



Public Health Association
AUSTRALIA

Submission from the Public Health Association of Australia to the National Health and Hospitals Reform Commission

INTRODUCTION

The Public Health Association of Australia Inc (PHAA) is a national organisation comprising individual members and representing over 40 professional groups concerned to promote health at a population level. This includes, but goes beyond the treatment of individuals to encompass health promotion, prevention of disease and disability, recovery and rehabilitation, and disability support. This framework, together with attention to the social, economic and environmental determinants of health, provides particular relevance to, and expertly informs the Association's submission to the National Health and Hospitals Reform Commission (NHHRC).

The prime focus of the PHAA and this submission is on prevention. A key issue is the stagnation of expenditure by governments over the last decade with the Australian Institute of Health and Welfare identifying about 1.8% of all health expenditure being dedicated to prevention over the last eight years. (AIHW 13 Feb 2008)

The PHAA is pleased with the approach taken by the NHHRC with regard to the emphasis that has been placed on the importance of prevention. With the emphasis on hospitals and waiting lists over the last decade in particular there has been constant pressure to increase funding in the tertiary sector. However, the approach does have the flavour of the ambulance at the bottom of the cliff rather than the fence at the top. There is an urgent need to increase the percentage of funding that goes into prevention across the spectrum. However, this applies urgently in the areas of obesity, tobacco, alcohol and mental health. Russell, Rubin and Leeder in the Medical Journal of Australia suggest that prevention funding needs to be based on long-term investment, a whole of government approach and substantial funding outside of the health sector. Who has responsibility for carrying out preventive health activity across the community needs to be carefully defined, identifying integration within the healthcare system and how prevention outcomes will be measured and evaluated. (MJA 2008; 188 (12): 715-719)

It would be appropriate for government to fund an organisation such as PHAA to build healthy public policy, provide linkages across the health system, to promote shared community responsibility for improving health, creating environments that support healthy choices and to deliver the sort of preventive health service *nationally* that is provided in Victoria by VicHealth.

The Public Health Association recommends that irrespective of the method of funding, high level indicators that are assessable will need to be set for ALL key areas of public health focussed on prevention. These should include areas from Indigenous health through obesity, tobacco and alcohol to oral and sexual health.

The PHAA is pleased to see that the NHHRC is working closely with Professor Rob Moodie and the Health Minister's Preventative Health Task Force. The PHAA will also liaise closely with that group.

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OVERVIEW AND FUNDING

The Australian Institute of Health and Welfare report on public health expenditure by all Australian jurisdictions provides an insight into the poor performance of governments on prevention as part of health care. There has been so much emphasis on hospitals and waiting lists that many governments have lost sight of the economic and social benefits of prevention. The PHAA considers that it is an embarrassment to governments across Australia that for the last seven years the expenditure on public health has stagnated at around 1.8% of all health spending.

Through such things as sanitation, clean water, nutrition, cessation of smoking and immunization the public health approach has been responsible for more lives saved than all the operations completed in hospitals. Effective investment in public health just makes good sense.

The stagnation of expenditure that is reflected in this AIHW report in February 2008 provides a challenge for all governments but particularly for the new Labor Federal Government. The NHHRC has the opportunity to support the government with vision and foresight by recognising and funding public health through key prevention measures. At a national level it would be appropriate to fund an organisation such as PHAA to deliver a similar service to that provided by VicHealth in the State of Victoria. Of key importance would be relationship to governments of all jurisdictions, other health organisations. Additionally, the development of relationships with organisations, associations, industry and industry groups that have an impact on health should be an important role in tackling prevention.

Key indicators used to measure success should be applied to the range of public health and health prevention measures to identify the importance of these measures. Such indicators will assist in ensuring that prevention is taken seriously and funds are not syphoned away towards tertiary health care. They should include as a minimum: indigenous health, obesity, tobacco, alcohol and other drugs, mental health, social determinants of health, oral health, sexual health, climate change and child health. Although we see these areas as fundamental, the PHAA recognises that there are many other areas where prevention will become a key tool in dealing with health issues. The Prime Minister, The Hon Kevin Rudd, on being told of the level of expenditure on prevention announced at the National 2020 Summit that he considered the level of expenditure as 'crazy'. The PHAA agrees with the Prime Minister and welcomes the long-term view taken by both Ministers.

Key recommendation on funding

The Public Health Association of Australia recommends:

- The National Health and Hospital Reform Commission sets a target for a marked increase in percentage of health funding beyond the AIHW level of 1.8% provided to prevention.
 - Our recommendation is that funding should in the first instance increase to 4%
- Funding be provided by government to the PHAA to deliver a national prevention approach modelled on the State level VicHealth
 - Linkages with other health organisations across the country would be a key responsibility as well as with other associations and industries that have an impact on health

Indicators

Key prevention indicators across all areas of prevention and public health need to be included in any accountability system so that prevention will be taken seriously.

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Background

Nationally Aboriginal and Torres Strait Islander health outcomes remain much worse than for other Australians. Life expectancy is 17 years less for an Indigenous person than other Australians and infant mortality is 2.6 times the rate for all Australians. Health expenditure per person is only 18% higher for Aboriginal and Torres Strait Islander Australians despite this demonstrable greater health need.

There are some signs of slow improvement in Aboriginal and Torres Strait Islander health, but this has been less than the greater improvement seen in the total Australian population.

Aboriginal and Torres Strait Islander health policy and health care must meet the needs of Aboriginal and Torres Strait Islander peoples in different contexts – 30% of Aboriginal and Torres Strait Islander people live in a major city, 20% in an inner regional town, 23% in outer regional areas, 9% in remote areas and 18% in very remote areas.

Key recommendations on Aboriginal and Torres Strait Islander health

- An immediate injection of significant additional funding to Aboriginal and Torres Strait Islander health (as recommended during the election by the PHAA, Australian Medical Association, Oxfam) and many other organisations.
- Cross jurisdictional and portfolio action to address the social determinants of Aboriginal and Torres Strait Islander health (including housing, unemployment, education, community grief) as the highest national responsibility and priority.
- A commitment to work with and develop the capacities of Aboriginal Community Controlled Health Services at local, regional and national levels.
- A 10-year National Training Plan for Aboriginal and Torres Strait Islander doctors, nurses, dentists, allied health workers and Aboriginal Health Workers to bridge the training gap with the general Australian population.
- Fully implement and fund the 2003-2013 National Strategic Framework for Aboriginal and Torres Strait Islander Health with a strong strategic focus on child and maternal health
- The application of public health principles when working with Indigenous people to improve health outcomes.

OVERWEIGHT AND OBESITY

Background

Obesity is one of Australia's most important public health issues. Obesity increases morbidity and mortality due to insulin resistance and type II diabetes, high blood pressure, dyslipidaemia, cardiovascular disease, stroke, sleep apnea, gallbladder disease, hyperuricemia and gout and osteoarthritis. It is also linked to cancer of the stomach, prostate, breast, uterus, cervix, ovary, oesophagus, colon, rectum, liver, gallbladder, pancreas, and kidney.

Over 5.3 million Australians aged 18+ years are overweight or obese. About 27% of Australian children are overweight, including 9% who are obese. In 2005, 3.24 million Australians were estimated to be obese - 15.1% of all males and 16.8% of all females. By 2025 nearly 30% of the total population could be obese, and up to 50% of all Australian children could be overweight or obese. Obesity is estimated to cost Australia \$21 billion each year.

A comprehensive approach is vital. As with other public health issues, some of the interventions to reduce or control overweight and obesity may bring about only modest gains when implemented in isolation, but when implemented in combination and over a long period, they can bring about substantial benefits.

A massive effort is required by the Federal Government in collaboration with all State and Territory Governments to implement a truly comprehensive, multi-sectoral, adequately funded, long-term program. Such a program should encompass: economic interventions, organisational interventions, policy interventions, and education programs in schools and the community.

Key recommendations on overweight and obesity

- Implement a truly comprehensive, adequately funded, across-government, long-term program to address nutrition, physical activity and related issues.
- Provide commercially realistic levels of funding for public and community education programs run independently of any food industry involvement. This should be funded to the level of at least \$100m pa.
- Implement rigorous legislated controls on the advertising and promotion of nutritionally undesirable or "junk" foods (those with low nutrient density and high in fat, salt, sugar or energy), with a special focus on preventing any form of promotion of these foods to children.
- Implement a tax/levy on selected nutritionally undesirable foods, using the funds raised to promote nutritionally desirable foods, fund prevention programs, and subsidise nutritionally desirable foods in remote Aboriginal communities and school canteens.
- Improve labelling of foods (preferably with a "traffic lights" system) so that nutrition / health information is clear, and impose effective controls over direct or indirect health claims for nutritionally undesirable foods.

ALCOHOL

Background

Each year in Australia more than 3,000 people die from drinking alcohol at risky or high risk levels and more than 2,000 die from drinking at low risk levels. Over 80,000 hospital admissions are caused each year by alcohol consumption. Alcohol accounts for at least a quarter of all emergency department presentations. The calculable cost of alcohol misuse in Australia exceeds \$7.5 billion p.a. and the harm caused to people other than the drinker (e.g. child abuse and neglect, mental and physical health of family members) is yet to be quantified. What is clear is that there is considerable harmful and hazardous use of alcohol in the Australian community.

In 2005-06 the Commonwealth government generated over \$5 billion in revenue from alcohol, none of which was earmarked for alcohol-related harm prevention, treatment or research. Alcohol taxation is one of the most significant powers available to governments genuinely keen to address alcohol-related harms. The current system of taxation is likely to contribute to risky levels of consumption and harms in some populations (e.g. young people, Indigenous communities), particularly in relation to the Wine Equalisation Tax, which contributes to low-quality, low-priced and high alcohol content wine-based beverages.

The proportion of young Australian teenagers who are recent drinkers and who drink at levels which would place an adult at risk of harm is currently higher than at any time in over two decades. Almost 50% of recent teenage drinkers now prefer pre-mixed spirits to any other beverage. The liquor industry has been allowed to develop and adjudicate on its own advertising code. Alcoholic beverages are not required to display warnings about the consequences of alcohol consumption. The current nutritional requirements exempts alcoholic beverages from carrying a panel of nutritional information, unless a nutrition claim is made, although depending on the beverage even low levels of consumption may account for as much as 12% to 23% of an average male's daily calorie requirement.

Key recommendations on alcohol

- Reform alcohol taxation; introduce a system based on volume of pure alcohol content for all beverages with additional excise for beverages that contribute inordinately to alcohol-related harm, and reduced excise on beverages shown to minimise harms.
- Earmark revenue from alcohol taxation to fund an alcohol prevention, treatment and research fund completely independent of liquor industry involvement; cease all Government association and support for the drinks industry's "Drinkwise" program.
- Replace the current system of self-regulated alcohol promotion by the liquor industry with a new independent expert committee.
- Legislate a ban on all alcohol promotions associated with sporting events.
- Legislate national labelling requirements for all alcoholic beverages including; illustrations of short- and long-term health and safety effects, and nutritional content.

TOBACCO

Background

Smoking is the cause of over 15,000 deaths a year in Australia, and is responsible for 7.8% of the country's entire burden of disease and injury. The cost of smoking to the economy is more than \$21 billion p.a. Smoking is far the leading cause of drug deaths in Australia. Smoking is well recognised as a cause of lung cancer and many other cancers, heart disease, respiratory disease and a wide range of other conditions.

While smoking is declining in Australia, it remains our largest preventable cause of death and disease. Unfortunately, the decline that has occurred amongst most Australians has not happened within Indigenous communities.

The most recent national reports show that 17.4% of adults, 17% of 16 - 17 year-olds and 7% of 12 - 15 year-olds are regular smokers, and that half the adult Indigenous population are current daily smokers. Passive smoking is also a major cause of death and disease, well recognised as a cause of heart disease, strokes, cancers, respiratory disease including emphysema, asthma and many other conditions.

In 2006 - 07 the Australian Government raised \$6.76 billion in revenue from tobacco duty.

The main opposition to action on smoking comes from the international tobacco industry. The tobacco industry in Australia is entirely controlled by companies based overseas (British American Tobacco, Philip Morris and Imperial Tobacco). The tobacco companies have a long history of opposing and undermining action on smoking at all levels of government. While cigarette smoke contains some 4000 toxic components, there is no requirement for tobacco companies to make a list of all product ingredients available to smokers or the public.

The World Health Organisations and other authoritative health and medical organisations have agreed that a comprehensive approach is required to reduce smoking. This should include a combination of legislative, educational and restrictive measures, with support for smokers who wish to quit. Public opinion surveys consistently show very high levels of support for all such measures, from controls on tobacco company activity to protection from passive smoking.

Key recommendations on tobacco

- An initial focus on program targeting the reduction of tobacco use amongst Indigenous Australians
- Commitment to a comprehensive, well-funded long-term tobacco control program
- 2% of revenue from tobacco duty (\$140 million) dedicated to public education programs to reduce smoking
- Significant regular increases in tobacco duty
- Tobacco companies required to make available full information on all product ingredients
- A complete ban on all forms of tobacco company advertising, promotion, marketing and public relations, including donations to political parties.

MENTAL HEALTH AND WELL-BEING

Background

Mental health is the foundation for the well-being and effective functioning of individuals and communities. The World Health Organisation (WHO) defines mental health as more than the absence of mental illness, but as a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

The burden of mental health problems has been highlighted in recent years but there is no room for complacency, with much to be done for mental health in Australia. Unlike many other public health priorities, mental health continues to languish as an individual's problem rather than a population issue for which governments have a significant responsibility.

The significant injection of funding under the 2006 Council of Australian Governments' (COAG) Plan must be used effectively if we are to obtain optimal mental health outcomes for all Australian. It is critical that mental health is maintained as a national health priority and that the Commonwealth assists the States and Territories to develop comprehensive mental health planning and service delivery.

The COAG agenda and funding must be used to ensure a genuine increase in the funding available at State and local levels to meet the needs of those with mental health problems. This will require comprehensive planning focused beyond acute treatment, with an endeavour to change community acceptance of mental health issues and to target those most in need of help. The processes and the funding at both the national and State/Territory levels must be transparent, monitored and evaluated. Monitoring and evaluation criteria must be developed nationally with service providers, careers, those with mental illnesses and with communities.

Key recommendations on mental health and well-being

- Establishment and maintenance of mental health as a national health priority, the focus of comprehensive action and of regular public monitoring and evaluation reporting for individuals and systemic cost-effectiveness.
- Development of a transparent, effective policy, national mental health strategy, framework for States/Territories for planning service delivery and a monitoring program for mental health and well being across Australia via COAG .
- Provision of long term health, medical and welfare support for individuals and their families whether they have episodic or chronic mental health issues.

CHILD HEALTH

Background

There are some 4 million children aged fewer than 15 in Australia, representing around 20% of the total population. Indigenous children aged 0-14 years account for 39% of the Indigenous population and 4.5% of the total Australian child population. The majority of Australian children are generally healthy. However, there are emerging concerns that rapid social change and new morbidities in behavioural, developmental, mental health and social problems will counter these health gains.

The range of child public health issues includes poverty and health inequalities (especially for Indigenous children), overweight and obesity, healthy eating, physical activity, psychosocial and emotional health, behaviour and development, tobacco, alcohol and drug use, child protection, injury prevention and oral health.

In 2004-05, 41% of children aged less than 15 years had a long-term health condition, with diseases of the respiratory system being reported for 19% of children, diseases of the eye and adjoining structural parts of the body in 10% of children, and mental and behavioural problems in 7% of children. 14% of young people aged 4-17 years were reported in the last national survey of health and well-being as having a mental health problem. State-based estimates of the incidence of Type 1 diabetes in children has increased from 12.3 per 100,000 in 1983 to 23.2 in 2002.

The prevalence of ear/hearing problems, including total/partial hearing loss and otitis media is three times higher among Indigenous children than non-Indigenous children. Mortality rates for Indigenous infants were nearly three times higher than those for non-Indigenous infants and the death rate for Indigenous children is more than twice that of other Australian children. 15% of total deaths of children are attributable to traffic accidents and 7% to accidental drowning. Assault accounted for 9% of childhood deaths, with 65% of these occurring in children under the age of five. 4% of Australian children, and 20% of Indigenous Australian children, are “children of prisoners”

Key recommendations on child health

- A minimum \$25 million a year plus initial set up costs to provide all Aboriginal and Torres Strait Islander pregnant women with antenatal, postnatal and early childhood services.
- Fund and target early childhood intervention and prevention programs to ensure that health outcomes and life expectancy for Aboriginal and Torres Strait Islander children equal those of other Australian children within a decade.
- Recognise that improvements in child health outcomes require prevention and early intervention and the recognition of the complementary role of economics, housing, the environment, parental incarceration and education in improving child health and develop and implement a national child and youth health and well-being comprehensive data collection and research warehouse.
- Develop and provide early childhood development and intervention programs for pre-school children funded to at least the levels provided during school periods with funding made available to communities and families according to need.
- Provide incentives to ensure all children’s and young people’s medical consultations are fully rebated.

CLIMATE CHANGE AND HEALTH

Background

There is substantial evidence from the Intergovernmental Panel on Climate Change that the Earth's climate is changing as a result of human activity. It is now an environmental, economic and social imperative to immediately address climate change. Climate changes are expected to have a range of adverse effects on human health. Reductions to total greenhouse gas emissions and locally focused adaptation plans are a primary preventive health strategy.

Climate changes are producing social and health impacts as well as the better-studied economic impacts. Direct health effects include heat-related mortality and morbidity death, injuries and dislocation as a result of extreme weather events. Indirect health effects include changes to the range and seasonality of vector-borne infectious diseases, food-borne infections, water-borne diseases, famine and malnutrition, damage to public health infrastructure from weather disasters and population displacement.

Some sub-groups of the Australian population are particularly vulnerable - Indigenous Australians, people on low incomes and the elderly – and will be least able to adapt to changes.

The PHAA believes that this is a complex issue that requires Australian Governments to take immediate and collaborative actions to both ameliorate climatic change and help Australians adapt to climate change.

Key recommendations on climate change and health

The collaborative development and funding by Commonwealth, State and Territory governments of a comprehensive national climate change and health strategy that:

- Prescribes a minimum 50% reduction (below 1990 levels) target for greenhouse gas emissions nationally by 2025 and a 90% reduction by 2050;
- Provides a significant increase in new funding over five years for incentive schemes to reduce greenhouse gas emissions and to fund research and development of renewable energy production in Australia;
- Establishes a networked health care and emergency help system that can manage multiple disasters and monitor changes in infectious disease patterns.
- Specifically addresses community and individual health impacts and funds ameliorating actions at a local level and around vulnerable population groups;
- Prescribes continual monitoring and mandatory reporting on greenhouse gas emissions and consequent health impacts in Australia.

SOCIAL DETERMINANTS OF HEALTH

Background

There is now a significant body of evidence about the direct impacts of the social determinants of health (SDH) on individuals, communities and populations. SDH are the strongest predictors of people's health, structuring our opportunities in life and lifestyle choices. Taking account of social conditions that underlie health and how they translate into health impacts is critical for overcoming the deep divide between 'haves' and 'have-nots' and the social unrest that arises from such disparities.

The SDH about which we have the strongest evidence for action are the early years of life, education, employment and working conditions, unemployment, gender, health services, housing, income security, income distribution, incarceration and the social gradient, social support and social exclusion. These factors have specific and significant effects on health, underpinning behavioural risks such as smoking and substance use. Based on their social position, individuals experience differential exposure and vulnerability to health-compromising factors that arise from social and economic conditions. People closer to the bottom of the socio-economic scale more frequently engage in health-damaging behaviours and less frequently in health promoting behaviours than do the more privileged.

Many countries including the United Kingdom, Norway, Sweden, Finland and Canada have set benchmarks for tackling the social determinants of health through serious, pragmatic policies and interventions designed to increase social equity and reduce health inequality gaps through action on the social determinants of health.

Key recommendations on the social determinants of health

- Decrease social stratification by raising minimum wages, the aged pension, welfare benefits and family support measures so that they are sufficient for people to be housed, clothed, fed and educated, using indicators of poverty, child poverty, homelessness and educational participation to measure progress;
- Decrease the specific exposure to health-damaging factors suffered by disadvantaged communities by targeting programs to low-income groups and communities using indicators of improvements to built, social, cultural and physical environments;
- Take action on health inequalities by increasing access to bulk-billing, strengthening the reach of public health programs including screening and health education, prevention, early intervention and community-based care, to prevent further socio-economic degradation among disadvantaged people especially those with chronic conditions;
- Minimise the impacts of poverty on the criminal justice system (and vice versa)
- Develop crosscutting initiatives to tackle inequalities through joined-up government approaches to policy, particularly strengthening education; focus on developing the economy to become more equitable and sustainable for social equality and increasing opportunities for all rather than just growing the economy for the sake of growth.

ORAL HEALTH

Background

There are deep inequalities in access to oral health care for many Australians. In Australia today there are: 5 million adults eligible for public dental care, many of whom experience acute problems in obtaining access to dental service; 650,000 people on waiting lists for public dental care with an average waiting time of 27 months; and 2.1 million adults not eligible for public dental care but who delay or avoid treatment because of costs.

Populations with particularly poor oral health experience the greatest barriers to accessing oral health care. These include low income adults, people living in rural and remote areas, Indigenous Australians, nursing home residents, people with disabilities, young adults on income support payments and single parents.

There is an increasing shortage and growing maldistribution of the clinical workforce further reducing the capacity to provide services to populations at risk. Rural and remote areas, public dental services and Aboriginal health services are finding it increasingly difficult to attract and retain clinicians.

In the 2008-2009 Budget the Commonwealth provided \$490.7 million over four years for oral health in the 'Teen Dental Plan'. At the same time the Budget reduced expenditure of \$491.4 million on the Oral Health program for patients with chronic and complex conditions being treated under a multi-disciplinary care plans where a person's oral health impacts on their chronic medical condition or has potential to do so. Although the original program was recognised as an inadequate and poorly targeted response to the oral health care crisis in Australia, there is still a need for significant further investment in oral health rather than a reduction in the investment.

The PHAA believes that all members of the Australian public should have access to culturally appropriate, safe, affordable and timely oral health care. We are seeking a commitment to:

Key Recommendations in oral health

- Expand the Commonwealth funding of oral health to a national public oral health program that ensures equitable access to basic oral health services
- Provide the incentives that apply to the medical and allied health workforce in rural and remote areas to the oral health workforce and for student placements
- Strengthen the national oral health clearing house and its capacity to collect standardised quality data across all jurisdictions
- Fund a program with the States and Territories to ensure fluoridated drinking water is provided to all communities with a population over 1000
- Appropriately fund tertiary places and the academic workforce to ensure an effective oral health workforce for the future

SEXUAL AND REPRODUCTIVE HEALTH

Background

Sexual and reproductive health is a human right recognised in several international agreements ratified by the Australian Government. Despite this, we have unacceptably high levels of sexual and reproductive ill health.

Sexual activity occurs increasingly early in adolescents and young people. The median age of first sexual intercourse is now 16 years for both women and men. Most young people now experience 10 to 20 years of sexual activity before committing to a life partner. This increases the risk of unplanned pregnancy and sexually transmissible infections (STIs) such as Chlamydia and HIV infection.

Sexual vulnerability associated with high rates of substance use (especially alcohol) and sexual and reproductive problems is increasing. We are experiencing high rates of sexual violence (19.1% of female victims and 5.5% of male) associated with poor health outcomes including poor mental health and unplanned and unwanted pregnancies. Sexual and reproductive ill health disproportionately affects adolescents and young people and other marginalised groups.

We have inconsistent access to and use of a full range of available contraceptive methods. Australia's rate of 18.4 births per 1,000 teenage women aged 15 to 19 years is significantly higher than some other developed nations (e.g. Korea, Japan and Switzerland, with rates respectively of 2.9, 4.6 and 5.5). Teenage motherhood is associated with an increased risk of poor social, economic and health outcomes.

Australia has high estimated abortion rates; 19.7 per 1000 females aged 15-44 years (2003), compared with rates in Germany (7.7), the Netherlands (8.7) or Finland (10.9). We also have inconsistent access to abortion services and a continuing illegal status unless certain conditions are met in several states and Territories.

Australia experiences high rates of infertility (1 in 6 couples) and the economic costs of sexual and reproductive ill health to individuals and communities are substantial. Further, mental health problems associated with sexual and reproductive issues (e.g. homophobia and suicide in same sex attracted young men) are widely experienced.

Key recommendations on sexual and reproductive health

- Development of a comprehensive, evidence-based national sexual and reproductive health strategy to provide national leadership for a cohesive approach between government and non-government agencies, research organisations, service providers, private practitioners, community groups and the wider community, for the improvement of sexual and reproductive health outcomes.
- Such a national strategy should:
 - Involve key stakeholders and inter-sectoral collaboration
 - Invest heavily in prevention and early intervention
 - Be consistent with international human rights obligations
 - Include an action plan, a communications strategy and an evaluation strategy
 - Include a central co-ordination unit and have adequate funding attached.

CONCLUSION

The PHAA welcomes the opportunity to work with NHHRC and appreciates the opportunities provided for discussion and input.

Congratulations are in order for the efforts made by the Commission to improve Australian health. The approach of wide-ranging investigations, of partnering with others (such as the Prevention Taskforce) and by direct communication with so many ordinary citizens is welcomed. It bodes well for the future.

A range of funding mechanisms is being considered by the Commission. From our perspective, the time for a significant increase to funding prevention is long overdue. We are not concerned whether this is achieved through agreed national funding priorities between jurisdictions, through the Australian Healthcare Agreements, through SPP or by other methods. We are concerned about the outcome.

Funding and legislative support for prevention are the key issues. Each of the other areas that we have specifically included provides a guide to why that funding is so important.

The PHAA would welcome the opportunity to elaborate on all or part of our submission should the Commission consider that it might be useful.



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