefits for that family. So you will change the trajectory of whole generations in the long term. But it is a long game, but it is the most cost effective game.

MR MUSTON: To pick up on --

THE COMMISSIONER: Is that important also - and tell me if I'm wrong, because I might be. It's vitally important we shift the population to be healthier - I'll just use the word "old", I won't give an age - because if they're not, that's when things are really expensive for the health system?

MS MASTERSSON: Expensive for the health system, but also you're missing out on other co-benefits of prevention. So the productivity that is well proven, that Andrew spoke of, and if people - if we haven't shifted people's behaviour, that has impact on employment costs across the country, it has effects on environment, because people are choosing more packaged foods, they're not using active transport. There's the co-benefits of prevention - and it stretches beyond this Commission, which is on health care, but it has benefit to all of government.

THE COMMISSIONER: Yes.

MR MUSTON: Coming back to the Commissioner's example of the healthy older person, those benefits include that healthy's older person's children and grandchildren and potentially great grandchildren are dealt a better hand in terms of the social determinants of health; would that be, although slightly pejorative, a fair statement?

MS MASTERSSON: Yes.

PROFESSOR WILSON: Healthy nutrition is more than about obesity. We need healthy guides for a whole range of reasons, and we know that for the older people, their diets tend to be poorer, and by creating an environment where there is - where generally there is healthier nutrition, then we will have implications also for the nutrition which is available to older people.

So, you know, this comes back to a very basic tenet in prevention, which is if we can shift the population mean in relation to something, so we can make the overall blood pressure somewhat lower, while that, you know - while we'll still need to treat people with very high blood pressure, the overall preventive benefit is much greater if we can shift the mean for something like blood pressure, obesity and whatever, just down the scale a bit.

MR MUSTON: And that's where your primordial and primary and to some extent secondary forms of prevention are critically important?

MS MASTERSSON: Yes.

MR MUSTON: In terms of that adjusting mean before you're actually getting into needing to treat those people who you might be able to treat once they present with, in your case or your example, high blood pressure.

PROFESSOR WILSON: It's also really important from an equity point of view, that we know a lot of these things have quite inequitable distributions, so who smokes in Australia now? Tobacco smokes now, it's largely poorer people, it's largely people who have mental illness, mental health problems or other situations like that. Rates are higher in groups who are significantly disadvantaged, like First Nations people.

Similarly, with obesity, with particularly severe obesity, there is a very severe strong socioeconomic gradient. Some of the highest rates of obesity in the world are in some of our First Nations people, for example, from the Torres Strait.

We have to think about how we address those problems because they are determined very early in the course of people's life journey and in fact, you can actually think about them as being intergenerational in terms of the way these things are developed.

MR MUSTON: Does anyone else want to comment on that?

At paragraph 32 you have set out for us, by reference to some useful examples, the different levels of prevention. Accepting that they're probably not crisp categories and there will be a degree of drift across the two and views might differ as to which one something fits into, but I guess if we could focus our attention just for the moment on the first three, primordial, primary and secondary prevention, what role, in your view, should the Ministry of Health be playing in relation to each of them? Accepting, as you have told us, that these are whole of government issues, but whole of government can, in its own siloed way, try to deal with things, but is there a role

for the Ministry of Health, do you think, in relation to those three categories, and, in particular, one and two - that's primordial and primary?

DR MITCHELL: I would say definitely yes, and the following diagram is one that Queensland Health has developed, which also sort of demonstrates the role of a ministry or a Department of Health across all of those areas.

In terms of the primordial prevention, which, as we've said before, is more up - the upstream and the determinants focus, yes, health does have a role. So, for example, in New South Wales, there's work that happens between transport and health, to support and encourage active transport, and also with education, et cetera. So health has a role in supporting that work, providing some of the evidence and looking at how to link that up with other programs of work as well.

MR MUSTON: What's the nature of that relationship, insofar as you are aware, between health and - using your example - transport?

DR MITCHELL: I think that relationships across government, they change over time, and there are different imperatives at different times to be working with your interagency colleagues. So, for example, probably seven years ago there was a premier's priority on childhood obesity, for example, which sort of forced some of those connections and sort of gave a stronger authorising environment for that kind of work to happen.

So the Department of Health had been working a long time with education, for example, around the issue of healthy food in school canteens, and it was very difficult, over many, many years, to get traction, but when there was that stronger imperative and expectation, there were some break-throughs as well. So that, as a policy position, is now embedded in a way that it hadn't been before and it included monitoring and reporting on achievement of that as well.

So I think it's fair to say that it differs over time. The strength of the expectations is important, and also what's important too are the interpersonal relationships that policy officers have with their colleagues as well,

and that's often built up over time.

MR MUSTON: Accepting that it will vary obviously from program to program, what does that monitoring - what should that monitoring look like? We heard some evidence yesterday about healthy eating strategies in canteens and no doubt an excellence suite of policies that identified the perfect lunchbox fillers to be provided in school canteens, but the very limited extent to which, at least in Hunter New England, that was found at a particular point in time to be reflected in what was actually being sold in school canteens. Is there a role for the Ministry of Health in policing that, for want of a better term?

DR MITCHELL: Yes, I mean, I think there is always sort of arguments for and against that, but five years ago when I was at the ministry, there was work that was happening around providing support to schools to meet the standards for school canteens and, you know, there's an expectation of, you know, the different kinds of foods that are included. So, you know, sometimes that can get a little bit down in the weeds as well about what is in and what is out, et cetera.

But my understanding is that there is a separate organisation that has been commissioned to look at that as an issue and provide an external look on and a review of menus for school canteens. It's not perfect, of course, but I think that was quite a step forward but required quite a lot of negotiation at that time for that to become something that was accepted as reasonable on both sides.

MR MUSTON: One of the challenges is - sorry, Professor Wilson, you were, I think, going to say something?

PROFESSOR WILSON: I think you just need to sort of separate a little bit the primordial and primary and secondary. I mean, clearly, in the secondary space, you know, as listed here, identifying responding to disease through early detection and intervention is clearly primarily the responsibility of the health portfolio, albeit broader than NSW Health, and it needs to involve primary care, of which New South Wales is a contributor but not the primary purpose in relation to that.

MR MUSTON: Just on that, to the extent that the health

ministry might have an involvement in or might be the beneficiary of patients detected through a screening program, obviously decisions around funding for these sorts of programs need to extend to the adequate funding of services to then pick up the people who have been identified through a screening program and provide the intervention that they require.

PROFESSOR WILSON: Currently being introduced is a screening program for lung cancer, it's a really good example. We have done really good work in preventing tobacco in New South Wales, around 10 per cent of people continue to smoke at present, and they are hard core, the type that I described before, in terms of trying to do anything about that. But there are several decades of people who have been exposed to tobacco for which there will be an ongoing problem in relation to that, so we have a screening program to try and detect this disease. We know if it is treated early, you get better results, for a whole range of reasons.

But it's not an easy cancer to treat. It's not an easy cancer to detect or treat. So even though we know we can do it, you are absolutely right, you need a very well developed program which has lots of quality controls in it to ensure that people get - who get screened, detected, then get an appropriate treatment for that to get the benefit from it, because just detecting the disease is of no particular benefit if you don't get adequate treatment for it.

MR MUSTON: And would the same apply in the case - an example that we've used almost to death in the Commission is the Brighter Beginnings program, which detects developmental challenges that kids face. A wonderful program if you screen as many children as possible, particularly those who don't have worried well parents who are taking them to have them screened themselves, but the benefits of that program from a prevention point of view, if it is a species of prevention, are limited if, having detected them, there is not an adequate suite of services available within a timely way to deliver intervention?

PROFESSOR WILSON: This comes right back to the start of your question, which is: what's the role of health, of the health portfolio - let's keep it generic - versus, you know, other portfolios? Because most of the responses for

something like that probably are not going to sit within the health portfolio.

You know, if we have a program for the detecting of those sorts of problems, then it has to be a whole of government program that says, "Okay, what are we going to do about these kids", because they will need educational support, they may need better social care supports in some situations and a range of other things that would need to be considered.

So I think the further down that pyramid you go, the more you have to have a whole of government approach and you have to have a way of approaching it, and I think if government decides that it's good enough to do it, then it has to think about what are the contributions of the different parties to do that.

I guess, to me, and I say this with a lot of experience across health services both here and in Queensland, et cetera, it's always been a challenge to try and get that so government recognises what the need is but there is - it sort of then says, "Oh, well, health minister, you solve this problem." But actually, that's not the - you know, the health minister doesn't control all of government to do so. There needs to be a mechanism to get that full engagement if you're going to take these sorts of approaches.

So I think - I'm stressing here, it is a limitation of the structure, not of what NSW Health or any other health department can do. It's because you need that whole of government approach once you - when you get down to the - you know, when you are in that sort of primordial or primary prevention space.

THE COMMISSIONER: A number of the recommendations, for example, in the national prevention strategy or the national obesity strategy require - would require action by government that would have nothing to do with the Department of Health or the Ministry of Health - for example, where you put a tax on sugar or increase a tax on a particular unhealthy food or run an advertising campaign or something. They sort of require different levels - require commitment from places outside of health.

PROFESSOR WILSON: Absolutely.

THE COMMISSIONER: And without that - I mean, I'm sure the strategies that have been put together are excellent and by people with great expertise and experience, but without those commitments, there's big holes in the strategies, or at least the implementation of the strategies.

DR MITCHELL: The implementation.

MS MASTERSSON: I will add to that and return to your original question. If we recognise that in order to do primordial and primary prevention, the majority of the action does occur outside the health sector, that is correct, and so therefore we need a whole of government response. But who is going to lead that whole of government response?

So for me, the answer to your question is the New South Wales ministry should provide leadership and advocacy for how the normal day-to-day business of other sectors affects the health of and wellbeing and productivity of our population. So that is critical. So if there is no one department who can take leadership for something like that, that is a whole of government approach, it will fall down. So although health doesn't have to do the business, it needs to lead, coordinate and advocate for that to occur, but with whole of government support and infrastructure and processes in place for that to occur.

MR MUSTON: So you see the Ministry of Health having a potential beneficial role in being, as it were, a gatekeeper or coordinator of activities occurring across the full spectrum of government so as to enable the spending in those various sectors of government to be deployed in a way that best delivers bang for buck, to use the term you used a little bit earlier?

MS MASTERSSON: Absolutely, because we're not saying that just by NSW Ministry of Health being responsible for leadership and coordination, that they should then fund the activity that occurs in each of these departments. Each of these departments and sectors have funding to deliver their services. They just need to deliver their services in a slightly different way and be supported with evidence about how to change the way they deliver those services.

MR MUSTON: But does the ministry potentially also have a slightly greater ability than some of the other agencies to deal with the prioritising of some of these strategies?

Let's take a probably silly example of money that's potentially available to spend on a bike path or some sort of outdoor activity. You can't build them everywhere, unfortunately, within a limited budgetary envelope. There's some money which is potentially available through or to be made available to transport to build an active transport corridor, and the Ministry of Health perhaps has a better idea than the ministry of transport as to where, geographically, if you can only build one, that one should be built to produce the best bang for buck in terms of prevention, at least, until the other ones can be built as well.

MS MASTERSSON: That advisory and evidence role is critical.

DR WILSON: And as is --

DR McNAMARA: Sorry, Andrew. I was going to say that one of the challenges here, of course, is the alignment of interests between these different groups within government, the alignment of interests between transport's priorities and health's priorities, and I think when you think about action at the primordial level particularly, thinking about how you find the levers between - across those different agencies, the health department thinking it's a great idea is fantastic. Also thinking about what's in it for the transport sector, what are their benefits, how that might align to their interests, is a really important component of this. It can't be underestimated, the effort that might be required on that to actually have success.

PROFESSOR WILSON: So the Australian Prevention Partnership Centre, which we shorthand to the prevention centre, has been going for just over 10 years and we - it was a national initiative and we involved some really fantastic people from all over Australia and internationally.

One of the groups that was involved in that was led by Professor Billie Giles-Corti, from Victoria. Billie's had a focus on the area - on the issues around the built environment and how the built environment influences

health, influences factors like physical activity, green space and activities like this.

One of the things that Billie brought to the partnership was this long experience of being able to get - of working with people outside of the health portfolio, of working with the people who were responsible for design of the built environment, transport, et cetera. You know, she kept us sort of thinking about those issues, that these things require an interaction, they require effective interaction with other agencies. You have to work out what are the wins for both sides, in trying to do this.

Yes, so I think that issue is really still an ongoing challenge in the early prevention sort of space.

MR MUSTON: Just to use my silly example of the bike track, there could be a range of places that you could build bike tracks in Sydney but that coordinated approach between different branches of government might mean that the money that you have available to build it is best deployed and able to be deployed in an informed way, informed by a particular socioeconomic demographic and the health profile of that demographic and the extent to which an increase in physical activity might really produce greater benefits than it would in an affluent beach-side suburb with lots of gyms, for example. The location of schools and other catchment populations, which might be an education piece, to say, "Well, if you build it here, that's great, but that's not actually going to get kids who travel to school from this catchment population using it because they all go in the other direction. But if you build it in a slightly different location, then you've got a group of people who might be using it", and then, of course, you have the infrastructure piece that says, "Well, can we do it here and how does that work?"

PROFESSOR WILSON: This is why you need the whole of government thinking about this. There's a lovely example in the Sydney Morning Herald today which is about overcrowding on two school sites in Western Sydney, I think they're primary and secondary school sites. They are talking about, you know, the proliferation of demountable builds and building play space.

MR MUSTON: Yes, 106 demountables.

PROFESSOR WILSON: That is a really good example that says, "Well, wait a minute, yes, there is an education imperative here, kids need education", and that's something I think the prevention community is becoming increasingly sensitive to, post-COVID. But at the same time, there are actually structurally ways that you can address that and is that a priority for government to address that because it will actually give better educational facilities, but it will have this benefit that kids will have space to play, hopefully might even gets some green space as part of that, which is likely to substantially add not only to their educational experience, because we know that kids that are physically active actually perform better in their schooling, it will have physical benefits for them as well, as mental health benefits.

MR MUSTON: Part of the challenge is translating what are no doubt often noble policies, like the healthy eating strategies and the like, into lived reality. How do we go about doing that structurally? Are there levers that need to be pulled or structures that should be in place in order to translate what might be a wonderfully crafted policy into something that actually produces outcomes on the ground, in circumstances where, without those mechanisms, it might not?

MS MASTERSSON: I think there are two steps to that. One is to have the problem identified and have it accepted by government so that it becomes policy, because often there are plenty of policies out there that are needed that are not there, so it's a policy decision not to have it there.

Once the policy is decided that it is required and there is that authorising environment, there is that very nuanced way of working that we've been speaking about, about that mutual benefits approach, other people call it "Health in All Policies" approach, which is a little health imperialistic but, essentially, it is how do we achieve your sector's outcomes and the health outcomes for the community by working together?

So in terms of whether there's infrastructure that needs to be in place, again, it is advocacy for a whole of government approach so that is that leadership from government that's required, and then structures in place. But to do it carefully, so that you don't end up with committees that are simply meeting and rubber stamping

steps rather than making significant change.

DR MITCHELL: And in the area of obesity as well - and sort of food environments, for example - there's the added complexity of different levels of government as well. So that sort of, again, creates that complexity about the way in which those decisions are made.

As Martin has pointed out as well, the different interests in the status quo or, you know, opposing some of those bigger policy issues that have - or bigger legislative options that have been proposed for some time as well. It's a very contested space in terms of different interests and wanting to keep the status quo versus looking for change as well.

So that's a big challenge in all of these strategies - the obesity strategy but also in the - well, probably particularly in the obesity strategy. But, you know, we've also seen examples where some of those big changes have happened, for example, tobacco, but that wasn't a quick change, either, and it was not just a sudden success. It sort of was changes that happened over quite a long period of time, which sort of started, for example, with, you know, looking at billboards as the first stage of removing advertising and then, over time, that built.

It would be really great to be thinking about what's the way that you can fast-track that kind of a development so that it doesn't take 50 years to see reductions in - well, you know, to get to the great outcome that we have but still places to go in terms of tobacco smoking: how can you fast-track that? And it's a perennial challenge, particularly as, you know, prevention is not the primary focus across the board.

MR MUSTON: They're strong fiscal drivers.

DR McNAMARA: I think some of this does connect a little bit to the discussion yesterday, and I'm not sure if I can draw that in exactly, but --

MR MUSTON: Please do.

DR McNAMARA: I think there's a set of things that are going to drive action, one is what is the evidence base telling us about what should be done and what does the

research evidence show might be effective? Then there's a set of things to think about around how you might implement that evidence in the real world. And so there's, like we talked about yesterday, challenges around scaling, challenges around introducing action at local and system levels that need to be thought through.

I mean, Nadia might want to speak to this too, but some of the ways that the prevention centre is positioned is part of Australia's infrastructure as it relates to how you think about what the evidence base is around what might work in prevention and how you organise efforts to implement and use that evidence base in local systems. That's one of the reasons for being for the prevention centre, and that's part of the infrastructure that we have available to drive the prevention agenda forward.

MR MUSTON: But in relation to that, though - and I guess what I'm trying to explore - there are a range of things consistent with what, I think, Dr Mitchell, you have just indicated, we've known for a very long time. Like, the harmful effect of gambling on society, for example, whilst not a health issue, it certainly contributes substantially to the social determinants of health. But we all know that --

THE COMMISSIONER: I think it is a health issue.

DR MITCHELL: It is a health issue. Yes, I'd agree.

MR MUSTON: I will accept it as a health issue as well. But we see what feels like significant inaction in relation to this issue that everyone knows needs to be addressed. How do we cut through that structurally?

PROFESSOR WILSON: I think if you work in prevention, one of the first things you have to do is develop a very high sense of tolerance of frustration, but you also - you need - you have to think about the sorts of timeframes in a different way to treating - you know, to clinical medicine, in terms of what you're going to achieve. It's unusual that you get really big changes suddenly overnight. It does occur, but, you know, it's unusual. It's more that it is an incremental process.

As the Commissioner identified before in talking about obesity, you know, there are a range of things that we

progressively could do that can progressively increase in relation to this. But it's going to take years, and one of the --

THE COMMISSIONER: You mean the time horizon --

PROFESSOR WILSON: Yes, the time horizon, yes.

THE COMMISSIONER: -- for interventions like childhood obesity is you get the pay-off but it might be when the people are in their 30s, 40s, 50s, when there's a health pay-off for them, but also it's not until that later period you get the co-benefits like economic benefits as well?

PROFESSOR WILSON: Yes. Not just that. What I'm thinking of here is that it's sort of almost a ratcheting up of interventions that you do over time; and sometimes, you will have an environment, political, whatever, that's conducive to a lot of change; and sometimes you'll be in an environment where there will be little opportunity, and sometimes even some backward steps in relation to that. But what you're aiming to try and do over time is have an idea about the things that you want to achieve that will eventually get you closer to, you know, a full range of interventions in relation to that. But it will take time.

And the other thing it requires is it requires - and, sorry, just before I finish the time issue, Jo before referred to an earlier government initiative, earlier government's initiative in relation to childhood obesity. I mean, there was a very good plan developed around that childhood obesity intervention. The problem is that the government of the day, you know, lost interest in it, whatever - actually, we had a change of premier, from memory - and, you know, so it didn't progress, and the prevention area is riddled with these policies, which are good policies, even good programs, which have been put in place, but which have not been given --

THE COMMISSIONER: They're put it in place for a couple of years and then something else --

PROFESSOR WILSON: The prevention centre actually did some modelling, some very clever modelling, around the childhood obesity interventions and showed the sorts of timelines that you were going to require for this, and it was - you know, it was several periods of government, not, you know,

one period of government, and, of course, that's very difficult to maintain a sort of interest over that period of time.

THE COMMISSIONER: On this time issue, for all of you, is it the greatest roadblock for funding for prevention issues the time horizon that you might get benefits from them? What I had in mind --

PROFESSOR WILSON: It is sustaining the program rather than the time horizon. It's sustaining the effort, that these things take time and you have to be able to sustain the effort.

So that's why, you know, legislative change, regulation, you know, is good, it's nice, because once you have done it, it's unusual for you to go backwards. But if you are talking about something, you know, like changing the dietary - changing the nutritional environment, changing the food environment, you know, there's a whole range of things which might come from that. You referred to taxes on SSBs --

THE COMMISSIONER: Let me change my question then. Is the time horizon a problem if you are seeking new money, extra money, for a particular prevention program, intervention, whatever we call it, you've got to convince government that it's worthwhile making the investment?

MS MASTERSSON: But you've got to convince multiple governments at multiple time points to continue to invest in something that the previous government invested in, and that is the difficulty.

THE COMMISSIONER: Yes. But ultimately, you have to convince, let's just stick with New South Wales - we'll have to convince an expenditure review committee or treasury, whoever, that extra money should be provided for this particular purpose which is a prevention policy, program, intervention. And I imagine to get new money for something like that - Mr Muston mentioned gambling as a problem. I mean, in relation to that, government would look at what are the revenues we get from large amounts of people gambling in society, and what would be the benefits if we reduced the rates of mental and other illnesses caused by gambling if we brought in some regulation on the gambling industry so that they can't advertise to children

on certain platforms, assuming children can still get access to them, et cetera, et cetera?

But also, if you were bringing in - you know, take The First 2000 Days program. To get additional money for particular interventions in relation to that, I imagine you've got to go through a form of - well, the government would require a business case, there would be a cost benefit analysis associated with that, but the time frame would be really long as to when you get the - it would be way outside the lifetime of any government.

And no doubt you could model it and no doubt the modelling would be really difficult, but I've seen modelling done in all sorts of ways. You can do it. Usually the results are wrong but how close they are to right is important. You could no doubt model it, you could model the benefits of productivity, extra income tax, lack of absenteeism, et cetera - all sorts of things. But the time horizon would be very long. Is that a big impediment in relation to getting funding for prevention, or am I completely missing the point there? Any one of you - all of you.

PROFESSOR WILSON: So clearly, governments like to see results as quickly as possible, preferably within their term of government, because they want to, you know, rightly, demonstrate to the community that they've made sensible investments.

THE COMMISSIONER: See, right on that point - sorry to interrupt - I was thinking the other day, Sydney Metro was a government investment. It's got a long-term benefits horizon. Like, it might be 30 years you're still getting productivity gains, but you get a benefit on day one that it opens.

For prevention interventions of the kind, like early childhood or stopping smoking or healthy eating, you're not going to get a benefit on day one, you're not going to get a benefit probably in a four-year or a three-year electoral cycle, it's longer.

PROFESSOR WILSON: I don't think that's always the case. I think there are examples where prevention can have impacts very quickly. So, for example, interventions in women during pregnancy who smoke. We know that, you know,

if you target those, you can reduce smoking rates, it has immediate benefits in terms of both the health of the mothers and the health of the children subsequently, good data for that. So there are interventions where you can do this.

THE COMMISSIONER: Yes.

PROFESSOR WILSON: And I also just have this rule that this sort of thing - that I believe, that in any government, there are opportunities to introduce ideas for prevention. It may not be exactly what you want to achieve, but in that notion of ratcheting up, of having this long-term program, you work out for the government of the day what it is that is likely to be acceptable in that.

Some governments won't want to go near, you know, intervention such as the type that you are talking about. But, you know, they may well be more comfortable with the idea of a nutrition program in schools, so you take that opportunity to - you know, that's where you focus in relation to it.

So you have to be sensitive to the political environment that you're working in and public health has been very good at sort of mobilising to try and get these things to happen across a whole range of areas.

But as I say, you don't always get what you want at the same time, but you have to have that long-term view: how do these things tie together and how do we bring them together?

The sugar-sweetened beverage one I find a really interesting one. Taxes on tobacco generate a lot of money, and that's why treasury likes them in terms of what's there. It generates, in some people's estimates, more money than the cost of treating lung cancer and other complications of the disease. I'm not sure I actually believe that, but that's what's claimed in relation to it.

So if you think about sugar-sweetened beverages and having a very small tax on sugar-sweetened beverages, it would generate a significant amount of income. The Grattan Institute, for example, has modelled the sorts of returns at different levels of return in relation to that, and would finance potentially some of these things that we need

to happen.

But it has proven extremely - like, it's not a new idea. This has been around for probably 10 years, and the evidence base for it has been growing, that it actually has an impact.

So, you know, thinking about the barriers, so when - so I think at some point in time it will happen, but it will require us to sort of have, one, an overwhelming basis of evidence; two, to have spent a lot of time working with all the different partners to make sure that they see themselves as not losing out. Like it's highly unlikely that the SSB industry - sugar-sweetened beverage industry - is going to lose out. They'll just their switch their sweetener.

THE COMMISSIONER: Do other countries have --

PROFESSOR WILSON: Yes, and they have not suffered as a result of SSBs. The sugar industry is an important industry in Australia, not so much in New South Wales, but particularly in Queensland it still remains a big industry. So you have to address that. You have to recognise that that is going to be an issue that you are going to have to deal with. But we did it for tobacco and I am sure we will do it for this space as well. But the risk in --

THE COMMISSIONER: I think if I recommended the introduction of a sugar tax, it probably - I suppose I could recommend it, but I'm not sure it's within the power of the New South Wales Government to do.

MS MASTERSSON: It is within your power to advocate and work with the Commonwealth, who have interest in it.

DR MITCHELL: But there are leadership roles that can be looked at in New South Wales as well.

THE COMMISSIONER: Of course.

DR MITCHELL: If we think of advertising on government assets, for example, or what's available in government facilities, they are important opportunities for leadership and to demonstrate that you can make some of those changes and, you know, the world doesn't end.

So those sorts of demonstrations are really important, because one of the other elements of this, too, in terms of those big legislative changes as well is that there needs to be community support for that for the courage to do those sorts of things as well. And so if people have the experience that it's not saying that, you know, you cannot buy or you cannot consume these beverages, but that it's creating a healthier environment for your family, for example, in different places, then it sort of normalises it as not such a radical idea.

MR MUSTON: For example, the sugar-sweetened beverages that are available on my and no doubt most other railway stations through a vending machine, there's a government decision that has been made at some point to facilitate the sale of that product which, through a slightly different decision, could have --

DR MITCHELL: Could be different.

MR MUSTON: -- removed the opportunity whilst not necessarily changing people's desire to purchase it.

PROFESSOR WILSON: Coming back to your gambling argument, the one that irritates me is the ads on SBS. We know some of the most vulnerable communities for gambling addiction are non-English speaking, some of the non-English speaking background groups yet, you know, there are ads run on SBS, which is a government entity, which was set up to serve those communities, and yet we continue to run ads for it. I mean, hello?

That's a small step, you know, that could actually change, could be changed virtually overnight, and which, you know, would be part of a step - I'm not saying it's going to solve the problem, but it would be part of that sort of ratcheting up of controls.

DR MITCHELL: One of the challenges, too, and you talked about the long time frame as well, but sometimes, you know, some of these interventions can create a very small impact. So, for example, if you are thinking about advertising in public transport, for example, some modelling might suggest that you could reduce the kilojoule intake of a child by 12 kilojoules. That's meaningless. But at a population level over time, it is actually an important change. It won't solve the problem, but it is one of those steps along

the way that Andrew mentioned as well. So it's not - it's the laddering up, isn't it, it is sort of the building up?

DR McNAMARA: I think picking up on Jo's point, there is something about the shorter-term measures that tell you something about how you're tracking towards the longer-term ambition. So the decades that it might take to turn around the obesity curve, there's going to be a whole lot of intermediate points along the way where you see changes in community attitudes, increasing concerns around obesity starting to build up if the interventions are directed to the right areas. It's getting clear about what those short/medium term sort of measures should be that can tell you something about your pathway towards the longer term outcome. That is really important.

MS MASTERSSON: I'll also add to that. I think what we are speaking of is not a lineal process. So although Jo mentioned it is a small benefit to that individual, but we know that's population, we're not even accounting for the system shift that creates, because we're working with the complexity of prevention.

If you look at the whole system, that system shift will push New South Wales Government to think differently about another policy issue, which will then shift quicker. It will make Queensland Government think differently, it will make the Commonwealth think differently, and so it actually creates all these other shifts in the system in the right direction that are really hard to measure, but we are looking at how to measure system shifts, not just lineal behavioural and morbidity shifts.

MR MUSTON: I want to pick up on something you said a little bit earlier, Ms Mastersson, about it being not so much about the time, the length of time it takes to see results, but more being about the length of time you need to stay the course with a particular strategy in order to achieve any tangible results.

MS MASTERSSON: For me, I think that's one of the biggest challenges, that we have been successful over the years in getting funding but as Andrew pointed out, it's that ceasing of funding which has then cost - that funding that was invested is almost - not entirely wasted, because there have been system shifts, but we are then starting again at another time and another place. So if we count all the

losses that we've had over decades from stopping investment in policies, approaches, environmental changes, it's huge. So we need to look at that bipartisan support, ways to protect not only the investment but how the investment is made over time.

MR MUSTON: So the point you make there is - let's take the childhood obesity premier's priority of years gone by - no doubt a large amount of money was deployed through that premier's priority into a range of strategies, the formulation of strategies, reviews and research into ways of dealing with childhood obesity and formulation of a plan, which, if the premier's priority then changes, is money which has, in large part, gone to waste?

DR MITCHELL: I would just note, though, with the childhood obesity premier's priority, there wasn't new money, it was about bringing together and looking at doing things differently within existing resources.

I think, you know, there have been some benefits in New South Wales through the national funding through the national preventive health partnership, which was money that was for quite - I think it was a 12-year period, and it stopped prematurely, which had a devastating impact across the prevention community nationally.

Programs did stop, but New South Wales was able to continue some of the programs that had been established and, you know, that were able to be continued at scale in New South Wales as well. But certainly we see lots of examples of things starting and then not continuing or not being able to be continued at scale, which is a really important concept in prevention, from a programmatic perspective.

MR MUSTON: I look at your case example 2 on page 16 of the report and assume that at a time when it was seen as a government priority to deal with obesity, no doubt a significant amount of money went into the creation of the first of the two bullet points, but having created that, unless you then continue to provide a funding stream or funding streams in order to make and fund the consequence of decisions at the top, that that program was aimed at, that is one of those sunk costs that's produced a lovely piece of infrastructure that then, once priorities change, loses some of its value?

DR MITCHELL: Yes. Look, I think one of the key things around this particular cohort is that it's always changing, there's always a flow through as well. So particularly in childhood, the need to continue to have these interventions available is really important. You don't fix the problem.

MR MUSTON: No. Equally, the second bullet point, The Munch & Move, which, would it be a fair assumption to say that's an expensive re-imagining of Crunch&Sip, which I think is --

DR MITCHELL: Crunch&Sip is a component of Munch & Move. So Munch & Move is broader. Crunch&Sip is just one element. So it is - Munch & Move is a bigger program.

MR MUSTON: But coming to the more serious point, you can come up with Crunch&Sip and Munch & Move as fantastic and no doubt very carefully formulated strategies that have involved organisations like yours, no doubt a wide range of organisations deploying a lot of their own limited resources towards building, but telling everyone that they should be munching and moving and crunching and sipping for a few years and then moving on to another priority, even if the posters stay up in classrooms, ain't going to make a shadow of difference in terms of preventative outcomes.

PROFESSOR WILSON: Our health promotion people in New South Wales, we've been really lucky. We've got really some talented people in this area, and one of the things that they are good at is that when that sort of comes up, they sort of say "Actually, what are we trying to preserve here? What is the intent of what is, and can we repackage it in a way so the government feel like they are relaunching something, even though it's really following through on the same thing?"

So providing the strand of funding sits there, you can actually maintain it. And actually, it's not about - actually part of health promotion is that you actually do have to refresh your programs every so often. People do get, you know, bored, whatever, with them, and so that's, you know - so I think it's more important, what is more important behind it is maintaining the resource that's there and maintaining the intent of what you're trying to do. What the actual program looks like, can look like, you know, can be modified in that regard.

I think one of the other things to reinforce here is that what New South Wales does have is that it's one of the few states - well, it is the only state, actually, which has a substantive investment in building capacity in public health and prevention.

The public health officer training program in New South Wales is the only program in government in Australia that trains public health - people in medical and non-medical aspects of public health intervention programs. It has been a major part of the sustained capacity of NSW Health to maintain programs over a long period of time. It was started in the early '90s and has been going since. It has fluctuated in numbers and whatever over that period of time.

But it has also been a program which has responded to changes in the needs in the community. So when it started, it had a very strong, largely communicable disease focus, in terms of what it did. It now has a much broader - but that's still an important part because that's still something we have to address, as we saw with the COVID pandemic, but we're also broadening the skills within that cohort of trainees.

I just think it's really important to say here how that distinguishes the public health and prevention capacity in New South Wales from other states, and it would be a great pity to see that ever threatened.

MR MUSTON: If a body like that or a cohort of people like that, independent of political decision-making, were responsible for directing funding which was being deployed by government across all agencies into preventative health initiatives, that would potentially create - remove or reduce that risk of chopping and changing from one preventative health strategy to another with a change in government.

MS MASTERSSON: That would help but we'd want to make sure that it is multidisciplinary, because that is medical only focused and although that community is fabulous, what the strength of prevention is is having that multidisciplinary approach and understanding.

MR MUSTON: So if you had a multidisciplinary group of

people that crossed different portfolio areas - education, health, transport, no doubt others that I can't think of on the fly - and you had them together as a stable body which was responsible for driving decision-making around preventative health and the way in which preventative health dollars were deployed long term, would that potentially --

PROFESSOR WILSON: Well, a Holy Grail would be to have a prevention program, training program, of that sort which actually went beyond health and actually involved people who were in other portfolios, because there are different skills and different knowledge sets that you need to work in education or transport, than what you need to work in health. But, you know, it's a good start, what we've got at the moment.

MR MUSTON: Just having a look at your opportunity 2 on page 24, which is identifying mechanisms to increase investments in prevention, you point out there, at paragraph 114, that Australian Governments have already committed to increase investment in primary prevention over time. A commitment of that type, whilst no doubt good news from your perspective, it's not much use until the dollars start flowing and keep flowing. I'm just interested in the second sentence:

> *This commitment includes developing innovative, fit-for-purpose financing mechanisms to scale primary prevention interventions and reviewing and addressing health system barriers to prevention.*

That again sounds good, but what is it?

DR MITCHELL: I think it's fair to say that this is not a new commitment, as well, and certainly sort of - I think some of these efforts at that level were impacted by COVID as well, but, you know, one example of some of the ways in which that sort of thinking started to happen was - and we've referenced this in this report as well - that through an incentive payment as part of this process, Queensland Health commissioned some work to look at embedding prevention within the system and actually looking at, well, what are the things that will help to shift the system internally as well?

That's sort of really about building understanding and capability and building on clinicians' passion for prevention, but it's very much sort of in that downstream prevention, the clinical prevention as well.

THE COMMISSIONER: When you say "embedding prevention within the system", you mean clinical prevention in Queensland?

DR MITCHELL: Clinical prevention, yes, indeed. I think that distinction is really important as well, that as we talked about before, there's a role for health systems or health departments in the downstream prevention that we've been talking about, as well as the clinical, and so both of those things are important.

So I think it's sort of fair to say - and Andrew, you probably have more insight on this than I do - there are probably different things that people are thinking about there, which are sort of behind closed doors.

MR MUSTON: Can I quickly clarify something? You said there is a role for health in terms of the downstream as well as the clinical. When you use "downstream", are you talking about the primordial and primary?

DR MITCHELL: Primordial and primary prevention. As you say, there's sort of - there's fuzziness around the edges and so just having two down and upstream sort of helps reduce that fuzziness.

MR MUSTON: A role to be played for health in the formulation and implementation of prevention strategies which are aimed at preventing people from getting sick and darkening the doors of hospitals with illness before you get into that more classical stage, where the Ministry of Health might be dealing with screening to identify and intervene in disease?

DR MITCHELL: Which is good clinical practice, so prevention is part of good clinical practice.

THE COMMISSIONER: Can I just ask a question on the paragraph Mr Muston just drew your attention to about Australian Governments committing to increase investment in primary prevention over time, et cetera.

This is not a criticism, but there's a footnote 63, in the second sentence, and at least in my - I was looking for the source of that. At least in my copy, there's no footnote 63. Is that a reference, though, to the health agreement, the National Health Reform Agreement?

DR MITCHELL: It's in the National Health Reform Agreement, so it's in the public domain, yes.

THE COMMISSIONER: Okay. So in that, at least the addendum 2020 to 2025, we've got prevention as a long-term reform.

DR MITCHELL: Yes.

THE COMMISSIONER: In the period 2020 to 2025, was there much - I know in the Huxtable review there is a recommendation for a renewed focus on prevention, whatever that means, but also, in fairness, with I think some funding milestones, again whatever that means, but at least it's a reference to money of some sort. But would I be right to say that at least there was little progress in relation to prevention programs, funding of prevention interventions, in the period 2020 to 20 - well, we're not at 2025 yet, but in that part of the health reform agreement, or did something emerge? You're shaking your head, Professor Wilson.

PROFESSOR WILSON: To the best of my knowledge, there is nothing specific within the National Health Reform Agreement that actually carries dollars with it at the present time.

THE COMMISSIONER: That's what I wanted to ask.

PROFESSOR WILSON: But I think what Ms Huxtable was referring to in her review was that this is something that needs to be looked at.

THE COMMISSIONER: My reading of the national prevention strategy, and my research can certainly be imperfect, but whilst all aspects, I think, of the strategy I understood, I couldn't find any funding streams attached to it. And you're shaking your heads.

DR MITCHELL: That's correct.

MS MASTERSSON: That's correct.

PROFESSOR WILSON: There are some components of it which the Commonwealth has committed funding to, so there are some elements of it, but there was no overall commitment to the strategy as such.

THE COMMISSIONER: How should I think about this? The responsibility for prevention is both a state and Commonwealth responsibility, is that --

MS MASTERSSON: And local.

DR MITCHELL: And local government.

THE COMMISSIONER: Okay. There are aspects of - would I be right in thinking that there is at least an aspect, or perhaps even a significant aspect, of prevention-type clinical prevention advice, at least in primary care? Would that be right?

MS MASTERSSON: Yes.

THE COMMISSIONER: Which is a Commonwealth responsibility.

PROFESSOR WILSON: Yes. There's a significant amount of clinical prevention which goes on in primary health care, probably the majority of it, everything from --

THE COMMISSIONER: Might be GP, might be allied health --

MS MASTERSSON: Secondary prevention is primarily --

PROFESSOR WILSON: Yes, might be blood pressure monitoring, cholesterol, blood glucose, those sorts - you know, diabetes programs, obesity. There are also nutritional assessments made within the primary health care space, and, obviously, in the mental health space, an awful lot of work which is done in relation to that primary health care space.

I guess the thing that we're sort of trying to say in the paper here is, "Yes, sure, primary health care has an important and critical role in the sort of clinical prevention aspect, but actually, it's something that everybody across the healthcare system needs to think about", whether it's - you know, if you've got a patient

who is admitted for surgery, for a knee replacement, and they're obese, then the chances are, if nothing is done about their obesity, they will be back for the other knee, if it's not already having to be booked. And, look, we understand that orthopaedic surgeons are probably not going to take it on themselves to enter into a prevention process, but there needs to be mechanisms within the healthcare system so that those prevention things are addressed.

If the hospital system says, "Oh, well, that's not our responsibility, that's the responsibility of primary care", it just ignores the fact that this is a continuum of care and from a prevention perspective we have to have that across that spectrum. If you're not going to do it yourself, then, you know, you need to make sure there is a mechanism so that that issue is addressed, you know, somewhere else, and not just say "It's not our business."

THE COMMISSIONER: In terms of the national approach from the National Health Reform Agreement, at least in terms of the recommendations that Rosemary Huxtable made, a renewed focus on prevention, you probably all agree, at a general level sounds like a good thing. Having some funding associated, you probably all agree, sounds like a good thing, but beyond that, we don't really know any of the details. It's a wait and see. Is that --

PROFESSOR WILSON: So Jo referred to before a thing called the national health partnership --

DR MITCHELL: National preventive health partnership agreement.

PROFESSOR WILSON: That was an agreement which was a program which was an initiative under the Rudd government, I think.

MS MASTERSSON: I think so.

PROFESSOR WILSON: And there are attributes of that which really deserve reconsideration in terms of national negotiations.

MS MASTERSSON: Yes.

PROFESSOR WILSON: The prevention centre actually did an

analysis. We actually went to all the state and territory governments and asked them what they thought about it and tried to understand what it was - why it was such a - seen very positively by the states and territories. It wasn't just about the fact that there was money, because what the partnership agreement did was it said, "Here are some expectations that you will deliver for this money." Right? So it was outcome based. You had to achieve these things to get the full money. You got some of it, as you went along, but a lot of it was at the back end of the program.

So the state had to invest the money to be able to get the money from the national agreement in relation to that. There was a process for monitoring what it was about. There was an agreement, I think from memory, on eight different areas which were the focus of that particular agreement. And agreements varied between states, the actual - you know, what was going to be delivered, et cetera, but they were all approaching this level.

It gave that coordination and the ownership across the state and Commonwealth in a way that we don't have at the moment for this space. And it was performance based, because there was an outcome, you know, there were expectations in relation to it. In the, I think, three years that it was active before it was dissolved, it was clearly having major impacts in the way prevention was operating at the state and territory level.

MR MUSTON: In relation to that coordination and ownership that you talk about, if we confine ourselves momentarily to the state and the various agencies that make up the state government, do you feel that there is coordination and ownership that exists within the state at the moment? Putting to one side the benefits, obvious benefits of bringing the Commonwealth into that tent, a starting point from the point of view of delivering good preventative care through the state presumably is that coordination and ownership within the state government. Would I be right in that assumption?

DR MITCHELL: The thing that I - for me, that question I think about within the health system and, you know, like with other clinical services, the mechanism of the ministry and the connection to the local health districts holds for the prevention side of things, the public health side of things, as well. So there is that sort of level of policy

and implementation split between local health districts and the ministry, but I'm not sure if you're looking at that more broadly than within health.

MR MUSTON: I take on board your observation that, really, prevention, particularly in the primordial and primary space, which is best bang for buck, is a whole of government issue.

PROFESSOR WILSON: There is no structure for whole of government for monitoring whole of government approaches to these things.

MS MASTERSSON: Monitoring, leading or coordinating.

PROFESSOR WILSON: Yes. There is no overall structure for that at a whole of government level.

MR MUSTON: A structure that was multidisciplinary, probably multiagency at the same time, which created that leadership coordination and perhaps had a decision-making function or, at the very least, a power to inform decision-making around spend on prevention, would be a great improvement on the existing system, would it not?

MS MASTERSSON: Yes, and evidence built into that, and some research ability.

THE COMMISSIONER: Can I ask, given Mr Muston has raised opportunity 2, in paragraph 115, the second bullet point:

> *Consider how to enhance prevention in the clinical setting as an extension of clinical care and funded through clinical rather than through limited budgets for upstream prevention ...*

Should I take that to mean consideration, in terms of the clinical setting, to MBS items and as part of ABF, or does it mean something else, in terms of funding it?

PROFESSOR WILSON: So if you think about funding for prevention, it has sort of four components, if you like, to it. And I will use the word "funding", probably "resourcing" is probably a better word because in some cases no actual dollar attaches to it, it's resources, as such.

So you have resources which maintain the infrastructure within the ministry, which both runs prevention programs, monitors prevention and runs specific health promotion programs. Then there are specific funds which are allocated for particular programs - it might be for a particular nutrition program, it might be for an immunisation program, but they're funds which are identified to a specific program, as such.

Then you have funding - then you have activity which is being conducted within a sort of clinical environment within the healthcare environment which can be broadly labelled as "prevention" as such. It's difficult to measure that, difficult to identify it. But clearly, even a - given the size of the expenditure for the clinical budget versus what we spend on the prevention budget, even a small allocation of that to the prevention area could be a substantive leveraging in relation to it, and it also is consistent with the whole notion that this is a whole of health business that we're trying to carry out here in terms of embedding and getting people involved in that.

Now, at the moment we have a very limited understanding of what expenditure goes on in that broader healthcare budget and to the prevention space. Now, it may be possible - not "may be" - there are ways that that could be better tracked and identified through the system. There are ways - and you might not do it across everything, it might be that you focus on particular areas where you know you're going to get the best opportunity, so you might focus within the chronic disease areas, for example.

So some work we did a few years back for the Queensland government, where we tried - where we actually said, "Here are some areas that you might focus on and say there's actually a specific component of funding which goes into these areas which is identified for the prevention purposes in relation to that."

There have been suggestions that you could have it as an incorporated component of the ABF.

THE COMMISSIONER: Yes, what I had in mind was whether you were expressing an opinion there that a prevention advice or action by a clinician in a public hospital could be recognised as a form of activity with an NWAU attached, to

which it would then attract funding.

PROFESSOR WILSON: Yes, I think that is one of the options which would be available. Whether you're trying to do it across everything or whether you say, "Okay, look" - you know, in the sort of metabolic diabetes area, that's an absolutely critical area where it's not only in the interests of the clinical services to do it, it's in the interests of patients to have a bigger focus on prevention in that space, so it's a bigger component of what you might do in there as opposed to the surgical space where --

THE COMMISSIONER: I mean it ultimately, I suppose, would be a question of convincing IHACPA that (a) it could be done and (b) it should be done.

PROFESSOR WILSON: Yes.

THE COMMISSIONER: Likewise, I mean, I think some MBS items are actually directed to what you'd loosely call - well, not "loosely", you would call - prevention in terms of plans for people with chronic disease, but there might be a case for expanding those as well to other aspects --

PROFESSOR WILSON: It might also be a case where you say, coming back to my point before, "If you are not going to do it, who is going to do it", that says, "Okay, well, if you're not going to do it, then that, let's say, 5 per cent of the activity funding which is committed to that, should go to somebody else to do it for you, if you are not doing it", so that there is commissioning of services or whatever to provide that particular aspect of care.

THE COMMISSIONER: Yes.

MR MUSTON: In a Utopian ideal, or at least as close to Utopia as you can get whilst still needing to deal with childhood obesity, you might, in fact, have a funding system which rewards you for curbing rates of childhood obesity in your area rather than just delivering some useful advice about how to do so.

PROFESSOR WILSON: This is an issue we'll obviously be exploring tomorrow, Commissioner, when we talk about resourcing, because I think what you're talking about really is part of the argument for, you know, some localised regional funding model because you can actually

then make decisions about how much - you know, whether you are going to put some investment into that space as part of your overall services to a particular community.

MR MUSTON: Perhaps if not for the whole of the delivery of health care within a region, there might be some scope - we can engage in relation to it tomorrow - for cordoning off that portion of health spend that might be devoted to prevention and dealing with that on more of a paying for results rather than the process way.

PROFESSOR WILSON: Look, I'm always cautious about further complicating what is a complicated system, and our funding system for health care is extraordinarily complicated. So, you know, I'm just flagging that I think you have to think very carefully and you need to be careful that you don't create something which just leads to people gaming how they - and we've seen a bit of that in the past in the prevention space, about what got counted as prevention. That has been one of the reasons why it's difficult to track what's happening with prevention expenditure, that we do see a bit of gaming where people count different things in different states as prevention activities.

MR MUSTON: Could I ask you about that --

THE COMMISSIONER: Sorry, could I just ask a question that flows from that, again to all of you, but in opportunity 1, where the heading is "Improved transparency in reporting on prevention expenditure", in paragraph 113, you list a number of ways in which you think transparency could be improved. One is the last dash on the third bullet point, which is "periodic expanded reporting to capture clinical prevention in health services". If we had really good data in that, that might help assist in making some sort of submission to IHACPA that this should be activity that has an NWAU attached to it. Would that be a fair view or am I missing the point?

PROFESSOR WILSON: I think it would help us to have some better clarity, even if we don't try and capture the whole entity, but actually be clear what we are counting, so we've got something which can reliably look at over time, in terms of whether it's changing and whether we can reliably look at it between states and say, "Yep, New South Wales is doing better" or worse "than elsewhere in that regard". I mean, the data that's there - so there was

a national collection in relation to prevention and public health expenditure. It was dropped in the late '90s - sorry, yes, in the late '90os early 2000s somewhere, wasn't it?

MS MASTERSSON: We did one on the --

PROFESSOR WILSON: No, no, this was the collection that the Australian Bureau of Statistics and AIHW did across the states to compare it, it was a national collection, and it was stopped. Anyway, it hasn't been restarted, but there is discussion about restarting that as an annual reporting from the states and territories about expenditure in this area.

There has been work done on defining what would be the elements that would go into that reporting arrangement. There were previously a set of rules about what could be counted, et cetera, but there was a bit of gaming that went on. I think we can - there's been further work done in relation to that. So it would be good to see that reinvented.

Sorry, Nadia, you were going to talk also about the work that we did at the prevention centre.

MS MASTERSSON: Yes, I can add to that, but Jo, did you want to --

DR MITCHELL: Yes, in terms of the discussion around point 115 and point 113, one of the things that I think we're wanting to put forward in the paper and express clearly is that it is important to track both the primary/primordial versus clinical, because it's a very limited amount of funding that goes into that sort of primary prevention side of things, and it would be very easy to see that draw into the clinical side of things, and if you take it from the proposition that this is good clinical practice, that it really needs to be part of the expectation of the way that health care is delivered. So that's an important principle, I think, in both 113 as well as 115.

MS MASTERSSON: I would add to that, if we choose to measure just one part of prevention, you're then valuing what you measure. So if you measure clinical prevention, it then means that primordial/primary prevention might be less valued because it's not counted, so we would need to

carefully measure across the spectrum.

The other thing that the report does highlight is it's also important how the funding is allocated. So the prevention centre did fund a significant piece of work by Alan Shiell and colleagues that is referred to in this report, that showed that the different types of funding mechanism need to be suited to the task at hand, and so when funding things like primordial/primary prevention, block funding is more effective than categorical tied funding.

THE COMMISSIONER: Can I just also ask in relation to 113, the first bullet point, where you say one way that transparency could be improved is having a clear definition of "prevention" - any one of you can answer on the basis that I assume I wouldn't get four different opinions about what the definition of "prevention" should be. Would your definition of "prevention" be the definition you've given in paragraph 25, or something different?

MS MASTERSSON: I would add to that, having spoken to Alan Sheill and some of his colleagues yesterday about the results of that report, that although the AIHW definition may not be perfect, it is good enough. We can waste more time trying to perfect it but then we'll lose the ability to compare over time, and that it is standardised to some degree across other countries. So I would invest more time in making a commitment to measuring against a standardised definition, and then using what Andrew said, which is satellite reporting, which is that periodic reporting style, to capture further detail that doesn't, I guess, upset the longevity of reporting against one common measurement and definition.

MR MUSTON: Just to pick up on the gaming of the system point that you raised earlier, though, if you had a proposal that was put forward for some funding on the basis that it would produce preventative health benefits, for example, the construction of a road or a transport corridor that had a bike track associated with it, just to stick with the same example, that might get a tick in the preventative health care box notionally, but if it's a bike track which no-one's actually going to use because it takes you from nowhere to nowhere along a highway, or if it gets removed as part of a value management process, I think is a phrase we've heard used in the Inquiry frequently, then

you've given yourself the tick or the pat on the back for spending money on prevention but it has not actually resulted in any money being diverted in that way. Is that what you had in mind, that sort of example, when you were talking about gaming the system?

PROFESSOR WILSON: Yes, exactly. You know, you've got to be very clear what you're counting and why you're counting.

NSW Health has fluctuated in the degree of reporting that it has required of its area health services or local health districts at different times and sort of gone from sort of very detailed reporting to high-level reporting in relation to this. And, you know, part of the reason - there's the burden of actually assembling that information as part of it, but also because when people did sort of collect data which was sort of at a detailed level, people were going, "Mmm, not sure about that, is that real?" So, you know, you can create incentives for people to - you know, if you require reporting, people will report. It doesn't necessarily mean what you get is useful information.

MR MUSTON: In terms of opportunity 2, identifying mechanisms to increase investment in prevention, we have heard some evidence about the way that new policy proposals are pitched to treasury, and the way decision-making at that level seems to hinge on the extent to which something can be brought within a premier's priority or a particular government priority of the day - do you think there would be benefit in, having regard to the scale of this issue and the size of the health budget relative to the other portfolios, a standing government priority of preventative health care, if we could come up - or preventative health, if we could come up with a definition for it, such that not just for one premier or a particular government, but for the foreseeable future there is scope for each agency to pitch for funding through that process, if it is able to persuade someone - and we'll come back to who that someone is in a minute - that it would be to the benefit of preventative health? That is to say, the proposal.

PROFESSOR WILSON: I'm certainly in favour of having something which takes a whole of government approach to particularly primordial and primary prevention in relation to this, because I think if we did that, some of the investments might not be what might come to mind from the

health portfolio but might be seen as important and substantive in that regard, and I would think it would send a very clear message about these things that prevention is not just about what health does in that regard.

I don't even necessarily think it has to be an enormous amount of money. I think it's the signalling which is really important here about taking whole of government approaches. And I think particularly if it was focused around equity issues, if it was particularly focused on reducing inequities, then I think that would be, you know, something that - it would be hard for other agencies not to see that they had an important role in relation to that.

DR MITCHELL: Yes, I sort of think about that, too, from a broad - because it's not just prevention in health, I mean, there's obviously prevention in other government agencies; they have a prevention focus too. So that kind of opportunity would then sort of help bring together - say if it's a child focus, let's say early learning, for example, that sort of brings the opportunity for the other departments to come together in quite a structured way. And so it's prevention from a range of perspectives. So it's about the business of education as well as the business of health, rather than being the business of health, where you're trying to draw people in to the business of health.

So that kind of a concept I think would help think about things from a broader than health perspective but be much more opportunity, I think, for having a focus on a shared problem and the contribution that each agency makes to that shared issue.

MS MASTERSSON: I think, adding to that, it would be important to structure it so that it wasn't seen as the font of funding and the sole font of funding, that if you want to do prevention, you need to get it from that font of funding, because each government department has funding that they use that affects health of "New South Waleans" and Australians every day. So it would need to be a way to incentivise and support but not be the only source of funding for prevention across sectors, and that would be really critical, because otherwise it becomes a one-legged beast.

PROFESSOR WILSON: I think the other thing that would be useful in thinking about that is that it may not always be health priorities that come up in relation to it. So, you know, it might be that when you look at it, particularly through an equity lens, that drowning is a more important issue than, say - from a cross-sectoral point of view I mean - something else. So I think it also makes the health portfolio think a little bit about, you know, what are the important things when you look through an equity lens.

MR MUSTON: In a way, that gets us to a question I was going to ask about opportunity 3 and the safeguarding of further support for prevention. Opportunity 3 you have tied to NSW Health infrastructure, but can I take it back a step: if we have as a standing government priority prevention, preventative health prevention in that context, as a basis upon which each of the various agencies pitching for money through the new policy proposals could potentially attract some of that money and get a little bit more than another agency, but if decision-making around how that money and how those new policy proposals were to be assessed, at least from a prevention point of view, was required to be informed by a more stable multidisciplinary, multiagency group, informed by evidence that was making decisions about what the preventative health priorities were, targeting that spend and targeting decision-making around which new policy proposals should be favoured and which shouldn't, accepting that the government of the day ultimately has the choice, would that at least create a little bit of insulation, potentially, from this current situation where different governments change and their priorities change and we lose the benefits of the money that we've invested in one strategy because we flip to another one too quickly?

THE COMMISSIONER: Just before anyone answers that question, can I understand the question first?

MR MUSTON: Please do.

THE COMMISSIONER: You said, "Opportunity 3 you have tied to NSW Health infrastructure".

MR MUSTON: Yes.

THE COMMISSIONER: What does that mean?

MR MUSTON: The heading "Opportunity 3: Safeguard and further support the NSW Health infrastructure for prevention".

THE COMMISSIONER: Right, the general infrastructure, not --

MR MUSTON: Sorry, I didn't mean NSW Health infrastructure, the agency, no. They have a different role.

MS MASTERSSON: I think what you've described is a better opportunity because it embeds a couple of our opportunities together and says it needs to be whole of government and it needs to be embedded and safeguarded. So if there was a way to do that and protect it across different changes in government, then I believe that would absolutely - and had the support of each progressive government over time, I think that would certainly make a significant difference to safeguarding prevention for the state.

PROFESSOR WILSON: I think you have to be - in general I agree with what Nadia said. I think the only caution I would add to that is there is prevention which is health business, there is nobody else who should be responsible for immunisation other than health; right? It needs the assistance of other agencies. You know, we vaccinate in schools, for example, so we need, you know, cooperation from education to be able to do that.

What I don't want to see is those things which health can and should take a responsibility for moved into an environment where other people are making - you know, are trying to make decisions around that. But for those things which truly require an intersectoral perspective or where there are good equity reasons for addressing it as an added activity, or some other productivity reason, then I think the sort of notion that you're talking about is worth considering.

DR MITCHELL: Yes, very much with that social impact rather than being completely a health focus thing, I think, is again an important distinction.

PROFESSOR WILSON: I think this is particularly important as we start to think about prevention in mental health,

where a lot of - you know, the things which we could be talking about and which are really important for productivity in our community, you know, we have to think more broadly than this is a health issue.

MR MUSTON: Could I just ask one question about opportunity for --

THE COMMISSIONER: Can we just stick with three for a minute?

MR MUSTON: Sure.

THE COMMISSIONER: Can I just ask you, in relation to paragraph 118, the first bullet point:

> *Exploring the relative merits of enshrining responsibility and accountability for sustained investment in evidence-based prevention in state legislation ...*

Is that expressing a concern that what is in the NSW Health Services Act is not enough in relation to the obligation of LHDs, for example, to promote health, et cetera, and looking to the South Australian approach that you've given an example of?

MS MASTERSSON: I can speak to - I have a South Australian background. But to your first point --

THE COMMISSIONER: So do I.

MS MASTERSSON: Thank you. To your first point, the first legislation is specifically health, and I don't know the New South Wales legislation specifically, but if it doesn't call out the requirement to work across other sectors, then you're still within the health band, which is great for secondary and tertiary prevention but not much else.

In South Australia, there are two different legislations. One is embedded within a contemporary public health legislation, which actually does call out the requirement to work across different sectors and across different levels of government, so there is strength there. And what additionally has just passed through parliament recently is additional legislation, which legislates the requirement for a separate preventive health agency that

has a CEO, has specific funding and reports to the minister regularly. So they're two different things.

The being embedded within existing public health legislation I think is incredibly strong and is a call across sectors as well. Yes.

THE COMMISSIONER: Can you tell me - and please feel free to take it on notice - the recent South Australian legislation, I assume that resulted from some form of government report or inquiry of some kind, or review of some kind?

PROFESSOR WILSON: It has been happening for a while, though. It's not --

MS MASTERSSON: With the change in government, they made a commitment to a separate agency for preventive health, which there was, but it had hospital services within a preventive health agency, and so that was the change that that government made.

THE COMMISSIONER: That was an election commitment, was it?

MS MASTERSSON: I believe it came from an election commitment.

THE COMMISSIONER: So was this Inquiry, but it's a different thing. Okay. And in relation to the rest of your example in relation to what South Australia has done, do we know of any particular benefits that have flowed from the 2011 legislation?

MS MASTERSSON: Not published and not researched. Anecdotally, I think you could say that it gives - having worked in the system in that role, it gave legitimacy to health bureaucrats and colleagues like myself working with other sectors, because we were coming to them saying, "This is within state legislation. That encourages us to work together to this end." And one of those --

THE COMMISSIONER: It gives it the force of law.

MS MASTERSSON: Yes. So one of the clauses was around forming what was called "Public Health Partner Authorities", and so what that was was reaching out to

other sectors and other organisations saying, "We recognise the effect you have on health. We would like to partner with you to achieve your outcomes, whilst also protecting and promoting the health of South Australians." So it gave that legitimacy.

There is also a part in the state Public Health Act of codes of practice, which will be an incredibly strong mechanism, and hasn't been enacted yet. So there is the ability to be more forceful with the legislation if required, if political support is also there.

THE COMMISSIONER: Yes. Of course.

PROFESSOR WILSON: So I guess my comment would be it's horses for courses and different states start in different places. I think what we're trying to say here is it's worth looking at this and trying to understand, as Nadia has just nicely described, what was achieved in relation to that.

We're not saying, you know, we should necessarily have that sort of agency setup, but what was the intent of doing that, and how would that be best done within the New South Wales context, given, you know, a different history of its health service and particularly of its public health and preventive health services, which, say, compared to both South Australia and Queensland, have been better supported and better and more consistently supported over time. Both South Australia and Queensland, at various times, have had decimating changes to their preventive health infrastructure internally, as has Victoria, which recently, for example, got rid of a number of longstanding units within its health department in the preventive health space. New South Wales has had relative consistency, it has had relatively substantive investment in relation to that, but there is always room for improvement, so learning what was the intent here, and we think it does make - that the Act, at the very least, if not the establishment of that agency, the Act is much clearer about that responsibility for prevention both within the health sector but also more broadly across government.

THE COMMISSIONER: Because you have used the word "agency", can I ask a possibly unrelated question to all of you, and probably a stupid question, but I will ask it anyway. Is there a role, or a bigger role, for the Agency

for Clinical Innovation in relation to prevention? I know they don't have a prevention network, but when we're talking about clinical prevention - and maybe it's incorporated within all their other networks, but is there any role, or bigger role, for the ACI in relation to prevention, and if there is, what would it be?

PROFESSOR WILSON: So, just to be clear, I was the chair of the board of ACI up until the beginning of last year --

THE COMMISSIONER: You are the best person to ask.

PROFESSOR WILSON: -- until the board function for ACI was dissolved and it was reincorporated back into the department. So I'm just wanting to be clear.

I think the answer to your question is yes, there is an important role here, because the ACI has very strong clinical networks, it develops clinical policies, and if you look at many of those clinical policies, actually, they do incorporate and specify the preventive roles which are expected in relation to particular types of care situations. So it is there, but the extent to which it's actually operationalised is a different question, and I'm sure that's probably what you were discussing yesterday.

DR McNAMARA: Yes. I mean, we probably don't need to repeat where we went yesterday, but the implementation of that policy in the local environment is the challenge that they are confronted with quite often. Yep.

DR MITCHELL: I think with some of the work that we did with Queensland Health as well, clinicians - some clinicians have a real desire and passion to work in this prevention space, and so, you know, working through this kind of an agency can support that, because we heard clinicians talking about the frustration of having patients who present, who they think, "If there had been appropriate intervention earlier, I wouldn't have to be seeing this patient as well". So one of the recommendations that came out of that work was about, you know, how clinicians can be supported in their prevention role in their clinical setting.

MR MUSTON: Given what you know about the existing structures, preventative health structures that exist within NSW Health, do you have a view about what mechanism

might be effective, if introduced, to create that greater level of coordination and leadership between both the ministry and all of the other agencies so as to potentially provide greater stability in terms of decision-making around preventative health policy in New South Wales?

PROFESSOR WILSON: During COVID we saw a level of inter-government collaboration in effectively a prevention space, in responding, that I don't think I have ever seen before in my life, in my professional life, in terms of the way that government interacted, and, my, was that well - it had very high-level leadership, because the premier was on top of it every day. I mean, we don't need that level of intensity, but I think, you know, it did illustrate that when governments do want to act collaboratively and across government, they can do it, but it requires a very high-level leadership in terms of achieving that, and I guess that's what, you know, Nadia was pointing to, the health and wellbeing - the South Australian equivalent, and Queensland, as one way of doing that. But equally during COVID it was done through an interagency task force that was empowered to do it, and it was empowered at a very top level because it reported directly to the premier. So I think, you know, it is potentially possible to do it through other mechanisms.

MS MASTERSSON: Without specificity to the agencies within New South Wales, I would say that it would be important to look at the level of accountability and leadership within the Ministry of Health that has sole responsibility for prevention, because if they are not at a significant-enough level and therefore at the right tables in order to influence decisions, and they are being represented by people who have multiple different portfolios that they need to advocate and speak for, prevention will always be lost.

We have separate senior-level positions for heads of hospitals and heads of LHDs. If prevention is more important, or at least equally important, do we have that same level of leadership shown across the structure at the moment?

MR MUSTON: I have no further questions for these witnesses, Commissioner.

THE COMMISSIONER: Just give me a moment just to check

that we've covered everything that I wanted to ask. No, I think we've covered the matters that I wanted to ask, but is there anything that any of the four of you feel that you would like to expand on or didn't get raised in the session this afternoon that you think is important, that you would like to say something about? There may not be, but if there is anything, please feel free to say anything.

PROFESSOR WILSON: I guess just reinforcing, from my perspective, two issues. I think the state has a particular role in relation to health equity issues, and I think in terms of expenditure, particularly where it's moving in - where it's involved in the primary health care space, that focus of those funds should be on equity issues. So NSW Health does - it is a provider of last resort in many places, so it does work in the primary health care space.

THE COMMISSIONER: Yes, it does.

PROFESSOR WILSON: But it also works very closely with primary care in many different places, including in funding going into primary care in those spaces, and from a prevention point of view, I think the state should particularly have a focus on how those funds address issues of equity, because I think that's something which, at present, the general models, for example, of access to clinical services through primary health care actually miss out, because we know those people who most need it are actually the people who probably get the least access to primary health care, along with every other health service, so I think there is that issue of equity.

The second issue is just to flag that the complexity in prevention is actually likely to grow as demands on prevention are likely to grow with developments in the biomedical space. As we, for example, start to understand more of the gene environment and the interaction through enormous explosion in genomics work, there will actually be a greater demand for prevention to say, "Okay, well, what happens? I've been identified at risk of cancer, what happens to me" or whatever. So, actually, we need to both make sure that we're developing a workforce which is capable of meeting that new demand and understands what comes with that new demand, as well as recognise that, actually, there will be an increased need for preventive services in that space.

So we can't do that without additional resourcing and not abandon the other stuff that we must be doing at a population level, because that's individually focused, and yet, you know, we still need to carry out this population-level prevention.

THE COMMISSIONER: Yes. Thank you. Anyone else?

DR MITCHELL: For me, I think - and it sort of builds on Andrew's last comment - when we're thinking of the health system's role in prevention, yes, it's the clinical, yes, it's the primary prevention as well, but it's also that cross-government, cross-agency work, and that all of that needs to be in scope in thinking about prevention.

My bias is towards the primary and primordial prevention, but notwithstanding the important role that happens in clinical services in terms of the reach and the impact that that work has as well.

THE COMMISSIONER: Thank you. Ms Mastersson, is there anything you wanted to add?

MS MASTERSSON: I feel that we've covered the key issues so thank you for raising those.

THE COMMISSIONER: Dr McNamara?

DR McNAMARA: Nothing further from me.

THE COMMISSIONER: Thank you. Mr Cheney is there anything you want to ask?

MR CHENEY: No, thank you.

THE COMMISSIONER: To all four of you, thank you very much for your time today, we're very grateful. We're grateful for the assistance you have given the Inquiry through not just your evidence but through the report, so thank you all very much. We'll adjourn until 10 o'clock tomorrow.

<THE WITNESSES WITHDREW

AT 4.03PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO THURSDAY, 12 DECEMBER 2024 AT 10AM

B

D

E

F

G

H

S