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Contents

Executive Summary 1

About the PHAA 2

Introduction 3

❶ **The Economics of Illness Prevention** 5

Our national challenge: too many years of illness 5

Establish an ongoing mechanism for assessment and funding of illness prevention 6

Structural proposals 7

Service delivery program proposals 8

Policy proposals 9

❷ **Programs targeted at avoiding the key preventable diseases** 10

Service delivery program proposals 11

❸ **Climate change and public health** 14

Climate change is a public health issue 14

Public health lessons of the 2019-20 Bushfire season 14

Service delivery program proposals 15

❹ **Target Aboriginal and Torres Strait Islander health in the crucial adolescent years** 16

Conclusion 18

References 18

Executive Summary

PHAA submission on strategic directions for the Commonwealth 2020-21 Budget

Illness Prevention as a fundamental economic direction

The economic case is simple and powerful: prevention of illness saves governments – and the private economy – very significant costs in terms of financial and labour resources.

On average Australians live for around 13.2% of their lives in ill health, one of the largest ratios of any OECD nation, exceeded only by people in Turkey and the United States. This is a major economic and social challenge which national economic and fiscal policy must address.

We present evidence about the scale of the economic costs of illness, and the scale of potential benefits that can come from investing in illness prevention. Yet present public investment mechanisms fail to take up opportunities that are already available to make investments in health and wellbeing.

PHAA proposes, in outline, new government mechanisms for a major enhancement of preventive health investment. We call for a clear, strong and national commitment to investing in illness prevention and wellbeing, implemented through the creation of an ongoing mechanism by which the Government can assess proposed illness prevention programs, and followed up by means of an automatic system for ensuring that the best programs are quickly and consistently assessed and where appropriate, funded.

The institutional processes for selecting, approving and funding preventive health programs should have the same robustness as other key elements of our health architecture, the Medicare Benefits Schedule and the Pharmaceutical Benefits Schedule.

Key immediate investment proposals

This submission presents a shortlist of ready-to-go policy/program initiatives that could be included in the coming Budget. To the extent that they are expenditure initiatives, public health program costs are always offset by immediate, medium-term and long-term reductions in future expenditures on illness treatment.

We also provide evidence-based policy initiatives in regard to price signals for alcohol and sugar-added products. These proposals have the additional benefit of generating additional government revenue.

Climate change and public health

The fact that climate is changing is now undeniable. This altered climate is yielding dramatic changes to Australia's environmental, agricultural and economic circumstances. It also impacts on social conditions. These changes will bring a range of public health challenges into the future. While adaptive responses are essential, the case for serious new policy directions to mitigate the root causes of climate change – anthropogenic emissions into the atmosphere – cannot continue to be ignored.

The health of Indigenous Australians

This submission highlights the situation of health disadvantage experienced among Aboriginal and Torres Strait Islander communities in our country. We call for adequate funding for the current National Aboriginal and Torres Strait Islander Health Plan. We call for strategic engagement with Aboriginal Controlled Community Health Organisations, who are best placed to lead community-level public health programs, as they are to deliver illness treatment services.

About the PHAA

The Public Health Association of Australia

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 the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and 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.

The members of the Association are committed to better health outcomes based on these principles.

Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

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

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

Introduction

PHAA welcomes the opportunity to provide input on directions for the 2020-21 Commonwealth Budget.

The field of public health in which PHAA members work is concerned with preventing illness in all its forms. From the late 19th century this has manifested as a concern with public sanitation and communicable disease outbreaks. This aspect of public health is highlighted at present by the Wuhan coronavirus outbreak, which triggered well-prepared responses from Australia's public health officials.

The scope of public health has expanded during the 20th century into fields such as: immunisation; nutrition; the consumption of alcohol, tobacco and other drugs; a range of primary health care interventions that can reduce illness; injury prevention in homes, workplaces and public places; specific foci on preventive oral health and mental health issues; the promotion of health knowledge and behaviour throughout the community and the promotion of public policies supportive of healthy environments and behaviours.

This submission

As the drafting of this submission was being finalized, our nation was undergoing the most catastrophic fire event in post-colonial history. We are dynamically coming to terms with appropriate policy responses, as no doubt is the Treasury and the Government. It is likely that new thinking and fresh proposals will emerge in the months ahead, even as the 2020-21 Budget is being finalized.

Among the vital lessons to take from the present crisis is the importance of protecting our climate, landscape, and environment, and the health of all who live in it. We expect that this theme will loom large in this year's Budget.

The primary thrust of this submission is to make the economic case for the importance of illness prevention in general. We present evidence about the scale of the economic costs of illness, and the scale of potential benefits that can come from investing in illness prevention. We propose in outline new government mechanisms for a major enhancement of preventive health investment.

Consistent with those proposals, we present a number of program initiatives that could be included immediately in the 2020-21 Budget.

Our submission also takes note of climate change and its major challenges for public health. National and international political debate is roiled by ideological attitudes to the state of our climate, and the powerful impact of industrial sector interests. In this contested policy climate, Treasury owes the Government policy advice which is based on evidence and the long-term interests of our economy and the community. PHAA joins with millions of other Australians in demanding stronger action by the Government in reducing emissions and taking steps to mitigate the forces which are changing our climate. The obvious impact of the ongoing bushfire catastrophe is also highlighted.

Finally, we address the most pressing population health issue, which is the state of health and wellbeing among Indigenous Australians. We argue for focussed attention on young Indigenous people in particular, noting that lifelong health and wellbeing among Indigenous communities provides the maximum contribution to enhancing economic vitality, as well as constraining fiscal challenges for governments. We call for adequate funding for the current National Aboriginal and Torres Strait Islander Health Plan. We call for strategic engagement with Aboriginal Controlled Community Health Organisations, who are best placed to lead community-level public health programs, as they are to deliver illness treatment services.

An essential part of the solution is illness prevention

PHAA calls for a clear, strong and national commitment to investing in illness prevention and wellbeing, implemented through the creation of an ongoing mechanism by which governments can assess proposed illness prevention programs, and followed up by means of an automatic system for ensuring that the best programs are quickly and consistently assessed and, where appropriate, funded. The institutional processes for selecting and approving/funding preventive health programs should have the same robustness as the systems for guaranteeing individual Australians service delivery through the Medicare Benefits Schedule, and for providing medication through the Pharmaceutical Benefits Schedule.

The economic case is simple and powerful: the prevention of illness is a massive factor for government finances in terms of saved expenditure and also lost revenue. Avoidable illnesses also costs the overall economy in terms of wasted resources, lost labour productivity and weaker private sector economic vitality.

Yet present public investment mechanisms fail to take up many of the most efficient and prudent opportunities that are available to make investments in health and wellbeing. It is profoundly in Australia's economic interest – and the fiscal interest of its national and state governments – that new governmental decision and funding mechanisms are established as soon as possible. This submission provides an outline of what such a mechanism would look like.

Moreover PHAA urges governments to specifically make illness prevention in *children* a national priority. Diseases which have their origin in the childhood years remain a burden on individuals, on economic vitality and on government finances across the entire lifetime of the persons affected. In addition, arguments for the continuation of unhealthy practices and product marketing based on limited conceptions of 'consumer choice' have much less relevance to children, who have little control over their consumption of harmful food and drink and other products and services during the course of childhood. Furthermore, children are very vulnerable to suffering harms resulting directly from the unhealthy behaviours of their parents and other adults.

Finally, we note that at the time of writing, the Department of Health is working on its National Preventive Health Strategy. The economic logic of illness prevention is fundamental to this important strategic work. The NPHS is expected to provide clear direction as to specific program proposals.

1 The Economics of Illness Prevention

Our national challenge: too many years of illness

According to the Productivity Commission, on average Australians live for around 13.2% of their lives in ill health, one of the largest rations of any OECD nation, exceeded only by people in Turkey and the United States (Productivity Commission, *Shifting the Dial: 5 year productivity review*, 2017, supporting paper 4, *Why a better health system matters*, 11). This is a major economic and social challenge which national economic and fiscal policy must be framed to address.

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 of (increasingly expensive) treatment and care.

The degree of wellbeing and health – or alternatively, the degree of illness – of the population is a major driver of that population's economic vitality – to say nothing of the social importance of wellbeing. Illness is, in turn, a major driver of the inflow and outflow of government revenues and expenditures.

For example, the 2019 *Heavy Burden of Obesity: The Economics of Prevention* report by the OECD, 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 illness 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 fresh example, the October 2019 draft report of the Productivity Commission inquiry into Mental Health gave an estimate of the economic impact of mental illness in Australia at over $700 million pa in direct costs and lost economic productivity.

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 national and state 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 a holistic approach to ensuring that higher socio-economic policy goals can be delivered, and are delivered, in a manner which can be financially continued over many years. In fact, too much constraint on investing in illness prevention and wellbeing is actually financially counter-productive in the long term, if it increases the extent of ill health of the population.

In addition to the growing *scale* of the problem of illness, its *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 Indigenous Australians, by those of lower socio-economic status and resources, and by rural and regional Australians. This inequality has a compounding nature, because socio-economic disadvantage persistently causes inability to take illness preventing action, and inability to access services to deal with illness.

To these challenges there is one compelling economic (let alone social) policy goal, which is to substantially increase our national performance at preventing illness in the first place.

Establish an ongoing mechanism for assessment and funding of illness prevention

Leaving aside the social value of wellness, the financial logic for governments is clear: with annual Commonwealth and state budgets being continually strained by the rapidly growing costs of treatment and constant demands for increased productivity, there is a compelling financial case for preventing future illness. Conversely, failing to invest now will generate major costs in treating preventable chronic illnesses in the future, increasing health system costs and diminishing people's capacity to participate in the workforce.

However, while Australia has highly robust policy frameworks for the approval and funding of health care treatment services through the hospital system and Medicare, for pharmaceuticals through the Pharmaceutical Benefits Scheme, and for the resourcing of tertiary health care through state governments and the health care provider sector, a major gap in the nation's policy architecture is the absence of any organised system for assessing, approving and funding disease prevention programs. This submission proposes a means of filling that gap.

PHAA proposes a three-pronged new 'mechanism' to ensure that governments are making an efficient and effective investments in illness prevention, at a scale sufficient to make a major impact on economic vitality, and significantly ease long-term pressures on government budgets. The three prongs are:

A. ***Balance*** – Setting a serious national target for a balance of *illness prevention investment* against *illness treatment expenditure*, with that balance being 5% prevention to 95% treatment in national public expenditure (this ratio currently stands at around 1.4% : 98.6%), and committing a sufficient allocation of public funds to progressively approach and meet that target by the year 2025.

B. ***Assessment*** – Establishing an institutional mechanism for independent, expert-led, evidence-based assessment of the efficacy and efficiency of public health investment programs, similar in purpose and function to the independent panels which maintain the MBS and PBS components of our health system architecture.

C. ***Delivering*** – Combining the above two elements into a system where funding for the delivery of assessed and approved public health programs flows quickly and effectively to providers – be they state government services, non-government organisations, or specific providers engaged by any level of government – in response to need.

Why is 5% / 95% the appropriate balance between prevention and treatment? World's best practice in balancing prevention with treatment in national health spending is currently a prevention investment of around 5-6% of total health system expenditure. Investment at around this scale is being achieved in Canada, New Zealand, and the UK.

In contrast, Australia, at 1.4%, has one of the lowest levels of preventive health investment, as a proportion of total health system spending, of any of the OECD developed economies (OECD.stat database). This very low commitment to investing in prevention in Australia is causing a buildup of illness into future decades, including heart disease, cancer, diabetes, and many other chronic conditions. Such illness will be accompanied by economic costs from reduced workforce participation and productivity, and consequent negative impacts on both the expenditure and revenue sides of the Commonwealth budget.

The proposed rebalancing of investment does not need to come at the expense of other health current expenditures. No current service expenditure stream needs to be specifically constrained to directly fund any increase in resourcing for illness prevention. Rather, it should be recognised that investment in the avoidance of illness is an investment in the avoidance of future treatment costs to government, individuals and businesses. The proposed policy goal is, through reducing disease and thus the need to fund treatment

services, to reach the 5:95% balance over time. As a mark of serious ambition, we propose 2025 as a target year to achieve that goal.

Finally, it is important to note that the 'returns' on investment in illness prevention are not all long-term pay-offs; many illness prevention investments have immediate or early impacts. Improvements in immunisation, good nutrition, reduction in physical injuries, reduction in alcohol use and its related harms, and many others have immediate gains in reduced illness and harm, and thus reduced treatment costs (including borne by governments) and loses to productivity.

Structural proposals

[Note: proposals 2.1, 2.2 and 2.3 are intended to be taken together.]

2.1 Five Percent for Prevention

We are recommending that one in every twenty public dollars spent on our health is invested in illness prevention. Australia has had a broad range of health policy successes, with progress on tobacco, immunisation, SunSmart screening and more, highlighted in PHAA's *Top 10 Public Health Successes over the last 20 years* publication (2018). With a greater commitment we can achieve more, with the goal of making Australians the healthiest people on earth.

Performance against this goal is easily measured using current metrics. A consistent, long-used definition of 'public health activity' was developed last decade by the Australian Institute for Health and Welfare (AIHW) – for example, see *Public health expenditure in Australia, 2008-09*, AIHW, 2011). The AIHW definition includes all the major forms of public health programs, and was designed to be compatible with the OECD definitions used for international comparisons.

2.2 Mechanism to assess the best prevention investment

Australia has the Medical Benefits Scheme (MBS) to guide and fund our use of medical services and programs, the Pharmaceutical Benefits Schedule (PBS) to administer the investment in drugs, and the National Health and Medical Research Council (NHMRC), and more recently the Medical Research Future Fund (MRFF) to steer our commitment to research.

The established MBS, PBS and MRFF panels (MSAC, PBAC, etc) play the role of independent expert advisory which assesses the efficacy and cost effectiveness of proposed drugs, medical care and research. A similar expert, evidence-driven independent 'Preventive Health Advisory Committee' panel is needed to guide decisions on the best investments in preventive health.

2.3 Delivery mechanisms to fund prevention effort in a consistent, ongoing way

We have no established embedded structure funded to deliver preventive health programs. Drawing on the best advice, machinery is needed to ensure continued and reliable resourcing of such programs. The mechanism within government to bring this work together needs to be established as soon as possible.

2.4 Economics of Preventive Health Centre for research excellence

To support the proposals above, and so as to better understand the economic impact (potential benefits and disbenefits) of existing or proposed preventive health policies and expenditure, a modest research centre of excellence should be established with the relevant university/universities/research institutes to do the necessary research and analysis to a higher degree of sophistication than is currently available.

The research centre would be focused on policy relevant research and analysis and establish close links to policy makers and experts in its governance structures.

Economics of Preventive Health Centre for research excellence

Expense ($m)

	2019-20	2020-21	2021-22	2022-23	2023-24
Department of Health	-	2.0	2.0	2.0	2.0

2.5 Continuation of TAPPC for 5 years

The Australian Prevention Partnership Centre (TAPPC) is an existing research group focused on preventive health research, what does and what does not work, providing guidance on effective investment. There is a history of "stop start" preventive health efforts with proven benefit - only to cease due to funding uncertainty. The Centre aims to identify the very best investments and recommend cost effective initiatives that drives value for government dollars, not just at Commonwealth level but for any government investing in prevention.

Continuation of TAPPC for 5 years

Expense ($m)

	2019-20	2020-21	2021-22	2022-23	2023-24
Department of Health	-	2.0	2.0	2.0	2.0

2.6 Department of Health - Preventive Health Advisory Committee Secretariat

For an increase in commitment to preventive health efforts there is a need to small dedicated unit to administer the program and advance the processing of programs and policy development. The secretariat would draw in expertise across Australia to drive the prevention agenda and implement the strategy. Its role would be to provide relevant governance and accountability structures, assess and guide policy relevant initiatives, advise government and administer any relevant funding initiatives. The entity should be resourced at an appropriate level for the responsibilities undertaken and operate within an appropriate area of the department. We estimate a budget in the vicinity of $2 million pa.

Preventive Health Advisory Committee Secretariat

Expense ($m)

	2019-20	2020-21	2021-22	2022-23	2023-24
Department of Health	-	2.0	2.0	2.0	2.0

Service delivery program proposals

2.7 Local grants scheme

We propose a grants program to support local government authorities and NGOs to develop and implement locality-level preventive health programs.

This initiative would also seek commitments for policy reform at local government level, and where realistic co-investment with LGAs.

These might include but not be limited to:

- healthy eating options on catering facilities in local government controlled food outlets, removing sugary drinks, etc
- Health promotion related urban planning issues
- Promotion of physical activity and green space initiatives
- Extension of smoke-free area policies

- Alcohol consumption reduction initiatives including dealing with local liquor licencing provisions and other initiatives recommended by the National Alcohol Strategy

An additional benefit of this program is to enhance local promotion and maximise community reach of agreed national preventive health campaigns and priorities.

Finally, we note that state and territory governments are increasingly legislating requirements for local government authorities to establish Public Health plans. However no additional resources have been made available to implement such plans.

Preventive health local grants

Expense ($m)

	2019-20	2020-21	2021-22	2022-23	2023-24
Department of Health	-	50.0	50.0	50.0	50.0

Policy proposals

2.8 Volumetric tax on alcohol

PHAA and other organisations and experts have long argued for the correction of an obvious anomaly in Australia's regime of alcohol taxation: the different treatment of various categories of alcoholic products without regard to their actual alcohol content. Such differences are economically distorting between the product categories. But more importantly, the situation undermines the policy goal of using taxation to send price signals to modify consumer behaviours in favour of healthier outcomes.

PHAA supports the reform of the present alcohol taxation regime in Australia to make it uniformly 'volumetric'. Proposals made for a uniform system of volumetric alcohol taxation of all alcohol products have been developed in the past and are available for implementation as soon as Government is ready to support such a policy.

Existing proposals also generally have the forecast result of significantly increasing revenue from total alcohol taxation, making a positive contribution to the Budget.

The Foundation for Alcohol Research and Education (FARE) has carefully examined this subject. An ACIL Allen report prepared for FARE for their 2017-18 Budget Submission estimated that a well-crafted alcohol tax reform would result in a reduction of alcohol consumption by 9.4% and an increase in revenue by $2.9 billion per annum.

2.9 Taxation of sugar-added beverages

Sugar-addition to food and beverages across a large number of food and drink products is a major driver of reduced health and wellbeing, contributing to illness and mortality for millions of Australians.

Policies of price signalling through placing a health levy on added sugar in drink/beverage products – a category where sugar is most egregiously added – has been implemented in other countries with successful outcomes. In Britain, a well-crafted graded health levy had the effect of altering producer product formulation even in advance of the commencement of the new taxation policy.

The Obesity Policy Commission has done extensive work on sugar-related healthy levies. PHAA policy also expressly supports the introduction of a healthy levy policy in Australia.

Sugar taxation proposals have the forecast result of providing very significant new revenue, making a major positive contribution to the Budget.

2 Programs targeted at avoiding the key preventable diseases

It is estimated that one-third of all non-communicable disease is preventable simply by modifying consumption and other behavioural habits. Also, engagement in unhealthy behaviours has a clear socio-economic gradient, such that the most disadvantaged and vulnerable people are more likely to be those who are least healthy and most likely to be engaged in activities and behaviours that exacerbate ill health.

The circumstances in which the most disadvantaged Australians live, be it due to discrimination, poverty, low levels of education and related conditions, are clearly based in societal drivers. As a result addressing those societal drivers are central to advancing the health of the most vulnerable.

With these principles in mind we propose the specific initiatives presented below. These investments should be designed and conducted cognisant of the principles of addressing the most resources to those with the greatest need and the underlying philosophies and approaches of the any such initiative should give due weight to those societal drivers at every opportunity.

Many aspects of health, and the prevention of illness, 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 their 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. However such marketing practices do not affirm individual freedom of choice, but instead seek deliberately to manipulate and undermine real choice. 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 illness 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. Evidence shows that 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), and increase healthy activities (physical activity, promoting healthy diets).

As part of an ongoing health strategy, the Government should commit to substantial and sustained programs and social marketing campaigns in the following areas:

- Reduction of tobacco use and quitting
- Reduction of alcohol consumption, especially for high-volume users and high-risk users
- Reduction of sugar-added beverage consumption
- Reduction of junk food consumption
- Promotion of health diets and dietary patterns
- Reduction of gambling
- Better maternal and childhood health.

Service delivery program proposals

3.1 Implement the next National Tobacco Strategy (NTS)

Australia's national policies to this point have driven smoking prevalence in Australia to an all-time low, with statistics released in December 2018 showing that just under one in seven (13.8%) or 2.6 million adults were daily smokers in 2017-18(1). However this figure remains unacceptably high and – worryingly – rates of smoking decline have slowed in the last few years. Every year, over 18,000 Australians still die from their tobacco addiction(2), and thousands more suffer from associated chronic diseases.

The rapid expansion of the e-cigarette industry globally demonstrates that the tobacco industry has not reduced their product marketing efforts.

We propose a commitment from the Commonwealth Government to provide around $65 million per annum over four years for campaign and cessation programs so as to implement the next phase of the existing National Tobacco Strategy (NTS).

This investment would accelerate the decline in smoking prevalence in the general population. Most importantly, it would specifically benefit Australians experiencing social and financial disadvantage, and therefore reduce the significant inequities caused by tobacco smoking. It will work to reduce the large and increasing Australian Government health costs associated with treating preventable diseases in these groups and the broader community.

Investment should be allocated to the following initiatives.

3.1.1 TV-led National Tobacco Campaign: $40m per annum to reinstate, and maintain for the period of the NTS, a population based TV-led National Tobacco Campaign, targeting adult tobacco users in all states and territories which is evidence-based in both creative development and audience exposure, and supported with rigorous developmental research and campaign evaluation. This aligns with proposals made by Cancer Council Australia and other leading tobacco control agencies.

TV-led National Tobacco Campaign

Expense ($m)

	2019-20	2020-21	2021-22	2022-23	2023-24
Department of Health	-	40.0	40.0	40.0	40.0

3.1.2 National Smoking Cessation Strategy: $10m per annum to create and fund a dedicated National Cessation Strategy within the NTS to facilitate a consistent, evidence-based national approach to smoking cessation service provision. This would include the development and dissemination of national clinical guidelines and program support to embed the treatment of tobacco dependence into health services, primary care, and community and social service organisations as part of routine care, and the provision of a national Quitline™ as a referral, training and behavioural support provider.

National Smoking Cessation Strategy

Expense ($m)

	2019-20	2020-21	2021-22	2022-23	2023-24
Department of Health	-	10.0	10.0	10.0	10.0

3.1.3 Targeted smoking reduction programs: $15m per annum to specific, targeted programs that will provide additional support to groups in the population experiencing the highest levels of disadvantage. This will primarily be done through partnerships with the public health and community service sectors to provide direct services to high needs populations.

Targeted smoking reduction programs for groups experiencing the highest levels of disadvantage

Expense ($m)

	2019-20	2020-21	2021-22	2022-23	2023-24
Department of Health	-	15.0	15.0	15.0	15.0

The measures proposed here can be expected to have high impact. Investing in a comprehensive NTS over the next 10 years with funding allocated for the specific areas outlined in this submission could be expected to:

- reduce the prevalence of adult daily smoking to below 10% as set by the Minister for Health. [1]
- reduce the prevalence of 'at-least-weekly' smoking among teenagers aged 12-17 to <1% [2], and the prevalence of 'at-least weekly' smoking among young adults 18-25 to < 3%.[3]
- reduce the prevalence of adult daily smoking among Aboriginal and Torres Strait Islanders to <30%.[4]

These activities should be undertaken as part of a comprehensive next-phase National Tobacco Strategy that also addresses regulatory issues, including those associated with the sale, promotion and supply of tobacco.

We add a strong note of support for the continuation of the Tackling Indigenous Smoking program. While currently well-funded, this program is now half way through its funding cycle. It is showing substantial signs of success in reducing smoking rates in Aboriginal and Torres Strait Islander people, albeit coming from a much higher base smoking rate than the rest of the population. However continued levels of financial support will be necessary to achieve the vital goal of bringing smoking rates in Indigenous Australians down to the levels experienced by the rest of the community.

If the more aggressive target for reduced adult daily smoking by 2026-27 were achieved, this would equate to approximately one million fewer Australians smoking than would be the case if smoking continues to reduce only at the recent rate of decline.

(Note: more information on the above proposals can be found in the joint submission of PHAA, the Cancer Council and the National Heart Foundation to the Treasury during the consultations for the 2019-20 Commonwealth Budget, and in the Cancer Council Australia submission for Budget 2020-21.)

3.2 Live Lighter

Live Lighter is a proven healthy eating and physical activity campaign, with 6 years accumulated evidence of success in Western Australia.

Evidence generated out of the Live Lighter Campaign in Western Australia has suggested a sound public investment would be made in a sustained and well-run social marketing campaign focusing on healthy eating and prompting physical activity.(3-6)

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[1] As measured in the ABS National Health Survey, expected survey date 2026-27, first results of which likely to be published in 2028, from % of adults 18 and over currently smoking in 2014-15 (14.5% daily, 1.5% less than daily).

[2] As measured by the Australian Secondary Schools Alcohol and Drug Survey in 2026, to be available in 2028, from 3% in 2014 (White and Williams, ASSAD, DOH 2016).

[3] As measured by the Australian Bureau of Statistics National Health Survey in 2026-27, from 16.7% in 2014/15 (ABS 2015).

[4] As measured by the National Aboriginal and Torres Strait Islander Social Survey, from 41.4% in 2014-15 (ABS, 2016).

A measurable metric attributable to the Live Lighter campaign is a reduction in the consumption of sugary drinks by adolescents in WA has occurred at a faster rate than has been the case nationally in the period 2012 to 2018. Such campaigns not only prompt individual and group behavior on behaviors that reduce weight gain, but also are important in promoting healthy public policy relevance to obesity prevention.

Recent funding for the Live Lighter campaign in Western Australia has to date been around $3.5 million pa. The equivalent investment needed for a sustained and effective national campaign, allowing for some economies of scale, would therefore be around $30 million pa.

Live Lighter national campaign

Expense ($m)

	2019-20	2020-21	2021-22	2022-23	2023-24
Department of Health	-	30.0	30.0	30.0	30.0

3.3 Reducing Alcohol Related Harm

There is accumulating evidence, particularly in Australia, of successful social marketing campaigns in the area of alcohol consumption. The most sustained effort in this field is the Alcohol Think Again campaign undertaken in Western Australia. In addition to evidence demonstrating change in drinking intentions, these campaigns also create an important vehicle to heighten the need for action on policies aimed at reducing alcohol related harm.(7)

An additional need for public communication in this sphere will come with the expectation of the completion of the revised alcohol drinking guidelines currently being led by the National Health and Medical Research Council. The guidelines, last published in 2009 have been revised and a draft is out for consultation, with outcome expected in financial year 2020-21. For the guidelines to have any impact in reducing alcohol related harm there is a need to invest in a communication strategy that informs Australians as to the best health advice relating to the consumption of alcohol.(8)

Reducing Alcohol Related Harm Program

Expense ($m)

	2019-20	2020-21	2021-22	2022-23	2023-24
Department of Health	-	30.0	30.0	30.0	30.0

3 Climate change and public health

Climate change is a public health issue

In 2016 the World Health Organisation identified climate change as “the greatest threat to global health in the 21st century”.

Accordingly, PHAA joins the voices of millions of Australians in calling on the Government to adopt a leadership role in advocating for global action to reduce warming.

There are innumerable connections between the changing realities of the climate and public health and wellbeing, including direct harms from disrupted weather and disaster events, impacts on food security, impacts on communicable diseases, and many more. PHAA has a well-developed, evidence-based policy base on climate and public health issues.

Given its urgency and scale, in this present submission we will focus briefly on the impacts of the 2019-20 Bushfire season. We anticipate that recovery from the current bushfire season will see other public health concerns emerge.

Public health lessons of the 2019-20 Bushfire season

The most immediate impact of climate change has been the catastrophic bushfires event that is remains ongoing in multiple states. This is the worst environmental catastrophe our nation has experienced, and its immediate and ongoing impacts will rank among our most significant public health emergencies.

The evidence is very clear that global warming and related climate disruption is the primary driver of the increased duration and severity of the fire season.

The bushfires have already severely harmed the health of thousands of Australians. The effects of the bushfires on health include breathing and heart problems, due to prolonged exposure to smoke, and anxiety and other mood disorders, related to the trauma and dislocation directly associated with the fires. It is likely that there will be other health effects. The severity of these health effects varies from premature death to less severe health outcomes including hospitalizations and simply feeling unwell.

The economic and personal costs of the current disastrous and unprecedented season of bushfires is only beginning to being assessed, but its impact on the physical and mental health of millions of Australians will continue for decades to come. It must be assumed that this summer was not a one-off, but that similar public health impacts will recur, and will recur with increasing frequency and severity.

The 2019-20 disaster requires a complex and multi-layered response. The response must include a focus on harm and illness prevention.

Nonetheless, in the short and medium term, fires will continue to occur, we also need to do better in protecting people from the health effects of fire and smoke. The role of masks, filters, air filtration devices and smoke refuges together with the effect of behaviours such as avoiding exercise and staying indoors, needs to be investigated so that health authorities can give proactive, evidence-based advice in future episodes.

Impacts on those who are vulnerable, such as those with pre-existing heart and lung disease, pregnant women, infants and the elderly needs to be highlighted. They may need special intervention.

Improved systems for providing accurate, balanced evidence based and timely public health messaging and public health promotion are crucial.

Service delivery program proposals

3.1 "AirSmart" Air Quality Education Initiative

Recent challenges to air quality linked to the bush fires highlighted the need for an evidence based and consistent program to translate emerging evidence about air quality with public understanding and policy relating to the inevitable ongoing challenges to air quality problems in Australia. Public and policy maker literacy on evidence and technical aspects of air quality have been shown to be well below what will be necessary as we face ongoing issues with air quality in Australia.

An "AirSmart" program is proposed which is modelled on the experience with the "SunSmart" program, which has been successful in changing Australian attitudes and behavior relating to sun protection and skin cancer prevention. The program not only conducts public education programs, but is embedded in science, research and public policy issues related to UV exposure and related issues. So too is there a need for a public facing program which identifies and promotes the most up to date reliable and accurate scientific and public health advice on air quality. The program must help negotiate and communicate developments on agreed standards and measures of air quality, and support and encourage appropriate institutional and individual responses to those measures and standards.

As an essential component of that, ongoing core funding must be provided to the "AirRater" program at www.airrater.org. Currently based at the University of Tasmania, AirRater provides a free downloadable easy to use app which gives access to the best available air quality data on a real time basis. It also provides a vehicle to capture real time symptoms experienced by users and therefore valuable data about the ongoing impacts of poor air quality.

We estimate that the AirRater program would require a core grant of around $1 million pa to upgrade the existing program and expand its data capture and reporting program. We further estimate that a national "AirSmart" program would require around $9 million pa for four years to become effective.

Establishment of the AirSmart Program and Expansion of the AirRater health protection service

Expense ($m)

	2019-20	2020-21	2021-22	2022-23	2023-24
Department of Health	-	10.0	10.0	10.0	10.0

4 Target Aboriginal and Torres Strait Islander health in the crucial adolescent years

Major efforts have been undertaken in recent decades to improve Aboriginal and Torres Strait Islander people's health. Life expectancy has increased notably, from levels well below those enjoyed by Australia's non-Indigenous population. There have been 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**" (p122, emphasis added), and it is widely believed that the target cannot be achieved within the CTG 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 actually 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, having a median age of 23 compared with 38 (as at the 2016 Census). Over 60% of Indigenous people are aged under 30.

There are a number of current programs working to prevent illness in very young Aboriginal and Torres Strait Islanders people between 5 and 8 years old. However, there is a major 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, the evidence of a link between hearing loss in childhood and subsequent incarceration of Aboriginal people is overwhelming.

A program that has demonstrated the success of an Aboriginal controlled and led model is the Tackling Indigenous Smoking program. The initiative to reduce smoking rates in Aboriginal and Torres Strait Islander people has made valuable progress but more is required to close the gap in smoking rates between Aboriginal and non-Aboriginal Australians.

Major initiatives in illness prevention are required to improve the wellbeing of adolescent Aboriginal and Torres Strait Islander people by:

- reducing the suicide rate
- reducing use of alcohol and other drugs
- reducing tobacco use, with targets including:
- reducing age 15-17 smoking rates from 19% to 9%
- increasing age 15-17 'never-smoked' rates from 77% to 91%
- increasing annual health check for people aged 15-24

- reducing rates of juvenile incarceration, through programs such as justice reinvestment programs should aim to close the gap between Aboriginal and Torres Strait Islander People and the wider Australian population in all health metrics

Environmental factors also impact on health and wellbeing. Programs to improve environmental health help prevent eye and ear health problems which are more prevalent in Aboriginal and Torres Strait Islander communities. Rheumatic heart disease, including acute rheumatic fever, is almost exclusively experienced within Australia by Aboriginal and Torres Strait Islander people and is also associated with poverty, poor and overcrowded living conditions and poor hygiene.

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. One very obvious place for the Government to start in the coming Budget is to repair this defect. This would be consistent with the priorities, established by the COAG Joint Council on Closing the Gap co-chaired by the Pat Turner AM and the Hon Ken Wyatt MP, Minister for Indigenous Australians, 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
- ensuring all mainstream government agencies and institutions undertake systemic and structural transformation to contribute to Closing the Gap.

PHAA urges 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;
- Prioritises and escalates 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

The PHAA appreciates the opportunity to contribute to the development of the 2020-21 Commonwealth Budget. Please do not hesitate to contact us should you require additional information or have any queries in relation to this submission.

PHAA is committed to engagement with all government agencies to work on useful, evidence-based policy development. We would be happy to meet with Treasury officials to develop these arguments and present further evidence on any of the issues raised in this submission.

David Templeman
President

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Chief Executive Officer

31 January 2020

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