

**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

1 THE COMMISSIONER: Good afternoon.

2

3 MR MUSTON: Thank you, Commissioner.

4

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

11

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

14

15 <JO MITCHELL, affirmed: [2.02pm]

16

17 <NADIA MASTERSSON, affirmed:

18

19 <ANDREW WILSON, affirmed:

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21 <MARTIN MCNAMARA, affirmed:

22

23 THE COMMISSIONER: Go ahead.

24

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

30

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

39

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

43

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

1 Centre. I've worked in the - I'm a public health physician
2 by background. I've worked in the area of prevention for,
3 I don't know, about 40 years.
4

5 I also just note, for the record, that I have had many
6 roles with NSW Health as well, including chief health
7 officer in the past, and I currently chair the board of the
8 Clinical Excellence Commission and just note that any
9 comments that I'm making today I'm making in my role as one
10 of the authors of this paper and not for NSW Health.
11

12 MR MUSTON: Dr McNamara I think you introduced yourself
13 yesterday --
14

15 DR McNAMARA: Yes, correct.
16

17 MR MUSTON: -- so unless anything's changed within the
18 last 24 hours, we can take that as a given.
19

20 I might start with you, Ms Mastersson. Could you
21 explain to us what the prevention partnership is and how it
22 operates?
23

24 MS MASTERSSON: Absolutely. So the prevention centre, the
25 Australian Prevention Partnership Centre, is Australia's
26 leading collaboration of policymakers, researchers and
27 practitioners who are focused on prevention. So coming
28 together to bring best evidence into practice and policy to
29 ensure that we best use resources to make change to improve
30 health and wellbeing of Australians.
31

32 MR MUSTON: You've each contributed to the report,
33 "Strengthening the focus on prevention of chronic disease
34 through applying evidence based insights", dated
35 29 November 2024?
36

37 MS MASTERSSON: Yes.
38

39 PROFESSOR WILSON: Yes.
40

41 MR MUSTON: The views expressed in that document remain
42 views that each of you hold as you sit here now.
43

44 (All participants nod)
45

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

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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.

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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

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

7
8 But as a society, if we don't want to live with that
9 epidemic forever, then we have to address the determinants
10 of obesity, and to do that we have to act early because we
11 know this is a pattern which is set in childhood.

12
13 THE COMMISSIONER: Sure, yes.

14
15 MR MUSTON: You touch on that as an example in
16 paragraph 24, as an emerging health issue that will require
17 a prevention response. I gather in the second bullet point
18 there at the foot of page 7, the emerging health issue is
19 the development of Ozempic and drugs like it.

20
21 I gather what you're telling us is it's an emerging
22 issue because, to the extent that a drug like that becomes
23 available and it's able to treat or assist people with
24 obesity, it's a cost burden which will be borne by the
25 health system if we are to utilise it as part of our
26 preventative or public health response to the epidemic of
27 obesity?

28
29 PROFESSOR WILSON: So the point the paper is making is
30 that we have to think about two aspects of this. I'll
31 simplify it to some extent.

32
33 We need to think about the population prevention -
34 that is, preventing the onset of this condition in the
35 first place - and addressing the determinants that lead to
36 people becoming obese; but we also need to recognise that
37 we can do something about it once somebody is there and we
38 can prevent subsequent complications of obesity, such as
39 diabetes, osteoarthritis and a range of other conditions
40 that we know are associated with obesity.

41
42 MR MUSTON: So Ozempic as a treatment is very much in that
43 tertiary category of preventative --

44
45 PROFESSOR WILSON: Well, I guess there's a bit of an
46 argument about that in terms of where you would see that
47 happening, you know, how you would think about it. If you

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

5
6 But we know that we need to address the other
7 determinants like diet and like the dietary environment,
8 like physical activity, as well as have available those
9 treatments that will help people with this condition.

10
11 DR MITCHELL: I would also make the point as well that,
12 with the drug treatment, there is also the requirement for
13 also clinical support in terms of advice around diet,
14 et cetera, as well. So it's not just a set and forget,
15 that there's also counselling that happens with that, in
16 the same way that should also happen for bariatric surgery
17 as well. So not on its own is it a magic pill.

18
19 MR MUSTON: So is it the point that some of these sort of
20 primordial and primary, and perhaps secondary, to the
21 extent that Ozempic is not a secondary preventative
22 measure, all of those primordial, primary and secondary
23 also contribute to the prevention strategy that might be
24 applied, even in the case of someone who has tipped into
25 that debatably tertiary category of taking the Ozempic to
26 get their weight under control - all of those other factors
27 will continue to operate to the benefit of someone who has
28 progressed to a level of disease in exactly the same way as
29 they might be of benefit to someone who has not yet
30 encountered that disease or is in the very early phases of
31 it and potentially able to have their condition adjusted
32 through those sorts of measures.

33
34 PROFESSOR WILSON: Yes. I mean, one of the points we make
35 in the paper, in a more general sense, is that you need to
36 think about your whole portfolio of prevention around
37 a particular problem, and what you're describing really is
38 that portfolio: what's the investment in activities across
39 that portfolio that is likely to be able to address it and
40 what's the balance in trying to achieve that in that
41 regard?

42
43 At the moment, things are very weighted towards later
44 interventions in relation to most of these problems, and if
45 you actually take a more formal look at that, you would
46 probably reinvest differently if that was your objective
47 and you could - now, of course, you can't just freely move

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

8
9 MS MASTERSSON: And what I would add to that is if you
10 think about the upstream, or what you were saying is
11 primordial and primary prevention, that is your best bet,
12 because not only will it help shift those who are already
13 requiring secondary or tertiary prevention, that will shift
14 the entire population. So that is your population approach
15 and that is why Andrew's referring to "best bang for buck",
16 because it benefits everyone.

17
18 But more importantly, it has an equity benefit, so it
19 will reduce the gap between those who are well off and
20 those who are less able to control circumstances in their
21 life. And when we talk about the later burden and we're
22 talking about just moving people's disease status until
23 later, well, in fact, if you work at the primordial level,
24 you are changing the way they generationally will
25 experience their health. So it's more than shifting it,
26 it's actually changing. And so that has your best
27 effectiveness, best sustainability and most equitable.

28
29 MR MUSTON: And potentially a multi-generational effect?

30
31 MS MASTERSSON: That's exactly right and that's why it has
32 that strong equity benefit.

33
34 MR MUSTON: But one of the challenges with --

35
36 THE COMMISSIONER: Sorry, does that mean increased rates
37 of healthy elderly people as well?

38
39 MS MASTERSSON: Absolutely. So it will stretch: it will
40 benefit people across their lifetime by engaging early in
41 the social determinants of health - so education, good
42 employment, safe housing. So it will have longer-term
43 benefits for that person, but it will have generational
44 benefits for that family. So you will change the
45 trajectory of whole generations in the long term. But it
46 is a long game, but it is the most cost effective game.

1 MR MUSTON: To pick up on --

2

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

9

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

20

21 THE COMMISSIONER: Yes.

22

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

29

30 MS MASTERSSON: Yes.

31

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

39

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

1
2 MR MUSTON: And that's where your primordial and primary
3 and to some extent secondary forms of prevention are
4 critically important?

5
6 MS MASTERSSON: Yes.

7
8 MR MUSTON: In terms of that adjusting mean before you're
9 actually getting into needing to treat those people who you
10 might be able to treat once they present with, in your case
11 or your example, high blood pressure.

12
13 PROFESSOR WILSON: It's also really important from an
14 equity point of view, that we know a lot of these things
15 have quite inequitable distributions, so who smokes in
16 Australia now? Tobacco smokes now, it's largely poorer
17 people, it's largely people who have mental illness, mental
18 health problems or other situations like that. Rates are
19 higher in groups who are significantly disadvantaged, like
20 First Nations people.

21
22 Similarly, with obesity, with particularly severe
23 obesity, there is a very severe strong socioeconomic
24 gradient. Some of the highest rates of obesity in the
25 world are in some of our First Nations people, for example,
26 from the Torres Strait.

27
28 We have to think about how we address those problems
29 because they are determined very early in the course of
30 people's life journey and in fact, you can actually think
31 about them as being intergenerational in terms of the way
32 these things are developed.

33
34 MR MUSTON: Does anyone else want to comment on that?

35
36 At paragraph 32 you have set out for us, by reference
37 to some useful examples, the different levels of
38 prevention. Accepting that they're probably not crisp
39 categories and there will be a degree of drift across the
40 two and views might differ as to which one something fits
41 into, but I guess if we could focus our attention just for
42 the moment on the first three, primordial, primary and
43 secondary prevention, what role, in your view, should the
44 Ministry of Health be playing in relation to each of them?
45 Accepting, as you have told us, that these are whole of
46 government issues, but whole of government can, in its own
47 siloed way, try to deal with things, but is there a role

1 for the Ministry of Health, do you think, in relation to
2 those three categories, and, in particular, one and two -
3 that's primordial and primary?
4

5 DR MITCHELL: I would say definitely yes, and the
6 following diagram is one that Queensland Health has
7 developed, which also sort of demonstrates the role of
8 a ministry or a Department of Health across all of those
9 areas.
10

11 In terms of the primordial prevention, which, as we've
12 said before, is more up - the upstream and the determinants
13 focus, yes, health does have a role. So, for example, in
14 New South Wales, there's work that happens between
15 transport and health, to support and encourage active
16 transport, and also with education, et cetera. So health
17 has a role in supporting that work, providing some of the
18 evidence and looking at how to link that up with other
19 programs of work as well.
20

21 MR MUSTON: What's the nature of that relationship,
22 insofar as you are aware, between health and - using your
23 example - transport?
24

25 DR MITCHELL: I think that relationships across
26 government, they change over time, and there are different
27 imperatives at different times to be working with your
28 interagency colleagues. So, for example, probably seven
29 years ago there was a premier's priority on childhood
30 obesity, for example, which sort of forced some of those
31 connections and sort of gave a stronger authorising
32 environment for that kind of work to happen.
33

34 So the Department of Health had been working a long
35 time with education, for example, around the issue of
36 healthy food in school canteens, and it was very difficult,
37 over many, many years, to get traction, but when there was
38 that stronger imperative and expectation, there were some
39 break-throughs as well. So that, as a policy position, is
40 now embedded in a way that it hadn't been before and it
41 included monitoring and reporting on achievement of that as
42 well.
43

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

1 and that's often built up over time.

2

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

14

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

24

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

32

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

36

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

46

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

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

8
9 PROFESSOR WILSON: Currently being introduced is
10 a screening program for lung cancer, it's a really good
11 example. We have done really good work in preventing
12 tobacco in New South Wales, around 10 per cent of people
13 continue to smoke at present, and they are hard core, the
14 type that I described before, in terms of trying to do
15 anything about that. But there are several decades of
16 people who have been exposed to tobacco for which there
17 will be an ongoing problem in relation to that, so we have
18 a screening program to try and detect this disease. We
19 know if it is treated early, you get better results, for
20 a whole range of reasons.

21
22 But it's not an easy cancer to treat. It's not an
23 easy cancer to detect or treat. So even though we know we
24 can do it, you are absolutely right, you need a very well
25 developed program which has lots of quality controls in it
26 to ensure that people get - who get screened, detected,
27 then get an appropriate treatment for that to get the
28 benefit from it, because just detecting the disease is of
29 no particular benefit if you don't get adequate treatment
30 for it.

31
32 MR MUSTON: And would the same apply in the case - an
33 example that we've used almost to death in the Commission
34 is the Brighter Beginnings program, which detects
35 developmental challenges that kids face. A wonderful
36 program if you screen as many children as possible,
37 particularly those who don't have worried well parents who
38 are taking them to have them screened themselves, but the
39 benefits of that program from a prevention point of view,
40 if it is a species of prevention, are limited if, having
41 detected them, there is not an adequate suite of services
42 available within a timely way to deliver intervention?

43
44 PROFESSOR WILSON: This comes right back to the start of
45 your question, which is: what's the role of health, of the
46 health portfolio - let's keep it generic - versus, you
47 know, other portfolios? Because most of the responses for

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

3
4 You know, if we have a program for the detecting of
5 those sorts of problems, then it has to be a whole of
6 government program that says, "Okay, what are we going to
7 do about these kids", because they will need educational
8 support, they may need better social care supports in some
9 situations and a range of other things that would need to
10 be considered.

11
12 So I think the further down that pyramid you go, the
13 more you have to have a whole of government approach and
14 you have to have a way of approaching it, and I think if
15 government decides that it's good enough to do it, then it
16 has to think about what are the contributions of the
17 different parties to do that.

18
19 I guess, to me, and I say this with a lot of
20 experience across health services both here and in
21 Queensland, et cetera, it's always been a challenge to try
22 and get that so government recognises what the need is but
23 there is - it sort of then says, "Oh, well, health
24 minister, you solve this problem." But actually, that's
25 not the - you know, the health minister doesn't control all
26 of government to do so. There needs to be a mechanism to
27 get that full engagement if you're going to take these
28 sorts of approaches.

29
30 So I think - I'm stressing here, it is a limitation of
31 the structure, not of what NSW Health or any other health
32 department can do. It's because you need that whole of
33 government approach once you - when you get down to the -
34 you know, when you are in that sort of primordial or
35 primary prevention space.

36
37 THE COMMISSIONER: A number of the recommendations, for
38 example, in the national prevention strategy or the
39 national obesity strategy require - would require action by
40 government that would have nothing to do with the
41 Department of Health or the Ministry of Health - for
42 example, where you put a tax on sugar or increase a tax on
43 a particular unhealthy food or run an advertising campaign
44 or something. They sort of require different levels -
45 require commitment from places outside of health.

46
47 PROFESSOR WILSON: Absolutely.

1
2 THE COMMISSIONER: And without that - I mean, I'm sure the
3 strategies that have been put together are excellent and by
4 people with great expertise and experience, but without
5 those commitments, there's big holes in the strategies, or
6 at least the implementation of the strategies.

7
8 DR MITCHELL: The implementation.

9
10 MS MASTERSSON: I will add to that and return to your
11 original question. If we recognise that in order to do
12 primordial and primary prevention, the majority of the
13 action does occur outside the health sector, that is
14 correct, and so therefore we need a whole of government
15 response. But who is going to lead that whole of
16 government response?

17
18 So for me, the answer to your question is the
19 New South Wales ministry should provide leadership and
20 advocacy for how the normal day-to-day business of other
21 sectors affects the health of and wellbeing and
22 productivity of our population. So that is critical. So
23 if there is no one department who can take leadership for
24 something like that, that is a whole of government
25 approach, it will fall down. So although health doesn't
26 have to do the business, it needs to lead, coordinate and
27 advocate for that to occur, but with whole of government
28 support and infrastructure and processes in place for that
29 to occur.

30
31 MR MUSTON: So you see the Ministry of Health having
32 a potential beneficial role in being, as it were,
33 a gatekeeper or coordinator of activities occurring across
34 the full spectrum of government so as to enable the
35 spending in those various sectors of government to be
36 deployed in a way that best delivers bang for buck, to use
37 the term you used a little bit earlier?

38
39 MS MASTERSSON: Absolutely, because we're not saying that
40 just by NSW Ministry of Health being responsible for
41 leadership and coordination, that they should then fund the
42 activity that occurs in each of these departments. Each of
43 these departments and sectors have funding to deliver their
44 services. They just need to deliver their services in a
45 slightly different way and be supported with evidence about
46 how to change the way they deliver those services.

47

1 MR MUSTON: But does the ministry potentially also have
2 a slightly greater ability than some of the other agencies
3 to deal with the prioritising of some of these strategies?
4

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

17
18 MS MASTERSSON: That advisory and evidence role is
19 critical.
20

21 DR WILSON: And as is --
22

23 DR McNAMARA: Sorry, Andrew. I was going to say that one
24 of the challenges here, of course, is the alignment of
25 interests between these different groups within government,
26 the alignment of interests between transport's priorities
27 and health's priorities, and I think when you think about
28 action at the primordial level particularly, thinking about
29 how you find the levers between - across those different
30 agencies, the health department thinking it's a great idea
31 is fantastic. Also thinking about what's in it for the
32 transport sector, what are their benefits, how that might
33 align to their interests, is a really important component
34 of this. It can't be underestimated, the effort that might
35 be required on that to actually have success.
36

37 PROFESSOR WILSON: So the Australian Prevention
38 Partnership Centre, which we shorthand to the prevention
39 centre, has been going for just over 10 years and we - it
40 was a national initiative and we involved some really
41 fantastic people from all over Australia and
42 internationally.
43

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

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

3
4 One of the things that Billie brought to the
5 partnership was this long experience of being able to get -
6 of working with people outside of the health portfolio, of
7 working with the people who were responsible for design of
8 the built environment, transport, et cetera. You know, she
9 kept us sort of thinking about those issues, that these
10 things require an interaction, they require effective
11 interaction with other agencies. You have to work out what
12 are the wins for both sides, in trying to do this.

13
14 Yes, so I think that issue is really still an ongoing
15 challenge in the early prevention sort of space.

16
17 MR MUSTON: Just to use my silly example of the bike
18 track, there could be a range of places that you could
19 build bike tracks in Sydney but that coordinated approach
20 between different branches of government might mean that
21 the money that you have available to build it is best
22 deployed and able to be deployed in an informed way,
23 informed by a particular socioeconomic demographic and the
24 health profile of that demographic and the extent to which
25 an increase in physical activity might really produce
26 greater benefits than it would in an affluent beach-side
27 suburb with lots of gyms, for example. The location of
28 schools and other catchment populations, which might be an
29 education piece, to say, "Well, if you build it here,
30 that's great, but that's not actually going to get kids who
31 travel to school from this catchment population using it
32 because they all go in the other direction. But if you
33 build it in a slightly different location, then you've got
34 a group of people who might be using it", and then, of
35 course, you have the infrastructure piece that says, "Well,
36 can we do it here and how does that work?"

37
38 PROFESSOR WILSON: This is why you need the whole of
39 government thinking about this. There's a lovely example
40 in the Sydney Morning Herald today which is about
41 overcrowding on two school sites in Western Sydney,
42 I think they're primary and secondary school sites. They
43 are talking about, you know, the proliferation of
44 demountable builds and building play space.

45
46 MR MUSTON: Yes, 106 demountables.

47

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

16
17 MR MUSTON: Part of the challenge is translating what are
18 no doubt often noble policies, like the healthy eating
19 strategies and the like, into lived reality. How do we go
20 about doing that structurally? Are there levers that need
21 to be pulled or structures that should be in place in order
22 to translate what might be a wonderfully crafted policy
23 into something that actually produces outcomes on the
24 ground, in circumstances where, without those mechanisms,
25 it might not?

26
27 MS MASTERSSON: I think there are two steps to that. One
28 is to have the problem identified and have it accepted by
29 government so that it becomes policy, because often there
30 are plenty of policies out there that are needed that are
31 not there, so it's a policy decision not to have it there.

32
33 Once the policy is decided that it is required and
34 there is that authorising environment, there is that very
35 nuanced way of working that we've been speaking about,
36 about that mutual benefits approach, other people call it
37 "Health in All Policies" approach, which is a little health
38 imperialistic but, essentially, it is how do we achieve
39 your sector's outcomes and the health outcomes for the
40 community by working together?

41
42 So in terms of whether there's infrastructure that
43 needs to be in place, again, it is advocacy for a whole of
44 government approach so that is that leadership from
45 government that's required, and then structures in place.
46 But to do it carefully, so that you don't end up with
47 committees that are simply meeting and rubber stamping

1 steps rather than making significant change.

2
3 DR MITCHELL: And in the area of obesity as well - and
4 sort of food environments, for example - there's the added
5 complexity of different levels of government as well. So
6 that sort of, again, creates that complexity about the way
7 in which those decisions are made.

8
9 As Martin has pointed out as well, the different
10 interests in the status quo or, you know, opposing some of
11 those bigger policy issues that have - or bigger
12 legislative options that have been proposed for some time
13 as well. It's a very contested space in terms of different
14 interests and wanting to keep the status quo versus looking
15 for change as well.

16
17 So that's a big challenge in all of these strategies -
18 the obesity strategy but also in the - well, probably
19 particularly in the obesity strategy. But, you know, we've
20 also seen examples where some of those big changes have
21 happened, for example, tobacco, but that wasn't a quick
22 change, either, and it was not just a sudden success. It
23 sort of was changes that happened over quite a long period
24 of time, which sort of started, for example, with, you
25 know, looking at billboards as the first stage of removing
26 advertising and then, over time, that built.

27
28 It would be really great to be thinking about what's
29 the way that you can fast-track that kind of a development
30 so that it doesn't take 50 years to see reductions in -
31 well, you know, to get to the great outcome that we have
32 but still places to go in terms of tobacco smoking: how
33 can you fast-track that? And it's a perennial challenge,
34 particularly as, you know, prevention is not the primary
35 focus across the board.

36
37 MR MUSTON: They're strong fiscal drivers.

38
39 DR McNAMARA: I think some of this does connect a little
40 bit to the discussion yesterday, and I'm not sure if I can
41 draw that in exactly, but --

42
43 MR MUSTON: Please do.

44
45 DR McNAMARA: I think there's a set of things that are
46 going to drive action, one is what is the evidence base
47 telling us about what should be done and what does the

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

7
8 I mean, Nadia might want to speak to this too, but
9 some of the ways that the prevention centre is positioned
10 is part of Australia's infrastructure as it relates to how
11 you think about what the evidence base is around what might
12 work in prevention and how you organise efforts to
13 implement and use that evidence base in local systems.
14 That's one of the reasons for being for the prevention
15 centre, and that's part of the infrastructure that we have
16 available to drive the prevention agenda forward.

17
18 MR MUSTON: But in relation to that, though - and I guess
19 what I'm trying to explore - there are a range of things
20 consistent with what, I think, Dr Mitchell, you have just
21 indicated, we've known for a very long time. Like, the
22 harmful effect of gambling on society, for example, whilst
23 not a health issue, it certainly contributes substantially
24 to the social determinants of health. But we all know
25 that --

26
27 THE COMMISSIONER: I think it is a health issue.

28
29 DR MITCHELL: It is a health issue. Yes, I'd agree.

30
31 MR MUSTON: I will accept it as a health issue as well.
32 But we see what feels like significant inaction in relation
33 to this issue that everyone knows needs to be addressed.
34 How do we cut through that structurally?

35
36 PROFESSOR WILSON: I think if you work in prevention, one
37 of the first things you have to do is develop a very high
38 sense of tolerance of frustration, but you also - you
39 need - you have to think about the sorts of timeframes in a
40 different way to treating - you know, to clinical medicine,
41 in terms of what you're going to achieve. It's unusual
42 that you get really big changes suddenly overnight. It
43 does occur, but, you know, it's unusual. It's more that it
44 is an incremental process.

45
46 As the Commissioner identified before in talking about
47 obesity, you know, there are a range of things that we

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

4
5 THE COMMISSIONER: You mean the time horizon --

6
7 PROFESSOR WILSON: Yes, the time horizon, yes.

8
9 THE COMMISSIONER: -- for interventions like childhood
10 obesity is you get the pay-off but it might be when the
11 people are in their 30s, 40s, 50s, when there's a health
12 pay-off for them, but also it's not until that later period
13 you get the co-benefits like economic benefits as well?

14
15 PROFESSOR WILSON: Yes. Not just that. What I'm thinking
16 of here is that it's sort of almost a ratcheting up of
17 interventions that you do over time; and sometimes, you
18 will have an environment, political, whatever, that's
19 conducive to a lot of change; and sometimes you'll be in an
20 environment where there will be little opportunity, and
21 sometimes even some backward steps in relation to that.
22 But what you're aiming to try and do over time is have an
23 idea about the things that you want to achieve that will
24 eventually get you closer to, you know, a full range of
25 interventions in relation to that. But it will take time.

26
27 And the other thing it requires is it requires - and,
28 sorry, just before I finish the time issue, Jo before
29 referred to an earlier government initiative, earlier
30 government's initiative in relation to childhood obesity.
31 I mean, there was a very good plan developed around that
32 childhood obesity intervention. The problem is that the
33 government of the day, you know, lost interest in it,
34 whatever - actually, we had a change of premier, from
35 memory - and, you know, so it didn't progress, and the
36 prevention area is riddled with these policies, which are
37 good policies, even good programs, which have been put in
38 place, but which have not been given --

39
40 THE COMMISSIONER: They're put it in place for a couple of
41 years and then something else --

42
43 PROFESSOR WILSON: The prevention centre actually did some
44 modelling, some very clever modelling, around the childhood
45 obesity interventions and showed the sorts of timelines
46 that you were going to require for this, and it was - you
47 know, it was several periods of government, not, you know,

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

4
5 THE COMMISSIONER: On this time issue, for all of you, is
6 it the greatest roadblock for funding for prevention
7 issues the time horizon that you might get benefits from
8 them? What I had in mind --

9
10 PROFESSOR WILSON: It is sustaining the program rather
11 than the time horizon. It's sustaining the effort, that
12 these things take time and you have to be able to sustain
13 the effort.

14
15 So that's why, you know, legislative change,
16 regulation, you know, is good, it's nice, because once you
17 have done it, it's unusual for you to go backwards. But if
18 you are talking about something, you know, like changing
19 the dietary - changing the nutritional environment,
20 changing the food environment, you know, there's a whole
21 range of things which might come from that. You referred
22 to taxes on SSBs --

23
24 THE COMMISSIONER: Let me change my question then. Is the
25 time horizon a problem if you are seeking new money, extra
26 money, for a particular prevention program, intervention,
27 whatever we call it, you've got to convince government that
28 it's worthwhile making the investment?

29
30 MS MASTERSSON: But you've got to convince multiple
31 governments at multiple time points to continue to invest
32 in something that the previous government invested in, and
33 that is the difficulty.

34
35 THE COMMISSIONER: Yes. But ultimately, you have to
36 convince, let's just stick with New South Wales - we'll
37 have to convince an expenditure review committee or
38 treasury, whoever, that extra money should be provided for
39 this particular purpose which is a prevention policy,
40 program, intervention. And I imagine to get new money for
41 something like that - Mr Muston mentioned gambling as
42 a problem. I mean, in relation to that, government would
43 look at what are the revenues we get from large amounts of
44 people gambling in society, and what would be the benefits
45 if we reduced the rates of mental and other illnesses
46 caused by gambling if we brought in some regulation on the
47 gambling industry so that they can't advertise to children

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

3
4 But also, if you were bringing in - you know, take The
5 First 2000 Days program. To get additional money for
6 particular interventions in relation to that, I imagine
7 you've got to go through a form of - well, the government
8 would require a business case, there would be a cost
9 benefit analysis associated with that, but the time frame
10 would be really long as to when you get the - it would be
11 way outside the lifetime of any government.

12
13 And no doubt you could model it and no doubt the
14 modelling would be really difficult, but I've seen
15 modelling done in all sorts of ways. You can do it.
16 Usually the results are wrong but how close they are to
17 right is important. You could no doubt model it, you could
18 model the benefits of productivity, extra income tax, lack
19 of absenteeism, et cetera - all sorts of things. But the
20 time horizon would be very long. Is that a big impediment
21 in relation to getting funding for prevention, or am
22 I completely missing the point there? Any one of you - all
23 of you.

24
25 PROFESSOR WILSON: So clearly, governments like to see
26 results as quickly as possible, preferably within their
27 term of government, because they want to, you know,
28 rightly, demonstrate to the community that they've made
29 sensible investments.

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

37
38 For prevention interventions of the kind, like early
39 childhood or stopping smoking or healthy eating, you're not
40 going to get a benefit on day one, you're not going to get
41 a benefit probably in a four-year or a three-year electoral
42 cycle, it's longer.

43
44 PROFESSOR WILSON: I don't think that's always the case.
45 I think there are examples where prevention can have
46 impacts very quickly. So, for example, interventions in
47 women during pregnancy who smoke. We know that, you know,

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

6
7 THE COMMISSIONER: Yes.

8
9 PROFESSOR WILSON: And I also just have this rule that
10 this sort of thing - that I believe, that in any
11 government, there are opportunities to introduce ideas for
12 prevention. It may not be exactly what you want to
13 achieve, but in that notion of ratcheting up, of having
14 this long-term program, you work out for the government of
15 the day what it is that is likely to be acceptable in that.

16
17 Some governments won't want to go near, you know,
18 intervention such as the type that you are talking about.
19 But, you know, they may well be more comfortable with the
20 idea of a nutrition program in schools, so you take that
21 opportunity to - you know, that's where you focus in
22 relation to it.

23
24 So you have to be sensitive to the political
25 environment that you're working in and public health has
26 been very good at sort of mobilising to try and get these
27 things to happen across a whole range of areas.

28
29 But as I say, you don't always get what you want at
30 the same time, but you have to have that long-term view:
31 how do these things tie together and how do we bring them
32 together?

33
34 The sugar-sweetened beverage one I find a really
35 interesting one. Taxes on tobacco generate a lot of money,
36 and that's why treasury likes them in terms of what's
37 there. It generates, in some people's estimates, more
38 money than the cost of treating lung cancer and other
39 complications of the disease. I'm not sure I actually
40 believe that, but that's what's claimed in relation to it.

41
42 So if you think about sugar-sweetened beverages and
43 having a very small tax on sugar-sweetened beverages, it
44 would generate a significant amount of income. The Grattan
45 Institute, for example, has modelled the sorts of returns
46 at different levels of return in relation to that, and
47 would finance potentially some of these things that we need

1 to happen.

2

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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.

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

11

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

18

19 DR MITCHELL: Could be different.

20

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

23

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

32

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

38

39 DR MITCHELL: One of the challenges, too, and you talked
40 about the long time frame as well, but sometimes, you know,
41 some of these interventions can create a very small impact.
42 So, for example, if you are thinking about advertising in
43 public transport, for example, some modelling might suggest
44 that you could reduce the kilojoule intake of a child by
45 12 kilojoules. That's meaningless. But at a population
46 level over time, it is actually an important change. It
47 won't solve the problem, but it is one of those steps along

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

3
4 DR McNAMARA: I think picking up on Jo's point, there is
5 something about the shorter-term measures that tell you
6 something about how you're tracking towards the longer-term
7 ambition. So the decades that it might take to turn around
8 the obesity curve, there's going to be a whole lot of
9 intermediate points along the way where you see changes in
10 community attitudes, increasing concerns around obesity
11 starting to build up if the interventions are directed to
12 the right areas. It's getting clear about what those
13 short/medium term sort of measures should be that can tell
14 you something about your pathway towards the longer term
15 outcome. That is really important.

16
17 MS MASTERSSON: I'll also add to that. I think what we
18 are speaking of is not a lineal process. So although Jo
19 mentioned it is a small benefit to that individual, but we
20 know that's population, we're not even accounting for the
21 system shift that creates, because we're working with the
22 complexity of prevention.

23
24 If you look at the whole system, that system shift
25 will push New South Wales Government to think differently
26 about another policy issue, which will then shift quicker.
27 It will make Queensland Government think differently, it
28 will make the Commonwealth think differently, and so it
29 actually creates all these other shifts in the system in
30 the right direction that are really hard to measure, but we
31 are looking at how to measure system shifts, not just
32 lineal behavioural and morbidity shifts.

33
34 MR MUSTON: I want to pick up on something you said a
35 little bit earlier, Ms Mastersson, about it being not so
36 much about the time, the length of time it takes to see
37 results, but more being about the length of time you need
38 to stay the course with a particular strategy in order to
39 achieve any tangible results.

40
41 MS MASTERSSON: For me, I think that's one of the biggest
42 challenges, that we have been successful over the years in
43 getting funding but as Andrew pointed out, it's that
44 ceasing of funding which has then cost - that funding that
45 was invested is almost - not entirely wasted, because there
46 have been system shifts, but we are then starting again at
47 another time and another place. So if we count all the

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

6
7 MR MUSTON: So the point you make there is - let's take
8 the childhood obesity premier's priority of years gone by -
9 no doubt a large amount of money was deployed through that
10 premier's priority into a range of strategies, the
11 formulation of strategies, reviews and research into ways
12 of dealing with childhood obesity and formulation of
13 a plan, which, if the premier's priority then changes, is
14 money which has, in large part, gone to waste?

15
16 DR MITCHELL: I would just note, though, with the
17 childhood obesity premier's priority, there wasn't new
18 money, it was about bringing together and looking at doing
19 things differently within existing resources.

20
21 I think, you know, there have been some benefits in
22 New South Wales through the national funding through the
23 national preventive health partnership, which was money
24 that was for quite - I think it was a 12-year period, and
25 it stopped prematurely, which had a devastating impact
26 across the prevention community nationally.

27
28 Programs did stop, but New South Wales was able to
29 continue some of the programs that had been established
30 and, you know, that were able to be continued at scale in
31 New South Wales as well. But certainly we see lots of
32 examples of things starting and then not continuing or not
33 being able to be continued at scale, which is a really
34 important concept in prevention, from a programmatic
35 perspective.

36
37 MR MUSTON: I look at your case example 2 on page 16 of
38 the report and assume that at a time when it was seen as
39 a government priority to deal with obesity, no doubt
40 a significant amount of money went into the creation of the
41 first of the two bullet points, but having created that,
42 unless you then continue to provide a funding stream or
43 funding streams in order to make and fund the consequence
44 of decisions at the top, that that program was aimed at,
45 that is one of those sunk costs that's produced a lovely
46 piece of infrastructure that then, once priorities change,
47 loses some of its value?

1
2 DR MITCHELL: Yes. Look, I think one of the key things
3 around this particular cohort is that it's always changing,
4 there's always a flow through as well. So particularly in
5 childhood, the need to continue to have these interventions
6 available is really important. You don't fix the problem.

7
8 MR MUSTON: No. Equally, the second bullet point, The
9 Munch & Move, which, would it be a fair assumption to say
10 that's an expensive re-imagining of Crunch&Sip, which
11 I think is --

12
13 DR MITCHELL: Crunch&Sip is a component of Munch & Move.
14 So Munch & Move is broader. Crunch&Sip is just one
15 element. So it is - Munch & Move is a bigger program.

16
17 MR MUSTON: But coming to the more serious point, you can
18 come up with Crunch&Sip and Munch & Move as fantastic and
19 no doubt very carefully formulated strategies that have
20 involved organisations like yours, no doubt a wide range of
21 organisations deploying a lot of their own limited
22 resources towards building, but telling everyone that they
23 should be munching and moving and crunching and sipping for
24 a few years and then moving on to another priority, even if
25 the posters stay up in classrooms, ain't going to make
26 a shadow of difference in terms of preventative outcomes.

27
28 PROFESSOR WILSON: Our health promotion people in
29 New South Wales, we've been really lucky. We've got really
30 some talented people in this area, and one of the things
31 that they are good at is that when that sort of comes up,
32 they sort of say "Actually, what are we trying to preserve
33 here? What is the intent of what is, and can we repackage
34 it in a way so the government feel like they are
35 relaunching something, even though it's really following
36 through on the same thing?"

37
38 So providing the strand of funding sits there, you can
39 actually maintain it. And actually, it's not about -
40 actually part of health promotion is that you actually do
41 have to refresh your programs every so often. People do
42 get, you know, bored, whatever, with them, and so that's,
43 you know - so I think it's more important, what is more
44 important behind it is maintaining the resource that's
45 there and maintaining the intent of what you're trying to
46 do. What the actual program looks like, can look like, you
47 know, can be modified in that regard.

1
2 I think one of the other things to reinforce here is
3 that what New South Wales does have is that it's one of the
4 few states - well, it is the only state, actually, which
5 has a substantive investment in building capacity in public
6 health and prevention.

7
8 The public health officer training program in
9 New South Wales is the only program in government in
10 Australia that trains public health - people in medical and
11 non-medical aspects of public health intervention programs.
12 It has been a major part of the sustained capacity of
13 NSW Health to maintain programs over a long period of time.
14 It was started in the early '90s and has been going since.
15 It has fluctuated in numbers and whatever over that period
16 of time.

17
18 But it has also been a program which has responded to
19 changes in the needs in the community. So when it started,
20 it had a very strong, largely communicable disease focus,
21 in terms of what it did. It now has a much broader - but
22 that's still an important part because that's still
23 something we have to address, as we saw with the COVID
24 pandemic, but we're also broadening the skills within that
25 cohort of trainees.

26
27 I just think it's really important to say here how
28 that distinguishes the public health and prevention
29 capacity in New South Wales from other states, and it would
30 be a great pity to see that ever threatened.

31
32 MR MUSTON: If a body like that or a cohort of people like
33 that, independent of political decision-making, were
34 responsible for directing funding which was being deployed
35 by government across all agencies into preventative health
36 initiatives, that would potentially create - remove or
37 reduce that risk of chopping and changing from one
38 preventative health strategy to another with a change in
39 government.

40
41 MS MASTERSSON: That would help but we'd want to make sure
42 that it is multidisciplinary, because that is medical only
43 focused and although that community is fabulous, what the
44 strength of prevention is is having that multidisciplinary
45 approach and understanding.

46
47 MR MUSTON: So if you had a multidisciplinary group of

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

8
9 PROFESSOR WILSON: Well, a Holy Grail would be to have
10 a prevention program, training program, of that sort which
11 actually went beyond health and actually involved people
12 who were in other portfolios, because there are different
13 skills and different knowledge sets that you need to work
14 in education or transport, than what you need to work in
15 health. But, you know, it's a good start, what we've got
16 at the moment.

17
18 MR MUSTON: Just having a look at your opportunity 2 on
19 page 24, which is identifying mechanisms to increase
20 investments in prevention, you point out there, at
21 paragraph 114, that Australian Governments have already
22 committed to increase investment in primary prevention over
23 time. A commitment of that type, whilst no doubt good news
24 from your perspective, it's not much use until the dollars
25 start flowing and keep flowing. I'm just interested in the
26 second sentence:

27
28 *This commitment includes developing*
29 *innovative, fit-for-purpose financing*
30 *mechanisms to scale primary prevention*
31 *interventions and reviewing and addressing*
32 *health system barriers to prevention.*

33
34 That again sounds good, but what is it?

35
36 DR MITCHELL: I think it's fair to say that this is not
37 a new commitment, as well, and certainly sort of - I think
38 some of these efforts at that level were impacted by COVID
39 as well, but, you know, one example of some of the ways in
40 which that sort of thinking started to happen was - and
41 we've referenced this in this report as well - that through
42 an incentive payment as part of this process, Queensland
43 Health commissioned some work to look at embedding
44 prevention within the system and actually looking at, well,
45 what are the things that will help to shift the system
46 internally as well?
47

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

5
6 THE COMMISSIONER: When you say "embedding prevention
7 within the system", you mean clinical prevention in
8 Queensland?

9
10 DR MITCHELL: Clinical prevention, yes, indeed. I think
11 that distinction is really important as well, that as we
12 talked about before, there's a role for health systems or
13 health departments in the downstream prevention that we've
14 been talking about, as well as the clinical, and so both of
15 those things are important.

16
17 So I think it's sort of fair to say - and Andrew, you
18 probably have more insight on this than I do - there are
19 probably different things that people are thinking about
20 there, which are sort of behind closed doors.

21
22 MR MUSTON: Can I quickly clarify something? You said
23 there is a role for health in terms of the downstream as
24 well as the clinical. When you use "downstream", are you
25 talking about the primordial and primary?

26
27 DR MITCHELL: Primordial and primary prevention. As you
28 say, there's sort of - there's fuzziness around the edges
29 and so just having two down and upstream sort of helps
30 reduce that fuzziness.

31
32 MR MUSTON: A role to be played for health in the
33 formulation and implementation of prevention strategies
34 which are aimed at preventing people from getting sick and
35 darkening the doors of hospitals with illness before you
36 get into that more classical stage, where the Ministry of
37 Health might be dealing with screening to identify and
38 intervene in disease?

39
40 DR MITCHELL: Which is good clinical practice, so
41 prevention is part of good clinical practice.

42
43 THE COMMISSIONER: Can I just ask a question on the
44 paragraph Mr Muston just drew your attention to about
45 Australian Governments committing to increase investment in
46 primary prevention over time, et cetera.

47

1 This is not a criticism, but there's a footnote 63, in
2 the second sentence, and at least in my - I was looking for
3 the source of that. At least in my copy, there's no
4 footnote 63. Is that a reference, though, to the health
5 agreement, the National Health Reform Agreement?
6

7 DR MITCHELL: It's in the National Health Reform
8 Agreement, so it's in the public domain, yes.
9

10 THE COMMISSIONER: Okay. So in that, at least the
11 addendum 2020 to 2025, we've got prevention as a long-term
12 reform.
13

14 DR MITCHELL: Yes.
15

16 THE COMMISSIONER: In the period 2020 to 2025, was there
17 much - I know in the Huxtable review there is
18 a recommendation for a renewed focus on prevention,
19 whatever that means, but also, in fairness, with I think
20 some funding milestones, again whatever that means, but at
21 least it's a reference to money of some sort. But would
22 I be right to say that at least there was little progress
23 in relation to prevention programs, funding of prevention
24 interventions, in the period 2020 to 20 - well, we're not
25 at 2025 yet, but in that part of the health reform
26 agreement, or did something emerge? You're shaking your
27 head, Professor Wilson.
28

29 PROFESSOR WILSON: To the best of my knowledge, there is
30 nothing specific within the National Health Reform
31 Agreement that actually carries dollars with it at the
32 present time.
33

34 THE COMMISSIONER: That's what I wanted to ask.
35

36 PROFESSOR WILSON: But I think what Ms Huxtable was
37 referring to in her review was that this is something that
38 needs to be looked at.
39

40 THE COMMISSIONER: My reading of the national prevention
41 strategy, and my research can certainly be imperfect, but
42 whilst all aspects, I think, of the strategy I understood,
43 I couldn't find any funding streams attached to it. And
44 you're shaking your heads.
45

46 DR MITCHELL: That's correct.
47

1 MS MASTERSSON: That's correct.

2

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

7

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

11

12 MS MASTERSSON: And local.

13

14 DR MITCHELL: And local government.

15

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

21

22 MS MASTERSSON: Yes.

23

24 THE COMMISSIONER: Which is a Commonwealth responsibility.

25

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

29

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

31

32 MS MASTERSSON: Secondary prevention is primarily --

33

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

41

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

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

10
11 If the hospital system says, "Oh, well, that's not our
12 responsibility, that's the responsibility of primary care",
13 it just ignores the fact that this is a continuum of care
14 and from a prevention perspective we have to have that
15 across that spectrum. If you're not going to do it
16 yourself, then, you know, you need to make sure there is
17 a mechanism so that that issue is addressed, you know,
18 somewhere else, and not just say "It's not our business."
19

20 THE COMMISSIONER: In terms of the national approach from
21 the National Health Reform Agreement, at least in terms of
22 the recommendations that Rosemary Huxtable made, a renewed
23 focus on prevention, you probably all agree, at a general
24 level sounds like a good thing. Having some funding
25 associated, you probably all agree, sounds like a good
26 thing, but beyond that, we don't really know any of the
27 details. It's a wait and see. Is that --
28

29 PROFESSOR WILSON: So Jo referred to before a thing called
30 the national health partnership --
31

32 DR MITCHELL: National preventive health partnership
33 agreement.
34

35 PROFESSOR WILSON: That was an agreement which was
36 a program which was an initiative under the Rudd
37 government, I think.
38

39 MS MASTERSSON: I think so.
40

41 PROFESSOR WILSON: And there are attributes of that which
42 really deserve reconsideration in terms of national
43 negotiations.
44

45 MS MASTERSSON: Yes.
46

47 PROFESSOR WILSON: The prevention centre actually did an

1 analysis. We actually went to all the state and territory
2 governments and asked them what they thought about it and
3 tried to understand what it was - why it was such a - seen
4 very positively by the states and territories. It wasn't
5 just about the fact that there was money, because what the
6 partnership agreement did was it said, "Here are some
7 expectations that you will deliver for this money." Right?
8 So it was outcome based. You had to achieve these things
9 to get the full money. You got some of it, as you went
10 along, but a lot of it was at the back end of the program.
11

12 So the state had to invest the money to be able to get
13 the money from the national agreement in relation to that.
14 There was a process for monitoring what it was about.
15 There was an agreement, I think from memory, on eight
16 different areas which were the focus of that particular
17 agreement. And agreements varied between states, the
18 actual - you know, what was going to be delivered,
19 et cetera, but they were all approaching this level.
20

21 It gave that coordination and the ownership across the
22 state and Commonwealth in a way that we don't have at the
23 moment for this space. And it was performance based,
24 because there was an outcome, you know, there were
25 expectations in relation to it. In the, I think, three
26 years that it was active before it was dissolved, it was
27 clearly having major impacts in the way prevention was
28 operating at the state and territory level.
29

30 MR MUSTON: In relation to that coordination and ownership
31 that you talk about, if we confine ourselves momentarily to
32 the state and the various agencies that make up the state
33 government, do you feel that there is coordination and
34 ownership that exists within the state at the moment?
35 Putting to one side the benefits, obvious benefits of
36 bringing the Commonwealth into that tent, a starting point
37 from the point of view of delivering good preventative care
38 through the state presumably is that coordination and
39 ownership within the state government. Would I be right in
40 that assumption?
41

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

1 and implementation split between local health districts and
2 the ministry, but I'm not sure if you're looking at that
3 more broadly than within health.
4

5 MR MUSTON: I take on board your observation that, really,
6 prevention, particularly in the primordial and primary
7 space, which is best bang for buck, is a whole of
8 government issue.
9

10 PROFESSOR WILSON: There is no structure for whole of
11 government for monitoring whole of government approaches to
12 these things.
13

14 MS MASTERSSON: Monitoring, leading or coordinating.
15

16 PROFESSOR WILSON: Yes. There is no overall structure for
17 that at a whole of government level.
18

19 MR MUSTON: A structure that was multidisciplinary,
20 probably multiagency at the same time, which created that
21 leadership coordination and perhaps had a decision-making
22 function or, at the very least, a power to inform
23 decision-making around spend on prevention, would be
24 a great improvement on the existing system, would it not?
25

26 MS MASTERSSON: Yes, and evidence built into that, and
27 some research ability.
28

29 THE COMMISSIONER: Can I ask, given Mr Muston has raised
30 opportunity 2, in paragraph 115, the second bullet point:
31

32 *Consider how to enhance prevention in the*
33 *clinical setting as an extension of*
34 *clinical care and funded through clinical*
35 *rather than through limited budgets for*
36 *upstream prevention ...*
37

38 Should I take that to mean consideration, in terms of the
39 clinical setting, to MBS items and as part of ABF, or does
40 it mean something else, in terms of funding it?
41

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

1
2 So you have resources which maintain the
3 infrastructure within the ministry, which both runs
4 prevention programs, monitors prevention and runs specific
5 health promotion programs. Then there are specific funds
6 which are allocated for particular programs - it might be
7 for a particular nutrition program, it might be for an
8 immunisation program, but they're funds which are
9 identified to a specific program, as such.

10
11 Then you have funding - then you have activity which
12 is being conducted within a sort of clinical environment
13 within the healthcare environment which can be broadly
14 labelled as "prevention" as such. It's difficult to
15 measure that, difficult to identify it. But clearly, even
16 a - given the size of the expenditure for the clinical
17 budget versus what we spend on the prevention budget, even
18 a small allocation of that to the prevention area could be
19 a substantive leveraging in relation to it, and it also is
20 consistent with the whole notion that this is a whole of
21 health business that we're trying to carry out here in
22 terms of embedding and getting people involved in that.

23
24 Now, at the moment we have a very limited
25 understanding of what expenditure goes on in that broader
26 healthcare budget and to the prevention space. Now, it may
27 be possible - not "may be" - there are ways that that could
28 be better tracked and identified through the system. There
29 are ways - and you might not do it across everything, it
30 might be that you focus on particular areas where you know
31 you're going to get the best opportunity, so you might
32 focus within the chronic disease areas, for example.

33
34 So some work we did a few years back for the
35 Queensland government, where we tried - where we actually
36 said, "Here are some areas that you might focus on and say
37 there's actually a specific component of funding which goes
38 into these areas which is identified for the prevention
39 purposes in relation to that."

40
41 There have been suggestions that you could have it as
42 an incorporated component of the ABF.

43
44 THE COMMISSIONER: Yes, what I had in mind was whether you
45 were expressing an opinion there that a prevention advice
46 or action by a clinician in a public hospital could be
47 recognised as a form of activity with an NWAU attached, to

1 which it would then attract funding.

2

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

12

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

16

17 PROFESSOR WILSON: Yes.

18

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

24

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

33

34 THE COMMISSIONER: Yes.

35

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

42

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

1 then make decisions about how much - you know, whether you
2 are going to put some investment into that space as part of
3 your overall services to a particular community.
4

5 MR MUSTON: Perhaps if not for the whole of the delivery
6 of health care within a region, there might be some scope -
7 we can engage in relation to it tomorrow - for cordoning
8 off that portion of health spend that might be devoted to
9 prevention and dealing with that on more of a paying for
10 results rather than the process way.
11

12 PROFESSOR WILSON: Look, I'm always cautious about further
13 complicating what is a complicated system, and our funding
14 system for health care is extraordinarily complicated. So,
15 you know, I'm just flagging that I think you have to think
16 very carefully and you need to be careful that you don't
17 create something which just leads to people gaming how
18 they - and we've seen a bit of that in the past in the
19 prevention space, about what got counted as prevention.
20 That has been one of the reasons why it's difficult to
21 track what's happening with prevention expenditure, that we
22 do see a bit of gaming where people count different things
23 in different states as prevention activities.
24

25 MR MUSTON: Could I ask you about that --
26

27 THE COMMISSIONER: Sorry, could I just ask a question that
28 flows from that, again to all of you, but in opportunity 1,
29 where the heading is "Improved transparency in reporting on
30 prevention expenditure", in paragraph 113, you list
31 a number of ways in which you think transparency could be
32 improved. One is the last dash on the third bullet point,
33 which is "periodic expanded reporting to capture clinical
34 prevention in health services". If we had really good data
35 in that, that might help assist in making some sort of
36 submission to IHACPA that this should be activity that has
37 an NWAU attached to it. Would that be a fair view or am
38 I missing the point?
39

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

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

5
6 MS MASTERSSON: We did one on the --

7
8 PROFESSOR WILSON: No, no, this was the collection that
9 the Australian Bureau of Statistics and AIHW did across the
10 states to compare it, it was a national collection, and it
11 was stopped. Anyway, it hasn't been restarted, but there
12 is discussion about restarting that as an annual reporting
13 from the states and territories about expenditure in this
14 area.

15
16 There has been work done on defining what would be the
17 elements that would go into that reporting arrangement.
18 There were previously a set of rules about what could be
19 counted, et cetera, but there was a bit of gaming that went
20 on. I think we can - there's been further work done in
21 relation to that. So it would be good to see that
22 reinvented.

23
24 Sorry, Nadia, you were going to talk also about the
25 work that we did at the prevention centre.

26
27 MS MASTERSSON: Yes, I can add to that, but Jo, did you
28 want to --

29
30 DR MITCHELL: Yes, in terms of the discussion around point
31 115 and point 113, one of the things that I think we're
32 wanting to put forward in the paper and express clearly is
33 that it is important to track both the primary/primordial
34 versus clinical, because it's a very limited amount of
35 funding that goes into that sort of primary prevention side
36 of things, and it would be very easy to see that draw into
37 the clinical side of things, and if you take it from the
38 proposition that this is good clinical practice, that it
39 really needs to be part of the expectation of the way that
40 health care is delivered. So that's an important
41 principle, I think, in both 113 as well as 115.

42
43 MS MASTERSSON: I would add to that, if we choose to
44 measure just one part of prevention, you're then valuing
45 what you measure. So if you measure clinical prevention,
46 it then means that primordial/primary prevention might be
47 less valued because it's not counted, so we would need to

1 carefully measure across the spectrum.

2
3 The other thing that the report does highlight is it's
4 also important how the funding is allocated. So the
5 prevention centre did fund a significant piece of work by
6 Alan Shiell and colleagues that is referred to in this
7 report, that showed that the different types of funding
8 mechanism need to be suited to the task at hand, and so
9 when funding things like primordial/primary prevention,
10 block funding is more effective than categorical tied
11 funding.

12
13 THE COMMISSIONER: Can I just also ask in relation to 113,
14 the first bullet point, where you say one way that
15 transparency could be improved is having a clear definition
16 of "prevention" - any one of you can answer on the basis
17 that I assume I wouldn't get four different opinions about
18 what the definition of "prevention" should be. Would your
19 definition of "prevention" be the definition you've given
20 in paragraph 25, or something different?

21
22 MS MASTERSSON: I would add to that, having spoken to Alan
23 Sheill and some of his colleagues yesterday about the
24 results of that report, that although the AIHW definition
25 may not be perfect, it is good enough. We can waste more
26 time trying to perfect it but then we'll lose the ability
27 to compare over time, and that it is standardised to some
28 degree across other countries. So I would invest more time
29 in making a commitment to measuring against a standardised
30 definition, and then using what Andrew said, which is
31 satellite reporting, which is that periodic reporting
32 style, to capture further detail that doesn't, I guess,
33 upset the longevity of reporting against one common
34 measurement and definition.

35
36 MR MUSTON: Just to pick up on the gaming of the system
37 point that you raised earlier, though, if you had
38 a proposal that was put forward for some funding on the
39 basis that it would produce preventative health benefits,
40 for example, the construction of a road or a transport
41 corridor that had a bike track associated with it, just to
42 stick with the same example, that might get a tick in the
43 preventative health care box notionally, but if it's a bike
44 track which no-one's actually going to use because it takes
45 you from nowhere to nowhere along a highway, or if it gets
46 removed as part of a value management process, I think is
47 a phrase we've heard used in the Inquiry frequently, then

1 you've given yourself the tick or the pat on the back for
2 spending money on prevention but it has not actually
3 resulted in any money being diverted in that way. Is that
4 what you had in mind, that sort of example, when you were
5 talking about gaming the system?
6

7 PROFESSOR WILSON: Yes, exactly. You know, you've got to
8 be very clear what you're counting and why you're counting.
9

10 NSW Health has fluctuated in the degree of reporting
11 that it has required of its area health services or local
12 health districts at different times and sort of gone from
13 sort of very detailed reporting to high-level reporting in
14 relation to this. And, you know, part of the reason -
15 there's the burden of actually assembling that information
16 as part of it, but also because when people did sort of
17 collect data which was sort of at a detailed level, people
18 were going, "Mmm, not sure about that, is that real?" So,
19 you know, you can create incentives for people to - you
20 know, if you require reporting, people will report. It
21 doesn't necessarily mean what you get is useful
22 information.
23

24 MR MUSTON: In terms of opportunity 2, identifying
25 mechanisms to increase investment in prevention, we have
26 heard some evidence about the way that new policy proposals
27 are pitched to treasury, and the way decision-making at
28 that level seems to hinge on the extent to which something
29 can be brought within a premier's priority or a particular
30 government priority of the day - do you think there would
31 be benefit in, having regard to the scale of this issue and
32 the size of the health budget relative to the other
33 portfolios, a standing government priority of preventative
34 health care, if we could come up - or preventative health,
35 if we could come up with a definition for it, such that not
36 just for one premier or a particular government, but for
37 the foreseeable future there is scope for each agency to
38 pitch for funding through that process, if it is able to
39 persuade someone - and we'll come back to who that someone
40 is in a minute - that it would be to the benefit of
41 preventative health? That is to say, the proposal.
42

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

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

5
6 I don't even necessarily think it has to be an
7 enormous amount of money. I think it's the signalling
8 which is really important here about taking whole of
9 government approaches. And I think particularly if it was
10 focused around equity issues, if it was particularly
11 focused on reducing inequities, then I think that would be,
12 you know, something that - it would be hard for other
13 agencies not to see that they had an important role in
14 relation to that.

15
16 DR MITCHELL: Yes, I sort of think about that, too, from a
17 broad - because it's not just prevention in health, I mean,
18 there's obviously prevention in other government agencies;
19 they have a prevention focus too. So that kind of
20 opportunity would then sort of help bring together - say if
21 it's a child focus, let's say early learning, for example,
22 that sort of brings the opportunity for the other
23 departments to come together in quite a structured way.
24 And so it's prevention from a range of perspectives. So
25 it's about the business of education as well as the
26 business of health, rather than being the business of
27 health, where you're trying to draw people in to the
28 business of health.

29
30 So that kind of a concept I think would help think
31 about things from a broader than health perspective but be
32 much more opportunity, I think, for having a focus on
33 a shared problem and the contribution that each agency
34 makes to that shared issue.

35
36 MS MASTERSSON: I think, adding to that, it would be
37 important to structure it so that it wasn't seen as the
38 font of funding and the sole font of funding, that if you
39 want to do prevention, you need to get it from that font of
40 funding, because each government department has funding
41 that they use that affects health of "New South Waleans"
42 and Australians every day. So it would need to be a way to
43 incentivise and support but not be the only source of
44 funding for prevention across sectors, and that would be
45 really critical, because otherwise it becomes a one-legged
46 beast.

47

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

11
12 MR MUSTON: In a way, that gets us to a question I was
13 going to ask about opportunity 3 and the safeguarding of
14 further support for prevention. Opportunity 3 you have
15 tied to NSW Health infrastructure, but can I take it back
16 a step: if we have as a standing government priority
17 prevention, preventative health prevention in that context,
18 as a basis upon which each of the various agencies pitching
19 for money through the new policy proposals could
20 potentially attract some of that money and get a little
21 bit more than another agency, but if decision-making around
22 how that money and how those new policy proposals were to
23 be assessed, at least from a prevention point of view, was
24 required to be informed by a more stable multidisciplinary,
25 multiagency group, informed by evidence that was making
26 decisions about what the preventative health priorities
27 were, targeting that spend and targeting decision-making
28 around which new policy proposals should be favoured and
29 which shouldn't, accepting that the government of the day
30 ultimately has the choice, would that at least create a
31 little bit of insulation, potentially, from this current
32 situation where different governments change and their
33 priorities change and we lose the benefits of the money
34 that we've invested in one strategy because we flip to
35 another one too quickly?

36
37 THE COMMISSIONER: Just before anyone answers that
38 question, can I understand the question first?

39
40 MR MUSTON: Please do.

41
42 THE COMMISSIONER: You said, "Opportunity 3 you have tied
43 to NSW Health infrastructure".

44
45 MR MUSTON: Yes.

46
47 THE COMMISSIONER: What does that mean?

1
2 MR MUSTON: The heading "Opportunity 3: Safeguard and
3 further support the NSW Health infrastructure for
4 prevention".

5
6 THE COMMISSIONER: Right, the general infrastructure,
7 not --

8
9 MR MUSTON: Sorry, I didn't mean NSW Health
10 infrastructure, the agency, no. They have a different
11 role.

12
13 MS MASTERSSON: I think what you've described is a better
14 opportunity because it embeds a couple of our opportunities
15 together and says it needs to be whole of government and it
16 needs to be embedded and safeguarded. So if there was
17 a way to do that and protect it across different changes in
18 government, then I believe that would absolutely - and had
19 the support of each progressive government over time,
20 I think that would certainly make a significant difference
21 to safeguarding prevention for the state.

22
23 PROFESSOR WILSON: I think you have to be - in general
24 I agree with what Nadia said. I think the only caution
25 I would add to that is there is prevention which is health
26 business, there is nobody else who should be responsible
27 for immunisation other than health; right? It needs the
28 assistance of other agencies. You know, we vaccinate in
29 schools, for example, so we need, you know, cooperation
30 from education to be able to do that.

31
32 What I don't want to see is those things which health
33 can and should take a responsibility for moved into an
34 environment where other people are making - you know, are
35 trying to make decisions around that. But for those things
36 which truly require an intersectoral perspective or where
37 there are good equity reasons for addressing it as an added
38 activity, or some other productivity reason, then I think
39 the sort of notion that you're talking about is worth
40 considering.

41
42 DR MITCHELL: Yes, very much with that social impact
43 rather than being completely a health focus thing, I think,
44 is again an important distinction.

45
46 PROFESSOR WILSON: I think this is particularly important
47 as we start to think about prevention in mental health,

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

5
6 MR MUSTON: Could I just ask one question about
7 opportunity for --

8
9 THE COMMISSIONER: Can we just stick with three for
10 a minute?

11
12 MR MUSTON: Sure.

13
14 THE COMMISSIONER: Can I just ask you, in relation to
15 paragraph 118, the first bullet point:

16
17 *Exploring the relative merits of enshrining*
18 *responsibility and accountability for*
19 *sustained investment in evidence-based*
20 *prevention in state legislation ...*

21
22 Is that expressing a concern that what is in the NSW Health
23 Services Act is not enough in relation to the obligation of
24 LHDs, for example, to promote health, et cetera, and
25 looking to the South Australian approach that you've given
26 an example of?

27
28 MS MASTERSSON: I can speak to - I have a South Australian
29 background. But to your first point --

30
31 THE COMMISSIONER: So do I.

32
33 MS MASTERSSON: Thank you. To your first point, the first
34 legislation is specifically health, and I don't know the
35 New South Wales legislation specifically, but if it doesn't
36 call out the requirement to work across other sectors, then
37 you're still within the health band, which is great for
38 secondary and tertiary prevention but not much else.

39
40 In South Australia, there are two different
41 legislations. One is embedded within a contemporary public
42 health legislation, which actually does call out the
43 requirement to work across different sectors and across
44 different levels of government, so there is strength there.
45 And what additionally has just passed through parliament
46 recently is additional legislation, which legislates the
47 requirement for a separate preventive health agency that

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

3
4 The being embedded within existing public health
5 legislation I think is incredibly strong and is a call
6 across sectors as well. Yes.

7
8 THE COMMISSIONER: Can you tell me - and please feel free
9 to take it on notice - the recent South Australian
10 legislation, I assume that resulted from some form of
11 government report or inquiry of some kind, or review of
12 some kind?

13
14 PROFESSOR WILSON: It has been happening for a while,
15 though. It's not --

16
17 MS MASTERSSON: With the change in government, they made
18 a commitment to a separate agency for preventive health,
19 which there was, but it had hospital services within
20 a preventive health agency, and so that was the change that
21 that government made.

22
23 THE COMMISSIONER: That was an election commitment, was
24 it?

25
26 MS MASTERSSON: I believe it came from an election
27 commitment.

28
29 THE COMMISSIONER: So was this Inquiry, but it's
30 a different thing. Okay. And in relation to the rest of
31 your example in relation to what South Australia has done,
32 do we know of any particular benefits that have flowed from
33 the 2011 legislation?

34
35 MS MASTERSSON: Not published and not researched.
36 Anecdotally, I think you could say that it gives - having
37 worked in the system in that role, it gave legitimacy to
38 health bureaucrats and colleagues like myself working with
39 other sectors, because we were coming to them saying, "This
40 is within state legislation. That encourages us to work
41 together to this end." And one of those --

42
43 THE COMMISSIONER: It gives it the force of law.

44
45 MS MASTERSSON: Yes. So one of the clauses was around
46 forming what was called "Public Health Partner
47 Authorities", and so what that was was reaching out to

1 other sectors and other organisations saying, "We recognise
2 the effect you have on health. We would like to partner
3 with you to achieve your outcomes, whilst also protecting
4 and promoting the health of South Australians." So it gave
5 that legitimacy.
6

7 There is also a part in the state Public Health Act of
8 codes of practice, which will be an incredibly strong
9 mechanism, and hasn't been enacted yet. So there is the
10 ability to be more forceful with the legislation if
11 required, if political support is also there.
12

13 THE COMMISSIONER: Yes. Of course.
14

15 PROFESSOR WILSON: So I guess my comment would be it's
16 horses for courses and different states start in different
17 places. I think what we're trying to say here is it's
18 worth looking at this and trying to understand, as Nadia
19 has just nicely described, what was achieved in relation to
20 that.
21

22 We're not saying, you know, we should necessarily have
23 that sort of agency setup, but what was the intent of doing
24 that, and how would that be best done within the New South
25 Wales context, given, you know, a different history of its
26 health service and particularly of its public health and
27 preventive health services, which, say, compared to both
28 South Australia and Queensland, have been better supported
29 and better and more consistently supported over time. Both
30 South Australia and Queensland, at various times, have had
31 decimating changes to their preventive health
32 infrastructure internally, as has Victoria, which recently,
33 for example, got rid of a number of longstanding units
34 within its health department in the preventive health
35 space. New South Wales has had relative consistency, it
36 has had relatively substantive investment in relation to
37 that, but there is always room for improvement, so learning
38 what was the intent here, and we think it does make - that
39 the Act, at the very least, if not the establishment of
40 that agency, the Act is much clearer about that
41 responsibility for prevention both within the health sector
42 but also more broadly across government.
43

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

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

7
8 PROFESSOR WILSON: So, just to be clear, I was the chair
9 of the board of ACI up until the beginning of last year --

10
11 THE COMMISSIONER: You are the best person to ask.

12
13 PROFESSOR WILSON: -- until the board function for ACI was
14 dissolved and it was reincorporated back into the
15 department. So I'm just wanting to be clear.

16
17 I think the answer to your question is yes, there is
18 an important role here, because the ACI has very strong
19 clinical networks, it develops clinical policies, and if
20 you look at many of those clinical policies, actually, they
21 do incorporate and specify the preventive roles which are
22 expected in relation to particular types of care
23 situations. So it is there, but the extent to which it's
24 actually operationalised is a different question, and I'm
25 sure that's probably what you were discussing yesterday.

26
27 DR McNAMARA: Yes. I mean, we probably don't need to
28 repeat where we went yesterday, but the implementation of
29 that policy in the local environment is the challenge that
30 they are confronted with quite often. Yep.

31
32 DR MITCHELL: I think with some of the work that we did
33 with Queensland Health as well, clinicians - some
34 clinicians have a real desire and passion to work in this
35 prevention space, and so, you know, working through this
36 kind of an agency can support that, because we heard
37 clinicians talking about the frustration of having patients
38 who present, who they think, "If there had been appropriate
39 intervention earlier, I wouldn't have to be seeing this
40 patient as well". So one of the recommendations that came
41 out of that work was about, you know, how clinicians can be
42 supported in their prevention role in their clinical
43 setting.

44
45 MR MUSTON: Given what you know about the existing
46 structures, preventative health structures that exist
47 within NSW Health, do you have a view about what mechanism

1 might be effective, if introduced, to create that greater
2 level of coordination and leadership between both the
3 ministry and all of the other agencies so as to potentially
4 provide greater stability in terms of decision-making
5 around preventative health policy in New South Wales?
6

7 PROFESSOR WILSON: During COVID we saw a level of
8 inter-government collaboration in effectively a prevention
9 space, in responding, that I don't think I have ever seen
10 before in my life, in my professional life, in terms of the
11 way that government interacted, and, my, was that well - it
12 had very high-level leadership, because the premier was on
13 top of it every day. I mean, we don't need that level of
14 intensity, but I think, you know, it did illustrate that
15 when governments do want to act collaboratively and across
16 government, they can do it, but it requires a very
17 high-level leadership in terms of achieving that, and
18 I guess that's what, you know, Nadia was pointing to, the
19 health and wellbeing - the South Australian equivalent, and
20 Queensland, as one way of doing that. But equally during
21 COVID it was done through an interagency task force that
22 was empowered to do it, and it was empowered at a very top
23 level because it reported directly to the premier. So
24 I think, you know, it is potentially possible to do it
25 through other mechanisms.
26

27 MS MASTERSSON: Without specificity to the agencies within
28 New South Wales, I would say that it would be important to
29 look at the level of accountability and leadership within
30 the Ministry of Health that has sole responsibility for
31 prevention, because if they are not at a significant-enough
32 level and therefore at the right tables in order to
33 influence decisions, and they are being represented by
34 people who have multiple different portfolios that they
35 need to advocate and speak for, prevention will always be
36 lost.
37

38 We have separate senior-level positions for heads of
39 hospitals and heads of LHDs. If prevention is more
40 important, or at least equally important, do we have that
41 same level of leadership shown across the structure at the
42 moment?
43

44 MR MUSTON: I have no further questions for these
45 witnesses, Commissioner.
46

47 THE COMMISSIONER: Just give me a moment just to check

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

8
9 PROFESSOR WILSON: I guess just reinforcing, from my
10 perspective, two issues. I think the state has
11 a particular role in relation to health equity issues, and
12 I think in terms of expenditure, particularly where it's
13 moving in - where it's involved in the primary health care
14 space, that focus of those funds should be on equity
15 issues. So NSW Health does - it is a provider of last
16 resort in many places, so it does work in the primary
17 health care space.

18
19 THE COMMISSIONER: Yes, it does.

20
21 PROFESSOR WILSON: But it also works very closely with
22 primary care in many different places, including in funding
23 going into primary care in those spaces, and from
24 a prevention point of view, I think the state should
25 particularly have a focus on how those funds address issues
26 of equity, because I think that's something which, at
27 present, the general models, for example, of access to
28 clinical services through primary health care actually miss
29 out, because we know those people who most need it are
30 actually the people who probably get the least access to
31 primary health care, along with every other health service,
32 so I think there is that issue of equity.

33
34 The second issue is just to flag that the complexity
35 in prevention is actually likely to grow as demands on
36 prevention are likely to grow with developments in the
37 biomedical space. As we, for example, start to understand
38 more of the gene environment and the interaction through
39 enormous explosion in genomics work, there will actually be
40 a greater demand for prevention to say, "Okay, well, what
41 happens? I've been identified at risk of cancer, what
42 happens to me" or whatever. So, actually, we need to both
43 make sure that we're developing a workforce which is
44 capable of meeting that new demand and understands what
45 comes with that new demand, as well as recognise that,
46 actually, there will be an increased need for preventive
47 services in that space.

1
2 So we can't do that without additional resourcing and
3 not abandon the other stuff that we must be doing at
4 a population level, because that's individually focused,
5 and yet, you know, we still need to carry out this
6 population-level prevention.

7
8 THE COMMISSIONER: Yes. Thank you. Anyone else?

9
10 DR MITCHELL: For me, I think - and it sort of builds on
11 Andrew's last comment - when we're thinking of the health
12 system's role in prevention, yes, it's the clinical, yes,
13 it's the primary prevention as well, but it's also that
14 cross-government, cross-agency work, and that all of that
15 needs to be in scope in thinking about prevention.

16
17 My bias is towards the primary and primordial
18 prevention, but notwithstanding the important role that
19 happens in clinical services in terms of the reach and the
20 impact that that work has as well.

21
22 THE COMMISSIONER: Thank you. Ms Mastersson, is there
23 anything you wanted to add?

24
25 MS MASTERSSON: I feel that we've covered the key issues
26 so thank you for raising those.

27
28 THE COMMISSIONER: Dr McNamara?

29
30 DR McNAMARA: Nothing further from me.

31
32 THE COMMISSIONER: Thank you. Mr Cheney is there anything
33 you want to ask?

34
35 MR CHENEY: No, thank you.

36
37 THE COMMISSIONER: To all four of you, thank you very much
38 for your time today, we're very grateful. We're grateful
39 for the assistance you have given the Inquiry through not
40 just your evidence but through the report, so thank you all
41 very much. We'll adjourn until 10 o'clock tomorrow.

42
43 <THE WITNESSES WITHDREW

44
45 **AT 4.03PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
46 **TO THURSDAY, 12 DECEMBER 2024 AT 10AM**
47

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