Public Health Association
AUSTRALIA

Public Health Association of Australia

Submission to the Senate Select Committee on Health to inquire into and report on health policy, administration and expenditure

Senate Select Committee on Health
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Introduction

The Public Health Association of Australia Incorporated (PHAA) is recognised as the principal non-government organisation for public health in Australia and works to promote the health and well-being of all Australians. The Association seeks better population health outcomes based on prevention, the social determinants of health and equity principles. The PHAA has a vision for a healthy region, a healthy nation and healthy people living in a healthy society and a sustaining environment while improving and promoting health for all.

Public Health

Public health 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 role.

The Public Health Association of Australia

PHAA is a national organisation comprising around 1900 individual members and representing over 40 professional groups concerned with the promotion of health at a population level.

Key roles of the organisation include the development of policy, capacity building and advocacy. Core to our work is an evidence base drawn from a wide range of members working in public health practice, research, administration and related fields who volunteer their time to inform policy, support advocacy and assist in capacity building within the sector. PHAA supports a preventive approach for better population health outcomes by championing appropriate policies and providing strong support for Australian governments and bodies such as the National Health and Medical Research Council in their efforts to develop and strengthen research and actions in public health. The PHAA is an active participant in a range of population health alliances including the *Australian Health Care Reform Alliance*, the *Social Determinants of Health Alliance*, the *National Complex Needs Alliance* and the *National Alliance for Action on Alcohol*.

PHAA has Branches in every State and Territory and a wide range of Special Interest Groups. The Branches work with the National Office in providing policy advice, in organising seminars and public events and in mentoring public health professionals. This work is based on the agreed policies of the PHAA. Our Special Interest Groups provide specific expertise, peer review and professionalism in assisting the National Organisation to respond to issues and challenges as well as a providing a close involvement in the development of policies. In addition to these groups the PHAA's Australian and New Zealand Journal of Public Health (ANZJPH) draws on individuals from within PHAA who provide editorial advice, and review and edit the Journal.

Advocacy and capacity building

In recent years PHAA has further developed its role in advocacy to achieve the best possible health outcomes for the community, both through working with all levels of governments and agencies, and promoting key policies and advocacy goals through the media, public events and other means.

Preamble

PHAA welcomes the opportunity to provide input to the Senate Select Committees on Health (the Committee) inquiry into and report on health policy, administration and expenditure. This submission addresses each of the Terms of Reference before the Committee by drawing on research and expertise from the PHAA member base of Australia's leading public health professionals and internationally recognised contributors to progressing of the public health agenda.

The submission focuses on health policy issues relating to preventive health, health equity and sustainability and protection of the fundamental Australian right to a universal health care system. In particular, PHAA has focused on cost saving preventative health initiatives, tackling the causes of the causes of poor health for disadvantaged Australians, health research needs and protection of Australia's universal health care system.

PHAA firmly believes that the impact of reduced Commonwealth funding for health, social welfare, Indigenous programs, education funding and the environment portfolio will have major ramifications for the future health outcomes of Australians. The creation of the new Medical Research Fund will do nothing to mitigate a diminished focus on preventive health at the national level and the redirection of health funding from those least able to afford it towards research likely to benefit only those who can already afford to pay for the newest treatments in medical practice will only serve to widen the gap in Australia's health system.

PHAA urges the Committee to implement the recommendations advised in order to progress issues raised in this submission and promote the health and well-being of all Australians.

This submission reinforces the recommendations provided in previous submissions to this and other Parliamentary Committees which continue to be a priority for PHAA, our individual members and the professional groups we represent.

Key messages

1. Increase spending on health prevention. This will bring substantial benefits in terms of both health and costs in years ahead to the Australian people. There are opportunities for raising revenue ($2 billion per annum) while playing a key role in improving long term health outcomes of individuals and the community when implemented as part of a comprehensive plan.
2. Improved health outcomes for all Australians can be achieved by tackling the "causes of the causes" of poor health with a specific focus on disadvantaged sectors of our community. Address health equity by addressing the social determinants of health in Australia.
3. The creation of a Medical Research Fund will do nothing to mitigate preventive health at the national level or reduce growing inequity in our health system. Change the 'Medical Research Fund' to the 'Health and Medical Research Fund' and fill the data gaps and research needs in Australian health.
4. PHAA calls on the government to maintain and protect the universal, publicly funded health care system in Australia and people's right to a healthy life.

Preventive Health/Health Promotion

The World Health Organization (WHO) describes preventive health as: Approaches and activities aimed at reducing the likelihood that a disease or disorder will affect an individual, interrupting or slowing the progress of the disorder or reducing disability. Primary prevention reduces the likelihood of the development of a disease or disorder. Secondary prevention interrupts, prevents or minimises the progress of a disease or disorder at an early stage. Tertiary prevention focuses on halting the progression of damage already done. Effective prevention brings significant benefits to society as a whole, including improved economic performance and productivity.[1]

"Health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health".[2] Health promotion not only embraces actions directed at strengthening the skills and capabilities of individuals but also actions directed towards changing social, environmental political and economic conditions to alleviate their impact on populations and individual health.

Health Equity

Health is a human right, a vital resource for everyday life, and a key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions of society that underpin people's health. The health status of all people is impacted by the social, political, and environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries.[3]

Universal Health Care

Universal access to primary health care based on need and not on the ability to pay is a fundamental human right.[4] Clean water, adequate nutrition, sanitation, satisfying employment, adequate housing, safety and social support, and access to appropriate primary health care are essential for good health.[5] Universal access to primary health care contributes to improving the health of disadvantaged and vulnerable groups and is an essential responsibility of governments.[6] Violence, war and conflict impact negatively on health and reduce opportunities for good Health. Peace and cooperation are essential to maintain and promote good health. Maintaining good health is an individual and collective responsibility. Investment in primary health care promotes social justice and equity that protects and enhances the public's health. A healthy well-informed population contributes to social and economic development.[7]

PHAA Response to Committee Terms of Reference

In this submission PHAA provides the Committee with the latest research and well-informed arguments for the direction of health policy, administration and expenditure in Australia.

a) The impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting

Commonwealth funding of Australia's health system has traditionally been limited to provisions for primary health care leaving State and Territory governments to deal with the growing costs of acute care. The National Health Reform Agreement signed off by the Council of Australian Governments (COAG), set about rectifying the blame game and cost-shifting exercises of the past. While abolishing this agreement will make the Federal Government's bottom line look better in a few years, tax payers will continue to foot the bill via taxes to State and Territory governments instead. The attacks on prevention and primary health care may not be deliberate but simply fit into a part of a broader process of cost-shifting and removal from Federal Government responsibility.

Many of the funding cuts will result in cost shifting from the Commonwealth onto State and Territory Governments, overstretched Not-for-profit and non-government organisations and the Australian people in terms of access to timely and effective health care interventions.

Broad trends reported in the recently released Australian Institute of Health and Welfare (AIHW) Report *Health Expenditure Australia 2012-13* indicates:

> *"In 2012-13, governments provided $100.8 billion, or 68.3% of total health expenditure in Australia. This was 1.6 percentage points lower than in 2011-12, the largest reduction observed over the previous decade. The Australian Government's contribution was $61.0 billion (41.4% of total funding) and state and territory governments contributed $39.8 billion (26.9%).*
>
> *Australian Government funding decreased between 2011-12 and 2012-13 by $70 million in nominal terms; state and territory governments' funding increased by $1.5 billion; and non-government funding increased by $4.0billion."*[8]

Since 2002-03 the Federal Government has decreased expenditure by 2.2% while state and territory and local governments' share of expenditure grew by 2.6%.[9]

The reduction of federal funding for health appears to be short sighted and lacking recognition of the health and economic costs associated with the growing burden of disease. Further, studies into the impact of cuts to health budgets for public health and prevention measures in European countries in recent years have seen rates of HIV, TB, suicide and infant deaths rise exponentially demonstrating the unintended impacts and false economy of funding cuts in those countries.

Cuts to funding and the abolition of a number of key advisory bodies undertaken in the initial months of the new Australian Government are of serious concern to PHAA. We believe that any additional cuts to the health system will invariably have a further negative impact on both service delivery and outcomes across portfolios. At the same time as regulations are being slashed by

governments, the NGOs who are in a position to present coherent arguments to governments are under threat. Examples include the loss of the Alcohol and Drug Council of Australia (ADCA) and a consequential lack of access to information previously available through its library service, and the loss of leadership around alcohol, obesity and tobacco issues with the demise of the Australian National Preventive Health Agency. Discontinuing funding for these bodies will make the mantra of less tax, smaller spending and less regulation more difficult to deliver.

The abolition of a number of key advisory panels further highlights this approach. Among the most notable are the Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF) and the Immigration Health Advisory Group. The latter included psychiatrists, psychologists, nurses and GPs who provide independent policy advice on the health needs of asylum seekers and refugees. Similarly, the government announced its intention to "wind down" the operations of the Prime Minister's Council on Homelessness and the Australian Charities and Not-for-profits Commission (ACNC).

Early action of the Abbott Government in defunding the Climate Commission may have resulted in its phoenix like reincarnation as the Climate Council, made possible by 'crowd-funding' activities. However, it is unlikely that many of the other bodies that exist to support improved health outcomes for the most vulnerable, by the nature of what they do, will be able to gain similar financial support.

The reports of Sir Michael Marmot and others on the 'social determinants of health' illustrate the prime fallacy in the push for more and more emphasis on personal responsibility. Prevalence of diabetes, for example, is currently better explained by where you live than behavioural risk factors such as smoking or exercise. Policies that utilise a broad understanding of all these issues have most chance of success.

Cuts to jobs, cuts to NGOs, cuts to advisory boards may not have an immediate impact. However, the cumulative effect is a matter for grave concern. Environmental impacts on health, limitations on the ability to deliver sensible policies around drugs and alcohol and understanding the detail on issues around migrant and refugee health are just the tip of the iceberg. The real challenge is that these cuts are already likely to have the heaviest impact on the most vulnerable.

Recommendations

Ensure adequate funding to the Australian Health System by:

- Providing (and maintaining) a high quality, accessible, culturally competent and safe publicly funded health system that includes access to essential medicines and holistic care, particularly for vulnerable, excluded or disadvantaged groups.
- Increase Government funding for primary health care and health prevention initiatives to improve the health and well-being of the community and create long term savings for the health budget.

b) The impact of additional costs on access to affordable healthcare and the sustainability of Medicare

As outlined in the Grattan Institute report *Access All Areas*, GPs are the first point of call for people needing health checks, treatment for chronic conditions or when they are generally feeling unwell.[10] It is where Australians go for diagnosis, treatment and advice and where early detection prevents escalating costs both in terms of people's health and a burden to health resources needed for treatment of acute or advanced issues.

The $7 co-payment for GP visits, out-of-hospital pathology and diagnostic imaging services is a regressive measure, creating barriers to primary care access for disadvantaged Australians and increasing burdens on hospitals. [11]

It is unethical to fund medical research with a GP Tax which will discourage people from visiting their GP and detract from the universal free-at-the-point-of-use nature of Medicare. This new tax will fall hardest on the most disadvantaged, and those with low incomes or a chronic condition. It will increase demand on already over-stretched emergency departments and public hospitals. We don't need a hastily thought out scheme that links GP Tax to research income.[12]

In March 2014, the Consumers Health Forum released a report into the potential issues relating to a GP co-payment finding that:

- Co-payments will result in people delaying treatments, leading to higher health costs overall.
- There is no evidence to show there will be overall cost savings but there is a clear risk of compounding existing problems and further disadvantaging people.
- Co-payments will create more financial hardship, have a big impact on sick and poor people and compound existing disadvantage.
- Introducing co-payments will result in decreased access to health care.
- Existing co-payments already cause financial hardship for many consumers – particularly people with chronic conditions and/or on low incomes.
- There is a significant body of international evidence to show co-payments create barriers to access for health care for many consumers without decreasing overall health costs.
- 17% of all total health care expenditure in Australia is now being funded by individual co-payments. It is now the largest non-government source of funding for health, goods and services and is significantly higher in Australia than in most OECD countries.[13]

If the Coalition's Health Policy is to support the recommendations made in the McKeon review as stated (page 2)[14], it will 'support policy with evidence'. However, there is a significant lack of evidence demonstrating the benefits of a GP co-payment[15].

Universal access to primary health care based on need and not on the ability to pay is a fundamental human right. Providing access to primary health care is an essential role of Government and not a cost that can be shifted onto those in the community who least can afford to pay.

Recommendations

- Re-commit to Medicare as a mechanism to provide accessible, affordable and appropriate healthcare to the Australian public regardless of individuals' ability to pay.
- Reject proposals to introduce a co-payment for GP and other primary healthcare services.

c) The impact of reduced Commonwealth funding for health promotion, prevention and early intervention

At a time of increasing demand for expenditure on tertiary care a government with a long term vision will invest in prevention. In this section PHAA outlines various different approaches that can be used to cost effectively address issues in health promotion, prevention and early intervention. These include:

- Raising expenditure on prevention
- Establishing an Australian Centre for Disease Control (ACDC)
- A comprehensive approach to food, nutrition and physical activity
- Reduce harm associated with the use of tobacco and alcohol
- Fund a National Injury Prevention Plan
- Revenue options with positive public health ramifications

Raise expenditure on prevention

The abolition of the *Australian National Preventive Health Agency* flies in the face of an agreement by all governments in Australia. It is a unilateral action by a single government to do away with an agreement reached between governments. It is one of a series of moves that undermine the actions that have been taken to promote preventive health in Australia. The abolition of the National Partnership Agreement on Preventive Health removed $367 million over four years from public health. This is at a time when the AIHW estimates Australian spending on prevention to be less than 2% of overall health expenditure.

Governmental commitment to prevention across Australia including the States and Territories currently stands at 1.7% of the health budgets,[16] much of which is dedicated to screening and immunisation programs. This is down from 2.2% in 2010.[17] While recognising the policy and funding commitments that have been made to prevention in recent years through the Council of Australian Governments (COAG) and other processes, we believe that any health program designed to improve the health of Australians must include a strategy to increase the funding allocated to prevention.

There is enormous potential for preventive programs to improve the health and well-being of the community and prevention spending makes good economic sense although, results are never short term. More spending on prevention initiatives in the areas of alcohol such as the reduction of alcohol supply to minors, advertising restrictions and behaviour change targeting binge drinking can prevent 14,000 unnecessary hospitalisations for alcohol misuse annually. Obesity costs Australia $120 billion annually, yet people who live in a walk-able neighbourhood are on average 3kg lighter than those who cannot walk to school or walk around their community and every time someone bicycles to work the economy benefits by more than $14.

The PHAA urges all parties to recognise the importance of prevention by presenting to the community a Public Health Policy document that commits to a significantly increased focus on all aspects of public health – from research to intervention and includes public health training, development and capacity building.

Recommendations

- Increase the level of funding for prevention from 2.2% to 4% of health expenditure. At the Federal level this means budgeting for $1.16 billion. This requires additional Federal funding of around $0.522 billion pa from an expected expenditure this financial year of $0.638 billion.

Establish an Australian Centre for Disease Control (ACDC)

The Finance and Public Administration Committee of the Senate reported on the progress in the implementation of the recommendations of the 1999 *Joint Expert Technical Advisory Committee on Antibiotic Resistance* (JETACAR). A series of recommendations from that Committee drive not just the issue of antimicrobial resistance but a broader approach to communicable disease. The PHAA urges all political parties to adopt the recommendations of the Senate Committee as a matter of urgency.

The first recommendation of the Senate Committee and the one PHAA has focused on as a priority for this submission is:

> *2.61 The committee recommends that the Commonwealth establish an independent body or national centre, to develop a strategy, report publicly on resistance data and measures taken to combat antimicrobial resistance and to manage the response to antimicrobial resistance in Australia.*

Keeping in mind that there were indications long before the 2013 election that the Australian National Preventive Health Agency (ANPHA) would be targeted by the incoming government, the PHAA had previously proposed that the work of the Agency could be incorporated into a much more extensive agency that went well beyond the relatively narrow prevention focus that was assigned ANPHA and could also deal with planning and evaluation around all forms of disease whether non-communicable or communicable. We perceived that in the short term the costs would not be dramatic as the functions are currently performed in a disparate way across a number of departments and jurisdictions.

Australia is unique in being the only OECD country without a recognised separate authority for the national scientific leadership and coordination of communicable disease control. Many comparable international bodies have been refocused or grown to not only focus on communicable disease control, but on prevention of non-communicable and preventable chronic diseases.

At the Communicable Disease Network of Australia (CDNA) and PHAA Communicable Disease Control Conference held in Canberra (4-6 April, 2011), the Australasian Faculty of Public Health Medicine of the Royal Australasian College of Physicians and PHAA progressed the concept of an Australian Centre for Disease Control (ACDC), which would provide national scientific leadership of surveillance and control of current and emerging infectious diseases across the country and, as appropriate, in the neighbouring region.

That the aim of establishing an ACDC would be to provide strong central, expert driving leadership and coordination of national communicable disease control. Secondly, an ACDC could operate as the central leading organisation (the hub), in partnership with existing government and non-government agencies: a "Hub and Spoke" model. Key functions could include:

- National coordination of disease surveillance. Experts in both non-communicable and communicable disease surveillance should lead the analysis and interpretation of notifiable disease information and the coordination of scientific effort;
- National leadership in communicable disease prevention programs e.g. National Immunisation Program, HIV and antibiotic resistance;
- Specialist expertise in the investigation, coordination and management of nationally significant outbreaks of communicable disease or other significant related issues (e.g. adverse events following vaccination);

- Specialist expertise in the investigation of prevention and management of non-communicable disease;
- Oversight and coordination of training and development of the disease control workforce; and
- Strategic contribution to the control of both non-communicable and communicable diseases in the Australian Area of Interest (Western Pacific and Near North) in partnership with WHO regional agencies.

Our perception was that such an agency would best be established through legislation to function as a national source of technical capacity separate to the existing Department of Health (and jurisdictional equivalents). This 'Agency' should report through a CEO to a Board of eminent leaders in disease control and prevention and ultimately through the Board to the Federal Minister of Health. Appointments to the Board should be made by agreement between the Federal, State and Territory Ministers of Health, through the Standing Council on Health (SCoH) and in consultation with recognised leaders in disease control.

A framework for implementation and evaluation of this model should be established which takes into account the costs involved, measures of functional improvement in disease control initiatives and particularly, improvements in disease control outcomes at jurisdictional levels. This would include measures based around priority targets for disease control and would also involve consideration of current arrangements under the legislative framework for the *National Health Security Act 2007.*

Australia has a track record of positive outcomes in disease control. This extends as far back as Australia's impressive response to the 1918-19 influenza pandemic and leadership in the early days of the response to HIV-AIDS. However, we continue to have concerns that:

- The pressures of globalisation, travel and environmental change have resulted in a complex and rapidly evolving communicable disease agenda.
- Modern and future communicable disease threats require a much more robust response capability than can be delivered through current systems.

Although the Australian Government plays a role in disease control, there are limitations to its authority and ability to influence the traditional roles of the States and Territories in securing disease control outcomes. It is not just in the area of health, or communicable disease in particular but that the interests of the State and Territory jurisdictions do from time to time differ from Federal interest creating a certain level of tension. Recently, for example, the Queensland government extensively cut areas of public health including some that have direct relevance to both communicable and non-communicable disease. The impact on public health and health promotion was significant with the Queensland government stating that this was the work of Medicare Locals (presumably this will now fall to the soon to be established Primary Healthcare Networks). The scrapping of the National Partnership Agreement on Preventive Health and ANPHA has marked an end to cooperation in the area of prevention and health promotion.

Recommendations

- Initiate an investigation into the establishment of a new Australian Centre for Disease Control (ACDC), including a broader remit to include health promotion and prevention.

Food, nutrition and physical activity

Good nutrition is vital for growth in early life, health and wellbeing, preventing the development of chronic disease and is integral to the treatment of disease to minimise disease progression. Lack of good nutrition is also a major contributor to the rise of 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 apnoea, 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.

The National Preventative Health Taskforce identified that "In only 15 years, from 1990 to 2005, the number of overweight and obese Australian adults increased by 2.8 million."[18] In recent figures from the Australian Institute of Health and Welfare report *Australia's health 2014,* the trend continues indicating that two thirds of the population is now overweight or obese.[19] The Taskforce also identified that a quarter of our children are also overweight or obese. This is up from just 5% of our children in the 1960s. Almost a third of our children do not meet national guidelines for physical activity and only about a fifth meet dietary guidelines for vegetable intake. Even moderately obese people have a life expectancy between two and four years less than those with a healthy weight, with some research indicating up to a seven year difference.[20]

A comprehensive approach to tackling obesity in Australia 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 National Nutrition Policy should be developed through an open, engaging and transparent process and in a manner that is linked with other policies such as the National Food Plan and other key policy areas such as physical activity, women's health, Indigenous health and the national curriculum.

Leadership by the Federal Government is needed to establish a National Nutrition Policy which is a truly comprehensive, multi-sectoral, adequately funded and long-term. The National Nutrition Policy must be followed with an implementation plan.

Recommendations

- Implement a tax/levy on selected nutritionally undesirable foods (such as sugary drinks), with a view to using the funds raised for preventive programs and to promote and subsidise nutritionally desirable foods for disadvantaged groups.
- Develop the National Nutrition Policy in a way that is consistent with current policies and plans that impact on food, nutrition and health.
- Implement and provide adequate funding for the recommendations of the Preventative Health Task Force Report: *Australia: the Healthiest Country by 2020*.
- Provide commercially realistic levels of funding for comprehensive evidence driven public and community social marketing programs to run independently of any food industry and political involvement with a focus on non-packaged foods. This should be funded to the level of at least $100 million per annum, which is modest compared with industry advertising and promotional expenditure. This program should incorporate or reflect expected systems of simple and interpretive front of pack labeling such as the Health Star Rating.

- Implement rigorous legislated controls and active monitoring to protect children from 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, including advertising, internet, sports/events promotion and promotions through schools.
- Improve labeling of foods with an effective interpretive system so that nutrition/health information is clear and consistent across nutrition/diet promotion activities, and impose effective controls over direct or indirect health claims for nutritionally undesirable foods.
- Commit to appropriately resource research and implementation of effective Health and Physical Education (HPE) in schools in the new Australian Curriculum, including achievement of specified hierarchies of health and food literacy (as Achievement Standards) across the stages of education.

Tobacco – reduce smoking and provide funding for prevention activities

Health groups believe that cigarettes in Australia should cost at least $20 per pack of 25 and that this is achievable within the life of the current National Tobacco Strategy 2012-2018. The National Preventative Health Taskforce recommended regular, annual tobacco excise and customs duty increases "to discourage smoking and to provide funding for prevention activities". There is overwhelming evidence on the impact of increasing prices, with special benefits in influencing children and low-income groups. There is also strong public support for this measure, all the greater if the revenue goes back into supporting health costs.

We applaud the previous Government's determination to reduce the massive harms of smoking, and its costs to the community, particularly through its world-leading plain packaging legislation and tax increases ensuring a further significant dramatic reduction in smoking.

Regular tobacco tax increases have been recommended by the major health and medical authorities and expert groups, including the World Health Organization, other international health groups, the PHAA, AMA, Cancer Council, Heart Foundation and many more.

Tax increases are a continuing comprehensive program of action, including strong public education programs, special support for disadvantaged groups (with a major focus on the Tackling of Indigenous Smoking Initiative) and further measures to reduce tobacco sales and protect non-smokers from the harms of passive smoking.

PHAA appreciates the continued pressure tobacco tax increases add to a comprehensive approach to reducing smoking, with revenue raised to be allocated to health funding.

Recommendations

- Reject all funding of political parties by tobacco companies and return any current donations.
- Use tax reform as part of a comprehensive approach designed to reduce harm associated with the use of tobacco.

Alcohol – replace the WET Rebate with a volumetric tax rate

The PHAA supports the case put to the government in a budget submission by the Foundation for Alcohol Research and Education (FARE), the submission of 29 January 2013 by the Alcohol and Other Drugs Council of Australian (ADCA) and the approach taken by the National Alliance for Action on

Alcohol (NAAA) for tax reform as part of a comprehensive approach, including regulation to curb alcohol promotion, research-based health warnings and information determined by government, increased expenditure on public education, and national approaches to ensure consistent and more effective liquor licensing measures and enforcement and reductions in alcohol-caused injury, violence, domestic violence and road crashes.

FARE's submission argued not only the public health case but also for projected revenues of $849 million by the introduction of a volumetric taxation system over one year as well as a further projected improvement in revenues per year of $200 million by abolishing the wine rebate. FARE argued as follows:

"Clear cost savings can be made by replacing the WET with a volumetric tax rate, through increased revenue to Government and in the longer term through reduced costs of alcohol-related harms.

The case for reframing the WET in Australia has never been stronger. The evidence supporting the need for change is considerable and addresses the economic, health and industry benefits for reforming the current illogical WET. The WET must be reformed as a matter of urgency for the following reasons:

- The current alcohol taxation system is incoherent and at the centre of this is the WET
- Nine separate government reviews have concluded that the WET needs to be reformed
- The wine glut has ended and can no longer be used as a reason to delay reforming the WET
- Reforming the WET is cost beneficial
- The majority of the alcohol industry supports reforming the WET, and
- Claims about the catastrophic impacts of changes to the WET on the wine industry have been discredited.

To address the inequities in the alcohol taxations system that result in wine being priced significantly less than other alcohol products, a volumetric tax should be applied to wine and the WET rebate should be abolished."

FARE also demonstrated long-term savings through preventive health measures for a small expenditure on public health measures around alcohol issues including Foetal Alcohol Spectrum Disorder. The full submission can be found at http://www.fare.org.au/policy-advocacy/submissions-2/. PHAA supports the recommendations in this submission and endorses immediate implementation.

Recommendations

- Implement the recommendations from the FARE 2013-14 Pre-Budget Submission, in particular:
    - Replace the WET Rebate with a volumetric tax rebate (projected savings of $849 million)
- Use tax reform as part of a comprehensive approach designed to reduce harm associated with the use of alcohol

Injury Prevention

The issue of injury prevention has not been high on the government's agenda to this point. Injury prevention is a key priority for public health. However, as the largest cause of death for those under 35, injury prevention requires attention and action. The most notable success in this area in Australia has been in regard to motor vehicles. The PHAA believes that many of the lessons learnt from the

interventions and campaigns around seat belts, speeding and alcohol related accidents have applicability in other areas where injury considerably increases the burden of disease. The PHAA has a number of injury prevention policies which illustrate the need for a comprehensive national approach. These include:

- **Firearms injuries** – Gun ownership is a privilege not a right and should not compromise public safety. Firearm injuries occur due to a combination of the availability of the firearm, opportunity to access, the motivation for use, and community attitude. Addressing all aspects will mean success in reducing firearms related injuries. Ownership of firearms should be permitted only for those with a genuine reason to do so.
- **Falls injury prevention in older people** – A comprehensive approach to Falls Injury Prevention for Older People needs to be developed and implemented in context with existing (and future) government initiatives, including the National Falls Prevention for Older People Initiative, National Strategy for an Ageing Australian and state and local government initiatives.
- **Hot Water Temperature and Scald Burns** – The majority of burns and scalds (males 95%; females 92%) refer to non-intentional events, involving contact with hot water or other hot fluids, or with fire, burning objects, or hot objects. The higher the water temperatures the greater the risk of producing a full thickness scald burn. Water at 65°C produces a full thickness burn in less than a second of exposure, at 60°C in around five seconds, and at 55°C, in around thirty seconds. Action can be taken to regulate temperatures for use in domestic and personal circumstances.
- **Smoke Detectors in Residential Housing** – Most deaths in residential fires occur at night, when the occupants are asleep and almost half of the deaths are as a result of smoke inhalation, not burns. Those who die from burns are often first incapacitated by smoke. All homes should be fitted with smoke alarms to offer the early warning necessary to escape a fire alive.

Recommendations

- Recognition of Injury Prevention as a Health Priority supported by the Health Minister and relevant government agencies.
- Inclusion of Injury Prevention in the Australian National Preventive Health Agency's work plan as a standalone key priority area.
- Funding ($200k) towards the evaluation of the existing injury prevention plan and development of a new plan.
- Resources allocated for the implementation of a National Injury Prevention Plan
- Increased resources allocated for the funding of injury prevention research in Australia.
- Resources are allocated for a nationally coordinated injury and falls prevention program.

Revenue options with positive public health ramifications

There should be a comprehensive approach to addressing each of the areas of revenue raising through the public health initiatives identified above. As an example revenue raising in relation to alcohol should fit in as part of a program that includes for example: regulation to curb alcohol promotion, replacement sponsorship for sports, research-based health warnings and information determined by government, increased expenditure on public education, and national approaches to ensure consistent and more effective liquor licensing measures and enforcement and reductions in alcohol-caused injury, violence, domestic violence and road crashes. Similar approaches should be adopted in comprehensive strategies addressing junk food and lowing carbon usage. The

government should use as a model the comprehensive approach that has been deployed by State, Territory and Federal Australian governments in dealing with the health consequences of smoking.

In advocating increased expenditure on public health, we would like to draw the Commission's attention to the potential returns on this investment. The 2003 publication '*Returns on investment in public health: An epidemiological and economic analysis prepared for the Department of Health and Ageing*' by Applied Economics, provides a thorough analysis of returns on investment for key public health measures to date. This report describes an epidemiological and economic analysis of five public health programs, namely: programs to reduce tobacco consumption, coronary heart disease, HIV/AIDS, measles and Hib-related diseases, and road trauma.

The report's conclusions illustrate the value of investments in public health prevention programs over time in terms of savings to the health budget. For each of the five key public health programs, the estimated net benefits were as follows:

- Programs to reduce tobacco consumption: $8.427 billion
- Programs to reduce coronary heart disease: $1.975 billion
- HIV/AIDS prevention programs: $2.541 billion
- Immunisation programs (measles only): $9.1 billion
- Road safety programs and road trauma: $3.4 billion

In considering the case for raising expenditure on public health/prevention programs from 2.2% to 4% of health budget expenditure, we recommend that the analysis of savings accruing from previous investments contained in the 2003 publication by Applied Economics be considered as an indicator of the size and scope of potential future savings.

Recommendations

Junk Food:

- Implement a tax/levy on selected nutritionally undesirable foods (such as high added sugar drinks), using the funds raised for preventive programs and to promote and subsidise nutritionally desirable foods for disadvantaged groups.

Tobacco Revenue:

- Cigarette prices in Australia are lower than in some comparable countries. Continue increases in excise duty per annum of at least ten cents per stick would reduce smoking and raise approximately $1.25 billion per annum in the first year.
- Reject all funding of political parties by tobacco companies and return any current donations.

Alcohol Taxation:

- Projected savings of $849 million if a volumetric tax is applied to wine and the WET rebate is abolished.

d) The interaction between elements of the health system, including between aged care and health care

It has long been acknowledged that people with complex needs often fall through the cracks in service delivery – between national and jurisdictional service delivery, between government and non-government services, and between services delivered by different portfolio agencies.

Around 640,000 Australians experience multiple disadvantage, or 5% of the population.[21] A 2013 study by the University of Canberra found people with persistent complex needs were more likely to experience chronic health problems, particularly disability and mental illness, and to suffer from financial deprivation: more than one-half of this group were living below the poverty line.[22]

While the experience of a single disadvantage can create difficulties for people, the experience of multiple disadvantages can have a compounding and persistent effect, reinforcing barriers to getting ahead and increasing the likelihood of other related problems later in life.[23] As well as the huge social and human costs, the economic costs to government are significant. A 2011 study on homeless people with complex needs found life-course institutional costs for 11 individuals, aged between 23 and 55 at the time, ranged from around $900,000 to $5.5 million each.[24]

There are some brilliant examples of collaborative approaches to achieving better health and social outcomes for people with complex needs at the local level, but these are often not supported by traditional approaches to policy and funding that usually focus on a single area of need. By facilitating cooperation between agencies providing support and assistance to people with complex needs, governments will also be able to achieve better returns on existing investments in funding. People don't live their lives within portfolios, and those with complex needs in particular need help to negotiate their way through the maze of available services.

Recommendations

PHAA with draws on recommendations from the National Complex Needs Alliance:

Funding Structures

- Acknowledgement of cross-portfolio and cross-sectoral collaborations in service delivery (cooperative case management) in government funding agreements and reporting requirements.
- Cross-portfolio policy development in relation to complex needs.

Supporting Collaborations in Service Delivery

- Explore potential for existing structures to play a role as Solutions Brokers/Project Managers in facilitating, supporting and building on cross-portfolio and cross-sectoral collaborations in service delivery.

Building the Evidence Base and Promoting Best Practice

- Support for research projects designed to build the evidence base on effective interventions in addressing complex needs.
- Support for efforts to promote the uptake of established models of best practice and the workforce training needed to enable it.

Council of Australian Governments

- A National Partnership Agreement on Complex Needs, establishing the respective roles to be played by different levels of government, bi-partisan support, and appropriate accountability mechanisms which minimise bureaucracy.

e) Improvements in the provision of health services, including Indigenous health and rural health

Social Determinants of Health

The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries.

There is evidence that health inequities are increasing in Australia.[25,26] The absence of specific indicators and measurement of health determinants hinders the ability to measure progress towards reducing health inequities across population groups,[27] and improvement in general population health outcomes may be obscuring the changes within specific groups.

Within developed nations that have an established public health system, cost-effective interventions to improve life expectancy are not adopted on a scale required to close the inequities gap because adequate funding is generally not committed where there is greatest need.[28]

Australians enjoy one of the highest life expectancies in the world however; this longevity is not shared equally among Australians. Significant differences remain across a range of health outcomes for different groups of Australians including: rates of death and disease, life expectancy, self perceived health, health behaviours, health risk factors and health service access and utilisation. These 'health inequities' are associated with a range of socio-economic factors including differences in education, occupation, income, employment status, rurality, ethnicity, Aboriginality, gender, housing status and disability.[29,30]

The cost of government inaction on the social determinants of health within populations is substantial; gains from enabling more Australians who want paid employment to access meaningful paid work could close the gap in self-assessed health status between most and least disadvantaged Australians of working age and could generate $6 to $7 billion per year in extra earnings.[31]

Reduction in social and health inequity nationally as a result of government policy directives should be recognised as a key measure of our progress as a society.

Recommendations

- The Australian Government, in collaboration with the states, territories and local governments, should outline a comprehensive national cross-portfolio and cross-government framework to reduce health inequities.
- The policy framework should be linked to or incorporated into the National Health Performance Framework endorsed by the Australian Health Ministers' Conference (AHMC).
- The Australian Government should work towards correcting inequities in health at the regional and global levels, through policies in all sectors (including foreign policy, development policy, official development assistance and trade policy). This requires both an adequate foreign aid budget and ongoing commitment to work towards achieving the United Nations Millennium Development Goals and the recommendations from the WHO Commission on Social Determinants of Health.[32]

Reduce social inequity by:

- Ensuring the equal distribution of the social determinants of health is a priority of policies in all sectors;
- Adopting a Health in All Policies (HiAP) approach[33] at all levels of government;
- Recognising that economic inequality is major health determinant; and
- Undertaking Health Inequality Impact Assessment of significant public policies to eliminate (or reduce) any inequitable impacts and/or to increase equity of impacts and outcomes.

Ameliorate adverse effects of social disadvantage on health by:

- Investing in strategies and programs to support the peri-natal periods and the early years of life; and
- Working with local communities and governments in disadvantaged regions to increase environmental and social infrastructure and thereby improve health and wellbeing.

Provide public health and health care services, especially to those most in need and disadvantaged communities by:

- Enabling the participation of disadvantaged groups across the continuum of health care including prevention;
- Providing comprehensive primary health care; and
- Providing a high quality, accessible, culturally competent and safe publicly funded health system that includes access to essential medicines and holistic care, particularly for vulnerable, excluded or disadvantaged population groups.

Aboriginal and Torres Strait Islander Health

Aboriginal and Torres Strait Islanders peoples have experienced the greatest social, economic, political and cultural deprivation of all population groups in Australia – the health consequences of which have been profound compared with the broader community. Indigenous life expectancy is approximately 10 years lower than the non-Indigenous population and Indigenous people have higher rates of death for almost all causes.[34] Indigenous people also bear a greater burden of disability and illness in a range of areas including cardiovascular disease, accidents and injuries, respiratory diseases and diabetes.[35,36,37]

There are some signs of slow improvement for Aboriginal and Torres Strait Islander peoples' health, but this has been less than the greater improvement seen in the total Australian population. To redress this imbalance, there should be an across-portfolio agenda and mandate (whole-of-government) with a clearly articulated vision informed by meaningful community consultation and specific funding. 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.[38]

Common themes emerging from key national framework documents include an emphasis on building capacity of community and workforce to enable access to holistic, evidence-based continuums of care in terms of the delivery of alcohol and other drug mental health and related services. The provision of such holistic continuums of care and referral to appropriate treatment pathways is dependent upon the establishment of intersectoral linkages.[39,40,41]

In other words, people will always have to access a number of different government and non-government services in order to have their needs met. If services are all adequately resourced, adhere to established standards of best practice within their respective areas of expertise and are able to work cooperatively together to meet the complex and multifaceted needs of individuals, then the journey of healing for people will be a lot smoother. There needs to be a focus on key "at-risk" or "target" groups that are experiencing disproportionate rates of harm.

Traditionally, community-controlled services have succeeded in attracting those people who are marginalised from mainstream services. Among this group of people are the "complex needs" clients, who have a range of needs that cross a number of categories of mainstream medicine (eg. coexisting mental health and alcohol and other drug problems). As many community-controlled services do not demand proof of Indigenous status, they often cater to the needs of some non-Indigenous people who have also had difficulty in engaging with mainstream services. [42]

In terms of both making mainstream services more accessible to Aboriginal and Torres Strait Islander peoples and strengthening the capacity of community-controlled services, workforce development is critical, and the employment of Aboriginal and Torres Strait Islander staff within mainstream organisations is one of the key measures proven to make mainstream services more accessible to communities.

Recommendations

- Facilitate the provision of a multifaceted range of services within communities, and aim for equitable levels of service delivery across the nation.
- Develop a National Aboriginal and Torres Strait Islander Social Determinants of Health Policy as a key strategy in closing the gap and overcoming Indigenous disadvantage. The policy needs to describe the social determinants, focus on social inclusion and support the provision of real opportunities in education, employment and health status, with funding tied to delivery of outcomes.
- Develop a policy for the inclusion of Aboriginal health equity and self-determination in the mandate of Local Hospital Networks and Primary Healthcare Networks. The policy should include reforms to increase the investment in culturally competent services by requiring:
    - Aboriginal community controlled health, legal and welfare services are prioritised and adequately supported
    - Mainstream services better meet the needs of Aboriginal and Torres Strait Islander people
- Greater investment in a holistic approach to mental health for Aboriginal and Torres Strait Islander people that supports prevention, treatment and opportunities to strengthen cultural identity, job readiness and social inclusion.
- Develop a national strategic framework to address food access and security for Aboriginal and Torres Strait Islander people including those living in regional and urban communities. Such a framework should identify determinants of food security, describe the burden of disease due to poor nutrition, determine the status of poor nutrition and support implementation of community driven programs.

f) The better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services

Primary Health Care

Comprehensive primary health care is a holistic approach to health and well-being that encompasses all services that can impact on health and wellbeing and is delivered in partnerships by an interdisciplinary team through a range of services and programs that are accessible, equitable, on-going, culturally appropriate, safe, effective and efficient.

Primary health care is founded on the interconnecting principles of equity, access, empowerment, community self-determination and intersectoral collaboration. It encompasses an understanding of the social, environmental, economic, cultural and political determinants of health.[43] It incorporates health promotion, the prevention of illness, and strategies to enhance individual and community control over health and wellbeing through a person-centred approach in addition to clinical care.

Universal access to primary care contributes to improving the health of disadvantaged and vulnerable groups and is an essential responsibility of governments.[44] While maintaining good health is an individual and collective responsibility, investment in primary health care promotes social justice and equity that protects and enhances the public's health.[45]

Insufficient primary health care resources negatively impact on the present cost of secondary and tertiary treatment and care. PHAA calls on the committee to strengthen health promotion and disease prevention in primary health care to improve the functioning, resilience and health of individuals and population health and wellness.

PHAA urges the Committee to support the development of a primary health care policy that addresses societal and contextual factors that promote and sustain good health as well as the delivery of primary, secondary and tertiary health care. The policy should support collaboration between health agencies, all levels of government, citizens and non-health sectors at local, jurisdictional, national and international levels.

There are systemic structural barriers to realisation of the principles of primary health care in Australia and the realisation of their potential contribution to more effective health outcomes. These include:

- parallel and inconsistent federal and state/territory involvements in program administration and cost-shifting between the jurisdictions;
- dominance of short-term project grants in funding of models to improve health outcomes for primary care and lack of systematic longitudinal evaluations of successful models;
- parallel and uncoordinated systems of primary health care service and delivery;
- differences of opinion about the meaning and proper practice of primary health care, health promotion and disease prevention;
- undue pressure on primary health care services to meet the needs of hospital avoidance and post-acute care at the expense of comprehensive primary health care;
- primary medical services as a driver for decision making about primary health care; and
- insufficient funding for research into determinants of health and well-being.

A national primary health care framework is essential as a driver to integrate and coordinate primary health care sectors and general practice.[46]

Recommendations

- Establish a National Primary Health Care Strategy to support and drive health services with emphasis on the social determinants of health, health promotion and early intervention.
- A national policy and planning framework for comprehensive primary health care should incorporate:
    - the strengthening of policy and strategic planning capacity in health promotion, public health and primary health care within health departments in all jurisdictions, to support arrangements for local and regional coordinating and planning activities;
    - reform of Australian Health Care Agreements to promote policy harmonisation, the potential for financial reform in resource allocation for primary health care, and the potential for key health issues to be addressed collaboratively both locally and nationally;
    - the establishment of evidence informed primary health care Key Performance Indicators from governments to health practitioners;
    - the encouragement of local government and non-government organisation sector involvement in population-based health planning particularly in the achievement of greater intersectoral cooperation and coordination at the local level;
    - the development of information and resources to improve both the quality of, and access to, timely information, and channels of access to support informed and organised citizen and community involvement in health care decisions;
    - strengthening the capacity and funding of research into primary health care, at the same time strengthening the institutional base for advocacy of primary health care principles and models of practice;
    - provision of support for primary health care agencies to engage in integrated service delivery and interdisciplinary learning opportunities, giving priority to interpersonal and team skills, social determinants of health and the rationale and scope for community-level initiatives in health promotion;
- Funds be available to the primary health care sector to:
    - support local and regional level arrangements for primary health care coordination including support for citizen and community involvement, both at the local, agency and regional levels;
    - increase centrally based funding for organisations that support self-management and community participation, without limitation being placed on their exercise of advocacy;
    - strengthen local government's involvement in public health to achieve intersectoral collaboration;
    - support education and training initiatives that lead to wider implementation of primary health care principles;
    - provide increased funding for research and evaluation of comprehensive primary health care in every state and territory that is available to community health services, local government and a range of primary health care practitioner groups;
    - plan extension of community health services as a key component of the primary health care sector, with provision for long-term funding for primary health care to avoid the costs and discontinuities associated with dependence on short term project funding; and
    - enable flexible funding arrangements to support enhancement of the primary health care sector, in accordance with local strengths and needs and covering all relevant community-based agencies and practitioners.

g) Health workforce planning

It is essential that health workforce planning reflect the changing health needs of Australians. PHAA believes this planning should be incorporated into the terms addressed above by building the competence and capacity of a national preventive health workforce that understands inequity and the social determinants of health and is skilled to deliver effective preventive health services at the local level.

Recommendations

- Invest in building the competence and capacity of a national preventive health workforce who understand inequity and the social and economic determinants of health and are skilled to deliver effective preventive health services at the local level.

h) Any related matters

Climate Change and Health – a safe environment

PHAA calls on the Government to commit to developing appropriate responses to climate change. The international medical journal The Lancet in May 2009 described climate change as the biggest global health threat of the 21st century. Since then, it has become apparent that climate change is already posing serious and immediate threats to the health and wellbeing of the Australian and global population, with grave implications for the medium to long term.

A safe environment is one of the core determinants of human health along with the socioeconomic and political structure of our society, and the complex individual and organisational factors affecting health and health services. Human activity including additional greenhouse gases is driving ecosystem and biodiversity changes.

The impact of global warming and its effects on climate, ocean levels, land and sea ice (the cryosphere), biodiversity and eco-services effects current and future human health and wellbeing. Global warming and consequent climate change as a result of human industrial and changed land use activity have been established at the highest level of scientific certainty beyond any reasonable doubt. Specific future impacts on health and society are uncertain in degree but are generally able to be forecast. They divide into direct and indirect effects. Direct impacts include temperature effects (heat waves), more frequent extreme weather, ocean changes and sea level rise. Indirect impacts include ecological disruption, social, economic and consequent psychological changes that affect human wellbeing and health.

The impacts are interdependent and synergistic. The indirect impacts will have larger effects than direct ones.

For example, there are serious implications for human health and wellbeing and safety from extreme weather events. Australians are already experiencing severe impacts from extremely dangerous and deadly weather events from relatively modest levels of global warming. The warming is anticipated to increase four-fold in the coming decades which is likely to create unprecedented conditions for our living environment, the parameters of which are beyond human experience.

What is needed is the collaborative development and funding of a comprehensive national climate change and health strategy, led by the Commonwealth and inclusive of input from State and Territory governments.

Recommendations

- Establish a requirement for a Climate Impact Assessment along with a Health Impact Assessment for all government policy and program decisions.
- Use of a range of taxes, revenue and other measures to support other changes to lower carbon.
- Funding for a National Climate and Health Plan designed to reduce the impact of climate change on health, including
    - a plan to deal with the impact of national heat waves
    - strategies to achieve urgent emissions reductions
    - national programs to raise awareness about climate impacts and proposed structural change to ensure emissions reductions
    - rollout of quality professional development for health and other community services personnel on climate change causes, impacts and solutions
- The establishment of and requirement for a Climate Impact Assessment and Health Impact Assessment to accompany all Government policy and program decisions.
- Inclusion of ecological economic indicators in policy, program and development assessments.
- Rapid removal of fossil fuel subsidies.
- Workforce support: There is an urgent need to improve the capacity of the health sector to manage future demand for services, as the current ability of the health sector to respond to the changing demands of climate change is compromised.

Research and Data Needs

Public health research has a history of underfunding in Australia relative to the level of funding available for medical research. Public health research has considerable potential to make a direct and central contribution to Australia's National Research Priorities. It makes a direct contribution to the priority of 'Promoting and Maintaining Good Health' and can also build synergies between health and other goals such as environmental sustainability. By informing effective strategies for health promotion and disease prevention across the life course, public health research can help to control the demand for, and public costs of, medical care. A continued focus on biomedical research, and on new forms of medical intervention (valuable as they may be), will not achieve our national research priorities in health, and may indeed contribute to growth in public costs of medical treatments. Public health research can support action to address the social determinants of health, so as to promote the public good and reduce health inequities.

Public health research is quite different from bio-medical research. It focuses on the health of whole populations and is concerned with documenting the incidence of disease, understanding the origins of disease, determining what factors make for healthy populations and evaluating the impact of measures (including policies, programs and social changes) that keep populations healthy and free from disease. Public health research is multi-disciplinary and includes epidemiology and the full range of social sciences (including sociology, psychology, economics, anthropology and ecology). Public health research focuses on how social, economic, physical and natural environments shape health and health-related behaviours. It also includes much health services research, especially that which monitors the effects on whole populations. Public health research addresses upstream structural drivers of health inequities (such as trade, macroeconomic policy, labour markets, environmental change etc.) and conditions of daily living that affect health (health care, urban

environment, working conditions and social relations). Public health research also covers evaluation of interventions, so as to determine what works in improving population health.

One of the central concerns of public health research is with increasing health equity, through actions to address the gradient in health status across social groups and to improve the health of vulnerable groups.

Aboriginal health is a particular focus of public health research, and to address the Council of Australian Government building blocks endorsed by the Commonwealth, requires an understanding of the social determinants impacting on the lives of Australia's Aboriginal and Torres Strait Islander people. To inform policy and program decision-making a gap that has been identified within Aboriginal and Torres Strait Islander research is the lack of evidence in intervention research specifically the evaluation of health interventions.

Another identified gap in Aboriginal and Torres Strait Islander research is translational research to evaluate the effectiveness of strategies used to implement policies to improve health service delivery and health outcomes. What we need to know is how these strategies can be scaled up within the health system.

To effectively close the gap in Aboriginal and Torres Strait Islander Health the NH&MRC needs to fund 'real' research that is 'solutions focused' with research that is aligned to addressing health policy that directly impacts on Aboriginal and Torres Strait Islander people.

Statistics focusing on individuals - as per the 'top down approach' – are not particularly useful, because to make any changes towards closing the gap we need to start presenting research data where the research, the methodology and the unit of analysis is developed in collaboration with communities or families and this means using the 'bottom up approach'.

Recommendations

Beyond the general need for increased funding support for various forms of public health research in Australia, we suggest that particular areas of research priority include:

- Research funding needs to be allocated to research for Aboriginal and Torres Strait Islanders that becomes the basis of which to inform policy decisions.
- Understanding social determinants of physical and mental health in Australia;
- Evaluation of public health interventions;
- Aboriginal and Torres Strait Islander health research;
- Health and social policy research, to understand what kinds of policy are best placed to support gains in population health and well-being, and improve health equity;
- Health services research, including in primary health care;
- Research on translation of public health evidence into effective public policy;
- Understanding, managing and preventing the adverse health effects of climate change; and
- Direct NH&MRC to fund research into examining the impact of trade and macroeconomic policy on health and health inequities.
- Disseminate information about the strategies that will be used to work with other Australian governments to ensure this program is widely accepted and accessed by the eligible Australian children and families to whom it is targeted.

Conclusion

The PHAA appreciates the opportunity to make this submission and looks forward to the possibility of further participation in the inquiry of the parliament into health policy, administration and expenditure.

PHAA seeks support from the Committee to ensure health policy, administration and expenditure is as closely as possible managed in line with this submission.

Please do not hesitate to contact the PHAA should you require additional information or have any queries in relation to this submission.

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