Public Health Association
AUSTRALIA

Build Back Healthier

Strategic Directions / Pre-Budget Submission for the 2021-22 Commonwealth Budget

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The **Public Health Association of Australia** (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public's health in Australia.

The PHAA works to ensure that the public's health is improved through sustained and determined efforts of our Board, National Office, State and Territory Branches, Special Interest Groups and members.

We believe that 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 that underpin people's health. The health status of all people is impacted by the social, cultural, political, 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. These determinants underpin the strategic direction of the Association.

Our mission as the leading national organisation for public health representation, policy and advocacy, is to promote better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health. Members of the Association are committed to better health outcomes based on these principles.

Our vision is for a healthy population, a healthy nation and a healthy world, with all people living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health and wellbeing for all.

The reduction of social and health inequities should be an over-arching goal of national policy, and should be recognised as a key measure of our progress as a society. Public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

Introduction

Every Budget sets a national strategic direction. In 2021, strategy-makers for the Government should recognise that the future of the Australian economy as a whole will depend more than ever on building a society which is strong in terms of population health.

Australia's strategic position – and its resulting budgetary position – is at a potential tipping point. The economic and wider social impacts of COVID have been highly dramatic, as have their fiscal impacts on government budgets across the nation. In order to ***build back healthier***, government strategy now needs to recognise that the way in which we manage the population's health is, more than at any previous point, determinative of our future economic wellbeing.

Population health in all its manifestations – but primarily in respect of the major determinants of chronic disease and their impacts on economic productivity – should therefore be a major strategic theme in the coming 2021-22 Budget.

Needless to say, communicable disease control sits front and centre as the most immediate matter of population health concern. The pandemic of 2020+ has provided people everywhere with a crash course in the issues and the responses required to protect the community. PHAA commends the efforts of all Australia's governments in their management of the pandemic so far. The response has been evidence-based, and by international comparisons very effective. For the coming year, we fully appreciate that pandemic response will continue to be a dominant concern of the 2021-22 Budget. In this submission, we will focus on the public health workforce as a key part of that response.

Nonetheless, the social, economic and fiscal shocks caused by the pandemic force our governments to make plans for a major economic reconstruction. As that work unfolds, the degree of chronic disease in our nation will powerfully determine the extent of our economic productivity, standards of living and overall wellbeing.

In addition, as trade and travel relations with other countries recovers coming out of this crisis, we have an opportunity to position Australia as one of the world's ***healthiest nations***, not only in terms of communicable disease control, but generally. This will have major implications for our goals relating to tourism, travel, educational services and connections, international workforce mobility, and immigration

Handled well, Australia could adopt a national strategy based on stronger health in every part of the community. Conversely, failing to do so would leave major economic drag forces on the economic and fiscal recovery task ahead.

Fortunately, a 'healthier nation' strategy is not impeded by insurmountable financial demands. Compared to the costs forced upon us by the pandemic, the scale of investments related to disease prevention are relatively modest. For many years, research has shown that public health interventions are relatively inexpensive, relatively strong in terms of benefit-cost ratios or 'returns on investment', and attract public support. There are also revenue options built into to some public health policy propositions that would provide automatic fiscal offsets for expenditure on population health investments.

Alignment with existing government policy directions

This year's Budget comes at precisely the moment that the Government is completing its ***National Preventive Health Strategy*** (NPHS), intended to form part of the Government's *Long-Term National Health Plan* (2019).[1] PHAA hopes that the NPHS will lay out plans for a significant new policies and an evidence-based investment direction-setting 'mechanism'. We have argued for a commitment to Commonwealth

health expenditure being rebalanced to embrace a target that 5% of expenditure is directed to disease prevention investment, with 95% continuing to be consumed by illness treatment costs.

In addition, Government commitments announced during 2020 clearly flagged the need for an expanded Australian public health workforce. Work is currently underway at state level to reform the landscape of that workforce, in terms of attraction, education and training, career structure, and long-term commitment to expanded workforces. This workforce planning needs to cover not only communicable disease management, but the whole interrelated effort of chronic disease management and minimisation. The Commonwealth has made a public commitment to these strategic directions. The coming Budget has a role to play in resourcing this vital national strategic effort.

Economic and strategic background

The overall economic significance of disease prevention

The economic case is simple and powerful: prevention (or minimisation) of disease in the community saves governments – and the private economy – very significant costs in terms of financial and labour resources. The benefits of having stopped something from happening are often difficult to perceive. But the COVID-19 pandemic has provided a tragically clear demonstration. We must learn from this experience.

According to the Productivity Commission, on average Australians live for around 13.2% of their lives in ill health – one of the highest proportions of any OECD nation, exceeded only by people in Turkey and the United States[2]. This is a major economic and social challenge. National economic and fiscal policy must be framed to address it.

Years spent in ill health present two major forms of economic loss: the opportunity cost of lost productivity during working years, and the direct cost (often increasingly expensive) of treatment and care. The reality is that we will inevitably expend resources on 'health'; but we have choices about whether we spend efficiently on preventing disease and maintaining wellbeing, or more expensively and less efficiently on treating illness.

The degree of wellbeing and health – or alternatively, the extent of disease – across the population is a major driver of that population's economic vitality, to say nothing of the social importance of wellbeing. Population health is also a major driver of the inflow and outflow of government revenues and expenditures.

For example, the OECD's *Heavy Burden of Obesity: The Economics of Prevention* report (2019)[3], examining 52 developed member nations, calculated the economic impact of overweight and obesity, which is one of modern society's most common forms of ill-health, and a driver of several major disease conditions. The report put the estimated economic cost to Australia at an astonishing 3.1% of GDP, including lowered labour market outputs equivalent to the productive output of 371,000 full-time workers, as well as an average reduction in lifespan of 2.7 years per person.

To give another example, the November 2020 *Report of the Productivity Commission inquiry into Mental Health*[4] gave an estimate of the economic cost (measured as at 2018-19) of mental illness in Australia (comprising direct expenditure on mental healthcare and support services, lower economic participation, and cost of replacing the support provided by carers) at up to $70 billion per annum.

These costs clearly form one of the largest economic burdens facing Australia's governments. They are drivers of continual pressure on national and state/territory governments to make our health systems (or more accurately, our *illness treatment* systems) more financially "sustainable". However, the concept of

sustainability does not simplistically imply a need for government expenditure constraint, but rather it makes a case for an holistic approach to ensuring that higher socio-economic policy goals can be delivered in a manner which can be reliably maintained over many years. In fact, too much *constraint* on investing in disease prevention and wellbeing is actually financially counter-productive in the long term, if it increases the extent of chronic disease and other illness and injury in the population.

In addition to the growing *scale* of problems of disease, their *spread* is becoming more socially uneven. Australia faces a steadily growing problem of economic inequality and inequity, including specifically inequity of health status and outcomes. While this is true of the population as a whole, the greatest challenges to wellbeing in Australia are the conditions faced by Aboriginal and Torres Strait Islander Australians, Australians of lower socio-economic status and resources, and rural and regional Australians. This inequality has a compounding nature, because socio-economic disadvantage persistently causes inability to take health enhancing action, and inability to access services to deal with illness.

Existing strategic advice to the Australian Government

PHAA's 2020-21 Budget submission (January 2020)[5] outlined an argument for the economic value of disease prevention investment. We also highlighted the significance of climate change for public health, noting in particular the public health impacts of the then-recent bushfires. We also noted the special circumstances of the conditions of disease in Aboriginal and Torres Strait Islander communities, which had been created as a result of Australia's history. The submission included specific proposals for a range of investment programs which government could adopt directly into its Budget decisions.

In August of 2020 the Treasury reopened 2020-21 Budget development to a second round of public submissions. ***PHAA's supplementary 2020-21 Budget submission – Rebuilding a Healthy Society***[6] focussed on the state of the Australian public health workforce and institutional capacity, which had been exposed by the dramatic events of the pandemic. We also noted the need for strong socio-economic principles in the development of a 'recovery' Budget, highlighting the principles of the UN Sustainable Development Goals and the World Federation of Public Health Association's (WHO-endorsed) Charter for the Public's Health. The urgent need was for policy decisions to ensure that the unfolding pandemic did not make Australia a more unequal society, both in health terms and in terms of broader material means and wellbeing. The supplementary submission also developed approaches to developing Australia's public health workforce as well as reviewing the national institutional structures for disease control. We restated the availability of a range of low-cost, strong benefit-cost programs for the minimisation of chronic disease in Australia.

On many of our policy and investment proposals, PHAA's voice is supported by a wide range of other non-government organisations, including health organisations such as the Cancer Council, Obesity Coalition, Heart Foundation, Australian Medical Association, welfare organisations such as ACOSS, climate organisations such as the Climate And Health Alliance, and many others. There is strong collegiality in Australia on a range of public health principles and strategic directions.

Australian and international research also supports our directions and proposals. A decade ago the work of the ACE Prevention study demonstrated that many disease prevention initiatives have strong benefit-cost outcomes.[7] More recently the World Health Organisation (WHO) *Tackling NCDs Bust Buys* report (2017)[8] has provided governments with a benefit-cost assessed smorgasbord of public health investments, all with positive economic returns.

Indeed, Australian governments have accepted this advice at a strategic policy level. The Government's National Health Strategy of 2018-19 confirmed a direction to improve the health of all Australians. PHAA

anticipates that the emerging National Preventive Health Strategy will likewise set clear principles and direction for the nation.

Nor have state and territory governments lacked for policy commitment, as well as good alignment with the Commonwealth and among each other. These include the *Victorian Public Health and Wellbeing Plan 2019–2023* (2019)[9], the strong prevention direction in the *State Public Health Plan for Western Australia 2019 - 2024* (2019)[10], the *Final Report of the Climate Health WA Inquiry* (2020)[11], and the *South Australian Health and Wellbeing Strategy 2020 - 2025* (2020)[12]. This suite of directional commitments indicates that the Commonwealth has an opportunity for collegiate action in this policy space, without political or jurisdictional impediments.

A national approach to population health investment

Australia's rate of health sector investment in preventive health has been less than 2% of health expenditure for at least the past 10 years, and stood at only 1.5% in 2018-19. Leading performance by Canada, New Zealand and the United Kingdom – nations with comparable health systems to Australia's in many ways – are around 5% of total health spending.

Higher preventive health spending is sound long-term financial management. It means reduced disease – and with that reduced health system cost pressure on governments, especially in regard to long-term chronic disease – in future years and decades. In addition, there are some conditions where there are immediate short-term payoffs in reduced illness and health system costs (e.g. skin cancer, alcohol harms).

PHAA therefore advocates for a standard that 5% of government budget expenditures on health should be directed to prevention at both Commonwealth and state/territory levels.

The Western Australian Government has already announced a policy to reach this point by the year 2029.[13] The South Australian Government has recently begun to indicate a similar policy inclination. However, effectively steering a focus on preventive health expenditure in Australia will require leadership from the Commonwealth Government if the goal is to be achieved.

One obvious way forward is to use a 'future fund' approach. This would provide funding for preventive health programs, campaigns, early detection, and other practical investments. (Note: *research* into preventive health is already provided for by the Commonwealth Government through the Medical Research Future Fund (MRFF)). It is not necessary that full funding of the target investment be reached in the year such a fund is created; funds could accumulate over time. Creating such a fund would be a lasting legacy for the Government.

PHAA estimates that if a 'Preventive Health Future Fund' (PHFF) was fully implemented, following a transition period, this goal would amount to *additional* federal investment on preventive health measures of around $800 million per annum. Into the long term, stronger preventive investment would reduce Commonwealth health spending pressures by far more than that through reductions in population chronic disease.

One available source of funds to flow into the PHFF fund would be proceeds from the national excise taxation of tobacco products. Even a modest portion of the existing levels of tobacco taxation, which raises

around $17 billion pa in federal revenue at present, would quickly and effectively establish a PHFF.[14] Increases additional to the current tax settings could also be directed to the Fund.

A mechanism to oversee this Fund would be needed. A PBAC/MBAC style expert body should be established to oversee PHFF investment directions in an evidence-based manner so as to maximise disease prevention outcomes, with a focus on the highest needs populations.

Realising this vision would require cooperative work between the Commonwealth and the states and territories. As mentioned above, policy alignment on public health directions is currently very strong. The role of the states and territories in delivering programs funded through a PHFF mechanism would be straightforward, with the Commonwealth Department of Health playing a role of coordination, standard-setting, outcome, and monitoring.

A national approach to a public health workforce

Australia's existing public health workforce is highly educated, committed and effective in the tasks it is set. However, for many years it has been insufficient in size to address all the population health challenges facing the nation. The pandemic of 2020 exposed this situation, not only in terms of communicable disease response capability, but in the inevitable diversion of public health-trained officials away from other population health concerns. It is strategically urgent that Australia take a coordinated approach to addressing this capacity gap.

The Government's 2017 *Joint External Evaluation of Australia's compliance with the International Health Regulations* (JEE)[15], and in particular, Australia's *National Action Plan for Health Security* (our response to the JEE) addressed the issue of our public health workforce. The Action Plan identified three priority actions:

- "Use existing data sources, including relevant accreditation schemes, to define the public health workforce in order to conduct forward planning, recruitment of appropriate categories of staff (including toxicology and radiation specialists) and development of future credentialing schemes.
- Work with states and territories to ensure sustainable mechanisms for epidemiologists and other public health professionals at state, territory and local level.
- Develop a long-term strategy that uses current and new channels to increase the international experience of the public health workforce."

PHAA supports these directions. In June 2020 PHAA, the Australasian Epidemiological Association and the Council of Academic Public Health Institutions Australasia (CAPHIA) jointly provided the Commonwealth Department of Health with a proposal highlighting the attraction, education, training, and capability resourcing issues, drawing on the Action Plan and other proposals. But to the best of our knowledge work is yet to commence on the three workforce recommendations in the JEE report or in the Action Plan.

National Cabinet commitment

In 26 June 2020 the nation's nine governments acting as the National Cabinet released an express commitment to:

- establish a national training program for surge workforce
- prioritise enhancing the public health physician workforce capacity

- consider options for developing a formal public health workforce training program.

However, while emergency repositioning of public servants occurred during the second half of 2020, the National Cabinet's specific commitments do not seem to have been effectively advanced by the end of the year. Noticeably, in the round of Commonwealth, State and Territory budgets released in late 2020, no government announced specific measures to act on these important commitments.

Chief Scientist's Review and recommendations

In late 2020 National Cabinet tasked the Australian Chief Scientist Professor Alan Finkel to conduct an urgent review of the capability of governments to undertake the essential tasks of tracking and tracing the COVID outbreaks. The resulting *Report of the National Contact Tracing Review* (November 2020)[16] identified the need to integrate a response to tracking and tracing capability with the state of the overall public health workforce. Specifically, the workforce issues could not be successfully addressed by a capability limited by a 'surge' response approach. The relevant recommendations were as follows:

"3. Workforce and training

3.1 Ensure ongoing investment in the medium to long term in accredited training programs for applied epidemiology and applied public health training.

3.2 The Commonwealth, states and territories should consider increasing the number of public health training positions in all jurisdictions.

3.3 All states and territories should continually invest in training surge workforces to be employed in a reserve capacity.

3.4 Ensure there is capacity for the Commonwealth to mobilise a trained contact tracing surge workforce through the Australian Public Service to assist states and territories with contact tracing should the need arise.

3.5 Continue funding rapid deployment capability to coordinate a standby pool of equipment (including personal protective equipment and transportable laboratory equipment) and senior clinical and public health experts for extreme situations requiring surge capacity anywhere in Australia.

3.6 Undertake forward planning for the pathology laboratory workforce, given the ongoing requirement for high volume testing in the near and medium term."

After considering this Review, on 13 November 2020 National Cabinet released a statement that it:

> "*… endorsed the review led by Australia's Chief Scientist Dr Alan Finkel of the contact tracing and outbreak management systems in each state and territory and agreed to adopt all 22 recommendations*."

Possible framing of a response to workforce needs

PHAA suggests that a response to the needs of the workforce should have a near-term urgent response to set in motion attraction and training of a growing public health workforce, as well as a longer-term approach captured by a national strategy.

Firstly, there should be a proposal for the Commonwealth, in partnership with all states and territories, to develop and fund a ***National Public Health Officer Training Program***. The principles of such a program would include that all jurisdictions, including the Australian Government:

1. Commit to funding and conducting an ongoing Public Health Officer Training Program sufficient to ensure that Australia is well prepared to deal with future communicable and non-communicable disease challenges;
2. Establish a system of recruitment into the training program, with minimum targets for each jurisdiction;
3. Agree consistent national training standards;
4. Provide for recruits from both medical and non-medical education/career backgrounds; and
5. Provide for the program to meet the needs of public health sub specialities including Aboriginal and Torres Strait Islander Health, biostatistics, epidemiology, and others.

We would not be starting from scratch, as it has been widely recognised that NSW Health has a long-established program of this kind, and we understand that NSW Health has indicated a willingness to cooperate in the planning and development of a national program.

The second part of the proposal would be to establish a ***National Public Health Workforce strategy***. While the training program would focus on recruiting and training the workforce in the near-term, there is still a need to ensure an appropriate long-term approach to our workforce structure. Such a long-term strategy would:

1. Establish the clearest possible understanding of the current public health workforce. This should include quantum of workforce, stability, growth levels, current skill and training levels, areas of focus, training opportunities, development pathways, and areas of unmet demand;
2. Engage with the necessary stakeholders across government (federal, state-territory and local) to establish current and anticipated needs, and assess existing investment in staff, programs and training initiatives;
3. Examine the current training infrastructure including the capacity, throughput and standards of tertiary education and other providers;
4. Consider issues of competencies, accreditation, registration at the level of individual, training providers and employing institutions;
5. Consider and make recommendations relevant to both medical and non-medically trained members of the current and future public health workforce;
6. Draw on models for the above from similar professional groups within Australia and from PHW accreditation structures overseas to guide recommendations on issues; and
7. Make clear recommendations relevant to all stakeholders aimed at improving the quantum and standard of the public health workforce in Australia for the medium and long term.

Near-term chronic illness program investments

Proposals made in PHAA's 2020 submissions

Many non-communicable diseases are preventable simply by modifying consumption and other behavioural habits. Further, engagement in unhealthy behaviours has a clear socio-economic gradient, such that the most disadvantaged and vulnerable people are more likely to be become the least healthy, and are most likely to engage in consumption and behaviour that exacerbates ill health.

In PHAA's *2020-21 Budget submission* (January 2020)[5], we outlined arguments for a stronger preventive health effort by the Australian government. Our submission included a number of well-developed, ready-to-roll program options, which remain available for immediate inclusion in the upcoming *National Preventive Health Strategy,* or as program initiatives for the 2021-22 Budget.

Such investments should be designed and conducted against the principle of directing resources to those with the greatest need. Initiative choices should give due weight to the societal drivers of health and wellbeing at every opportunity.

Delivery through the National Preventive Health Strategy

PHAA anticipates that, when it is finalised, the Government's National Preventive Health Strategy will include an implementation plan for program initiatives, potentially including programs resembling those mentioned above. PHAA has supported the Government's work on the NPHS since Minister Hunt announced the initiative at PHAA's Preventive Health Conference in Melbourne, May 2019. The NPHS would appear to be the appropriate vehicle to announce and follow through on disease prevention initiatives.

Through the NPHS and the 2021 Budget, the Government should commit to substantial and sustained programs and social marketing campaigns including:

- Cassation and reduction of tobacco use;
- Reduction of alcohol consumption, especially for those consuming alcohol at risky levels;
- Reduction of sugar-added beverage consumption;
- Reduction of junk food consumption;
- Promotion of healthy diets and dietary patterns;
- Reduction of harm associated with gambling;
- Better maternal and childhood health.

The role of marketing of unhealthy products, and the counter-balancing role of social marketing campaigns for health, need to be clearly understood. Many aspects of health, and the prevention of disease, involve individual choices and behaviour which are influenced – or manipulated – by product marketing. In Australia an under-regulation of such marketing has left many marketplaces and consumers vulnerable to the enormous resources of the advertising industry.

The marketing practices of industries selling unhealthy products are highly active in trying to shape individual behaviours towards the consumption of unhealthy but profitable products.[17] All too often, such marketing practices do not affirm individual freedom of choice, but instead seek deliberately to manipulate and undermine real personal choice. Arguments about commercial 'freedom' are often simply justifications of a licence for unhealthy product suppliers to manipulate consumers and dominate marketplaces. Such dominating influence does not promote personal freedom or personal wellbeing, but in fact reduces both.

Real personal choice can instead be empowered by sustained and effective programs to promote healthy behaviour and disease prevention.

Sustained programs to help people make healthy consumption choices have proven effective in many domains in the past. Positive information campaigning is simply a modern necessity to provide a counter-balance to harmful product marketing. Such social marketing campaigns work, but only when they are delivered at substantial scale and sustained over time. Investments of this kind yield social and wellbeing benefits and over time, repaying the public investment through reduced health system expenditure and other public costs. Effective and sustained social marketing campaigns and related programs help people to achieve reductions in harmful consumption habits (tobacco, alcohol, sugar-added beverages, junk food, etc), and increase healthy activities (physical activity and promoting healthy diets).

The role of welfare and equity in a healthy population

2020 has dramatically highlighted the role of income and wage support, in our society. PHAA strongly supports the 'Raise the Rate for Good' campaign led by the Australian Council of Social Service (ACOSS), because of the powerful role of social determinants in influencing population health outcomes. The Raise the Rate campaign calls on the Australian Government to maintain the mid-2020 increase in JobSeeker payment of $550 per fortnight, and the new Youth Allowance Payment (including the 'Coronavirus Supplement').

Health at a population level is directly undermined by poverty in the community. Reducing the recent levels of income support payments will directly increase the number of Australians living in poverty. The poverty line in Australia has been estimated to be around $480-$500 per week for a single person with no children, including housing costs. Before the COVID-19 pandemic, the rate of pay of $40 or less per day for people on Newstart, Youth allowance, and related payments was insufficient to cover the basic costs of living.

ACOSS surveys in 2019 found that of people on the old $40/day rates, 84% skipped meals to save money, 66% did not use heating in winter, and more than half had less than $100 per week left after housing costs.[18] A separate survey of young people revealed that they were struggling to get by on the old rate for Youth Allowance of $32.50/day, with over 60% having less than $14 a day left after paying their rent, over half couched-surfed or used other unstable forms of accommodation, more than 9 in 10 skipped meals, and more than 1 in 3 students had withdrawn from their studies because of a lack of funds.

In 2020 the number of Australians unemployed and seeking income support rose dramatically. PHAA applauds the Australian Government's decision to supplement JobSeeker and Youth Allowance payments during this time. This has softened the blow for the many newly unemployed Australians, and those on income support payments pre-COVID-19 reported significant improvements in health behaviours and quality of life.

The result was that in April 2020 when ACOSS again surveyed people receiving the JobSeeker payment, 93% said they were now able to afford fresh fruit and vegetables, 75% said they were now able to pay their bills, and 69% said they were now able to pay for essential medical and health treatments. Conversely, 94% indicated that removal of the supplement would have a significant or extreme impact on their ability to cover the cost of essentials.[19]

Research at the ANU's CSRM has also demonstrated the role of the rate increases in keeping Australians out of poverty, with direct effect on their food security and health, among other forms of wellbeing.[20] Systematically created social differences such as those faced by individuals on income support are a growing threat to national wellbeing and productivity, and to the idea of a 'fair go' in Australian society.

Being healthy requires the fundamentals of stable housing, affordable nutritious food, and access to affordable healthcare. Raising in the rate in 2020 has helped make this a reality for millions of Australians. We therefore urge the Australian Government to ensure that the 2021-22 Budget maintains income support for as long as is necessary to support social equity through the pandemic situation.

Climate change and the population's health

The connections between climate and health, and the importance of systemic changes in Australia to recognise and address them, have been highlighted in 4 major reports recently released – the *Lancet Countdown report* (2020)[21], the *MJA-Lancet Countdown report* (2020)[22], the *Report of the WA Climate Health Inquiry* (December 2020)[23], and the *Climate and Health – Preparing for the Next Disaster* report by the Grattan Institute (December 2020)[24]. Between them, these reports make clear that health impacts are happening now and accelerating; Australia has not been doing enough, and we are running out of time to turn the tide.

The Paris Agreement seeks to limit global warming to well below 2°C, and ideally to 1.5°C, but the situation has already reached an average of 1.2°C globally, and 1.5°C in Australia. The impacts here are significant:

- 22% increase in exposure to fire in the past 15 years;
- averaged across Australia, there were more days over 39°C in 2019 than in the rest of the period since 1960 combined;
- more intense heatwaves are resulting in excess ambulance demand, hospital admissions, and mortality;
- changing patterns of infectious disease;
- rising food insecurity;
- the impacts on mental health will continue to increase and unfold as time goes on; and
- health costs associated with mortality due to air pollution are estimated at $5.3 billion per year.

Despite the clear evidence of impacts in the reports cited above, Australia continues to defy the science. We are the only OECD country to have worsened the carbon intensity of our energy supplies over the last 3 decades, and we are now 36% worse than the global average.

The current position also defies economic logic. Compared with current commitments, limiting warming to 1.5°C by 2100 would generate a global accumulated net benefit of at least $US265 trillion, or more than 3 times annual global GDP.

The longer we delay serious action, the harder the position will be to rectify. Right now, the global emissions reduction effort required to meet the Paris Agreement target is a reduction of 7.6% annually. If we wait another 5 years, this will rise to 15.4% annually, and the impacts are making the task all the more difficult. The emissions from the 2019-20 fires in NSW and Victoria alone were more than equivalent to a year's worth of Australia's annual emissions.

The recommendations from the Climate Health WA Inquiry and the Grattan Institute report (cited above) centre around the need for governance and system structures which recognise the links between climate

change and health, and leadership at a national level to complement the work being done predominately in the states and territories so far.

PHAA support the recommendations of the Climate and Health Alliance to –

1. conduct a national climate and health consultation;
2. establish an AHPPC subcommittee on climate and health;
3. establish a Sustainable Development Unit in the Commonwealth Department of Health; and
4. develop a roadmap for the health sector to zero emissions.

We therefore urge the Government to move decisively to address these challenges in the coming 2021-22 Budget, and in its broader policy-making.

Aboriginal and Torres Strait Islander health

Major efforts have been undertaken in recent decades to improve Aboriginal and Torres Strait Islander people's health. Life expectancy has increased notably, with encouraging reductions in mortality rates from chronic diseases. Correspondingly, between 2012 and 2017, Aboriginal and Torres Strait Islander life expectancy at birth rose by over 2 years.

Nonetheless, it is vital that effort to maintain the increase in life expectancy is reinforced, as the gap in overall life expectancy between Aboriginal and Torres Strait Islander people and other Australians remains largely unchanged. It is unacceptable that, according to the 2019 Closing the Gap report, "The target to close the gap in life expectancy by 2031 is not on track",[25] and it is widely believed that the target cannot be achieved within the present Closing The Gap timeframe. It is urgent that the underlying causes of the gap are addressed. This must involve deliberate, coordinated and long-term commitments, developed and delivered with and by Aboriginal and Torres Strait Islander people.

Serious health care challenges remain for Aboriginal and Torres Strait Islander Australians. Rheumatic heart disease remains a massive concern. Alarmingly, mortality from cancer is actually rising, and the 'gap' in cancer mortality compared with the general population is growing. Rates of suicide remain far too high.

The health conditions of young Indigenous Australians should be a key focus. Aboriginal and Torres Strait Islander Australians have a younger age profile than the general population, with a median age of 23 compared with 38 (as at the 2016 Census). Over 60% of Indigenous Australians are aged under 30.

There are a number of current programs working to prevent disease in very young Aboriginal and Torres Strait Islander people between 5 and 8 years old. However, there is a lack of targeted attention to people from the adolescent years through to around age 25. This broad age group is formative of many lifelong health problems. Illnesses related to consumption habits (smoking, alcohol, sugar-added products and junk food) resulting in diabetes, cardiovascular disease, rheumatic heart disease, oral health problems, as well as mental health problems often have their genesis in this neglected period of adolescence and young adulthood. Specifically, there is evidence of a link between hearing loss in childhood and subsequent incarceration of Aboriginal people.

We note that the current *National Aboriginal and Torres Strait Islander Health Plan*, due to remain in effect until 2023, has not in fact been adequately funded to achieve its outputs. We note and welcome initiatives in the 2020-21 Budget in the area of Indigenous health. However further work will continually be needed, and indeed no Budget in the near or medium term will be able to ignore the need for further initiatives to Close The Gap. To give broad direction to such needs, the COAG Joint Council on Closing the Gap have set

out priorities to accelerate improvements in life outcomes of Aboriginal and Torres Strait Islander peoples by:

- developing and strengthening structures to ensure the full involvement of Aboriginal and Torres Strait Islander peoples in shared decision making at the national, state and local or regional level and embedding their ownership, responsibility and expertise to Close The Gap;
- building the formal Aboriginal and Torres Strait Islander community-controlled services sector to deliver closing the gap services and programs in agreed priority areas; and
- ensuring all mainstream government agencies and institutions undertake systemic and structural transformation to contribute to Closing the Gap.

PHAA urges the Government to adopt substantive and durable commitments aligned with the priorities identified by the National Health Leadership Forum (NHLF), the national representative body for Aboriginal and Torres Strait Islander peak organisations advocating for Indigenous health and wellbeing, which include:

- "Promote self-determination across national institutions, through Constitutional reform and the recommendations that arose from the Uluru Statement from the Heart;
- Close the gap in life expectancy and the disproportionate burden of disease that impacts Aboriginal and Torres Strait Islander people, through system-wide investment approach for the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan, with COAG Health Council;
- Prioritise and escalate actions under the National Aboriginal and Torres Strait Islander Health Workforce Plan – to address the massive shortfall in this workforce across all professions and levels, and is essential to improve Aboriginal and Torres Strait Islander health and wellbeing; and
- Acknowledge the adverse impact of racism on the health and wellbeing of Aboriginal and Torres Strait Islander people, and aspects of the health system that prevent people from accessing and receiving the health care they require – and to work with the NHLF and other Aboriginal and Torres Strait Islander health experts in embedding co-design and co-decision making processes to embed culturally safe and responsive health practices and systems."

Finally, noting the vital need for Aboriginal and Torres Strait Islander people to lead health and other initiatives central to their own health, PHAA supports the funding of programs that are initiated and run by Aboriginal and Torres Strait Islander people such as the National Aboriginal Community Controlled Health Organisation (NACCHO).

Conclusion

This submission has set out the case for preventive investment in health for Australia's future. Every Budget represents a significant set of choices about whether such a future will be embraced, or not. PHAA believes that the 2021-22 Budget will be measured by whether it –

- announces a commitment to a policy of balancing Commonwealth expenditure on health with at least 5% of total expenditure being investment in illness prevention, as opposed to meeting costs of illness treatment
- establishes a Preventive Health Future Fund for the Commonwealth
- provides for the development of a 'mechanism' for evidence-based commitment of the resources held in the Fund
- provides assistance to the state and territories in urgent public health workforce training
- supports the development of a longer-term public health workforce strategy for the nation
- initiates, through the Budget and/or the National Preventive Health Strategy, program initiatives to address the major drivers of chronic disease in Australia
- maintains a commitment to an equitable Australia through the welfare system
- acts to address climate change and its impacts on the population's health
- acts to Close The Gap regarding the health and wellbeing of Aboriginal and Torres Strait Islander Australians.

The PHAA appreciates the opportunity to make this submission. Please do not hesitate to contact our National Office should you require additional information or have any queries in relation to this submission.

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