AHHA Submission to the Consultation Paper for the National Preventive Health Strategy

Submission

25 September 2020

australian healthcare & hospitals association

the voice of public healthcare

OUR VISION

A healthy Australia, supported by the best possible healthcare system.

OUR MISSION

To conduct research, educate and influence the healthcare system to achieve better health outcomes, improved patient and provider experience, greater equity and sustainability.

OUR GUIDING PRINCIPLES

Healthcare in Australia should be:

Effective

Accessible

Equitable

Sustainable

Outcomes-focused.

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BACKGROUND

AHHA provided the following submission in response to the Australian Government Department of Health's Consultation Paper to inform the development of a 10-year National Preventive Health Strategy.

The consultation paper was made available at https://consultations.health.gov.au/national-preventive-health-taskforce/consultation-paper-for-the-national-preventive-hea/

The consultation closed on 28 September 2020.

1. VISION AND AIMS OF THE STRATEGY

Are the vision and aims appropriate for the next 10 years? Why or why not? (page 13-14)

The Australian Healthcare and Hospitals Association (AHHA) supports the vision in the National Preventive Health Strategy (the Strategy) consultation paper for 'improving the health of all Australians at all stages of life'. In this vision, health must be recognised as a multidimensional construct that incorporates physical, mental and social wellbeing, not just the absence of disease or infirmity (World Health Organisation [WHO], 1946). Variation across cultures must also be recognised in how health is defined. Aboriginal and Torres Strait Islander people, for example, take a broader perspective of health which includes the social, emotional and cultural wellbeing of the whole community (Australian Institute of Health and Welfare [AIHW], 2016).

The health of individuals and communities is influenced most significantly by the social determinants of health – factors such as housing, income, education, conditions of employment, power distribution and social support – and these require greater emphasis throughout the Strategy. For Aboriginal and Torres Strait Islander people, cultural determinants are important, with the need to strengthen languages, relationships, cultures, identity, place and networks for rebuilding resilience and cultural sustainability (Lowitja Institute, 2014). Mitigating and adapting to climate change (and its drivers) are also key to reducing the disease burden and avoidable deaths and illness.

To be effective, the Strategy cannot have a vision and aims that are health portfolio-centric. There needs to be accountability and inclusion across all portfolios, including social services, education, environment, mental health, transport, infrastructure, energy, population, cities, agriculture and regional development. This must be apparent within each aim:

Aim 1. Australians have the best start in life. The evidence for investing in all aspects of development and functioning in the first 1,000 days is strong, including health and wellbeing, mental health, social functioning and cognitive development (Moore et al. 2017). AHHA supports the aim for Australians to have the best start in life, but policy responses must be in line with the evidence. 'Early intervention' is important, but attention is needed to improve the environments and experiences during these earliest stages of development. The significance of contributions from physical environments (e.g. stable housing, built and natural environments, environmental toxins), community environments (e.g. social supports in pregnancy and infancy), family environments (e.g. parent-child attachment and parenting style, child abuse and neglect, domestic violence), as well as individual level factors, must be recognised. Prevention must ensure an integrated, cross-sector approach, in particular recognising the cumulative effect of environment and experiences (Moore et al. 2017).

Aim 2. Australians live as long as possible in good health. AHHA supports the strong focus placed in the Strategy on health promotion and prevention of infectious diseases, injuries and chronic conditions. However, preventive action in mental health must also be a focus, recognising the interconnected nature of mental and physical health.

The COVID-19 pandemic has again highlighted the dependency of preventive health on social determinants. Addressing social determinants must be a clear aim within the Strategy.

Overcrowded, informal or no housing leaves people exposed to increased risk of infection (Gurran et al. 2020). Unstable finances, casual employment, limited access to the internet and low literacy impacts the ability of individuals to respond to self-isolation protocols during a public health crisis, increasing spread of infection (O'Sullivan, Rahamathulla and Pawar, 2020).

Climate change also affects health in many ways; directly by the increased intensity and frequency of extreme weather events, such as prolonged heatwaves, floods and bushfires; and indirectly through worsening air quality, changes in the spread of infectious and vector-borne diseases, risks to food safety and drinking water quality, and effects on mental health (Climate and Health Alliance [CAHA], 2018). Climate change contributes to an increased risk of infectious diseases, cardiovascular disease, respiratory disease, asthma, allergies, mental illness, psychosocial impacts, violence, poor nutrition, injury, poisoning and mortality. Climate change must be addressed within a preventive health strategy (CAHA, 2018).

Aim 3. Australians with more needs have greater gains. AHHA supports the aim in the Strategy of health equity and reducing intergenerational disadvantage. Again, this requires recognition of and support for the social issues being faced by individuals. More integrated and proactive approaches will be needed to improve access to care and coordinate social supports around patients' needs (Andermann, 2016) to achieve the Strategy's vision of improving the health of all Australians.

It is also important that the Strategy adopt a strengths-based approach, where the self-determination and strengths of individuals and communities are emphasised. Successful adoption of such an approach has been demonstrated across aged care, at-risk families, Aboriginal and Torres Strait Islander people and more. People need to be seen as more than just their care needs, rather to be viewed first as experts and in charge of their own lives. Such an approach focuses on the strengths, skills and resources of individuals and communities, recognising their autonomy, and empowering choices and solutions right for them.

Aim 4. Investment in prevention is increased. Australia spends less on public health and preventive care than most other OECD countries. Peaking at 2.3% of recurrent expenditure on health in 2007-08, Australia's prevention spending fell to 1.6% in 2017-18. Comparatively, most OECD countries spend between 2% and 4% of total health expenditure on prevention (Gmeinder, Morgan and Mueller, 2017). AHHA supports that funding for preventive health should increase, but proposes that a return to 2.3% of recurrent health expenditure is initially targeted, to be progressively increased over a 5-year period to reach at least 4% of recurrent expenditure, with a dedicated focus on ensuring spending is on activities with demonstrated cost-effectiveness.

2. GOALS OF THE STRATEGY

Are these the right goals to achieve the vision and aims of the Strategy. Why or why not? Is anything missing? (page 15)

AHHA supports the goals highlighted in the Strategy consultation paper, in particular the need for different sectors working together to address complex challenges, environments supporting health and healthy living, community engagement and place-based approaches, empowerment of individuals, and an evidence-based approach.

The goals should also embed a strengths-based approach, where the self-determination and strengths of individuals and communities are emphasised. Recent successes for Aboriginal and Torres Strait Islander health in preventing the spread of COVID-19 (Crooks, Casey and Ward, 2020) and immunisation rates for those aged <5 years (Beard and Clark, 2019) have demonstrated the value of taking a strengths-based approach, and shifting away from a deficit narrative.

The connection between the goals within the Strategy and other documents need to be clear. These include the National Health Reform Agreement, the Long Term National Health Plan, the 10-year Primary Health Care plan, condition-specific plans (the Mental Health and Suicide Prevention Plan), population-segment plans (National Men's Health Strategy, National Women's Health Strategy, the National Action Plan for the Health of Children and Young People), disaster and emergency preparedness plans, and emissions-reducing targets and plans.

3. MOBILISING A PREVENTION SYSTEM

Are these the right actions to mobilise a prevention system? (page 17-18)

AHHA supports the actions proposed in the Strategy for mobilising a prevention system, although proposes that the critical significance of technology and data is currently absent from the Strategy and should receive greater emphasis.

Action important for reorienting the health system will draw on many of the other actions embedded in the Strategy, and AHHA proposes below some specific direction in terms of the shifts that need to be supported in primary care to reorient the health system towards promoting a prevention system.

Technology

The Strategy needs to recognise the rapid developments occurring in technology and data, and how these will revolutionise, not just mobilise, opportunities for preventive health.

The COVID-19 pandemic has revealed many ways technology and data can be used to protect health, including contact tracing apps, temperature sensing drones, apps to monitor social distancing and facial recognition surveillance.

Artificial intelligence (AI) offers promising opportunities to improve health through preventive rather than reactionary measures. It has the ability to collect, compile, analyse and learn from big data, augmented by real-time data from patients, and create personalised and predictive feedback for individuals. It can improve diagnostics, catalyse patient adherence through engagement, and integrate with remote monitoring devices, all directly influencing the behaviour of patients and improving preventive health action.

AI is dependent on big data, and there are ever-increasing data sources that can support preventive strategies, including electronic health records, personal digital devices, pervasive sensor technologies and access to social network data. While data and devices are often siloed, the feasibility of health-data-sharing platforms to obtain and aggregate health data is being explored (Dhruva et al. 2020) and integration being achieved.

However, the vast majority of Australians are concerned about the security of their personal data and information, and awareness of data privacy issues has been heightened during the COVID-19 pandemic (Australian National University [ANU], 2020). Yet, the experiences reported by health and social services in responding to the COVID-19 pandemic exposed issues with privacy laws limiting the sharing of information across sectors and impacting effective preventive responses that could be taken by service providers.

Ethical challenges of using AI also need greater consideration in the Strategy due to rapidly evolving technologies, new stakeholders, data quantity, novel computational and analytic techniques and a lack of regulatory controls or common standards to guide developments (Nebeker et al. 2019). Care must be taken to ensure existing biases and inequalities are not exacerbated with the use of AI,

rather it is used to correct disparities (Chen, Joshi and Ghassemi, 2020). Swift action is needed to prevent public trust in AI being eroded (Morley et al. 2020). Ethical collaboration within the Australian health care sector will be crucial to seeing this action achieved (Australian Consensus Framework for Ethical Collaboration and Interaction Among Organisations in the *Healthcare Sector* [ACF], 2018).

The Strategy needs to proactively include the opportunities that technology and data provide in mobilising a prevention system, address the data privacy concerns and actively advancing ethical practices and social responsibility.

Data

The Strategy needs to recognise the value of information held within primary health care and accelerate its use in mobilising a prevention system.

Expenditure on primary healthcare is over a third of all health expenditure and there is wide acceptance of the importance of primary health care within the larger health, aged and disability care systems. This includes better, earlier care in the community to avoid more costly hospital care and transport services, in addition to improving individuals' quality of life.

Consolidated primary health care data in Australia is poor. However, individual providers of primary health care hold significant amounts of information on the services provided to patients, the conditions for which they are being treated and the progression of patients' recovery or further deterioration of their condition. Consolidating this data should be facilitated, ideally, through the development of a primary health care national minimum dataset that provides common data standards and reporting frameworks.

Current activity by the Australian Institute of Health and Welfare (AIHW) to develop a National Primary Health Care Data Asset (NPHCDA) provides the opportunity to move our health system in a direction that can better inform our understanding of population health and mobilise a prevention system. However, in the medium to longer term, a national minimum dataset for primary health care is required, with coverage expanded beyond general practices to include specialists, pharmacy, allied health, dental, palliative care, community nursing, mental health, alcohol and other drugs, maternal and child health. The comprehensive collection of longitudinal data will facilitate a deeper understanding of the progress or deterioration of an individual's health and inform our understanding of public health issues and preventive action.

Reorienting the health system

The Strategy consultation paper identifies the use of data for monitoring and surveillance, yet primary health care data can also enable a proactive approach to preventive health care by providing clinicians with data about local populations, individuals in their care, and a directory to social care and other locally available supports. Health care providers need the time and supports to analyse and use the data for this purpose.

The Strategy consultation paper identifies building information and literacy skills to enable prevention. However, preventive health action requires health care teams also having access at the point of providing care to information about social determinants, patient activation measures (or equivalent), other scores (e.g. frailty, adverse child events) and local health and social care supports, to influence how preventive health may best be achieved with that individual within their community. The referral of patients to non-medical activities through social prescribing, from health and fitness programs to movie clubs and meditation, is increasingly recognised as important to incorporate in routine care to achieve preventive health goals and should be recognised in the Strategy.

The Strategy consultation paper identifies partnerships being important for cooperation between sectors. For this to be effective, there needs to be system level agreement on the goals and purpose of different entities, defined around population segments. This is more than just pathways of care, but agreement about how care will be systematically provided, and with each entity's role defined for clinical governance and accountability.

General practice teams can take a lead role in building these partnerships by shifting focus from just treating patients who present to the practice, to proactively engaging with their patient population and supporting patient navigation of the various sectors within a health care 'neighbourhood'. This would require a cultural shift from the biomedical to social model of health, and involve a range of other health and social care providers (clinical and non-clinical) in non-hierarchical relationships.

The focus must shift from volume to value, and currently the activity-based nature of funding (both in primary care and the hospital sector) does not incentivise this, with reduced activity from prevention programs reducing the funding available to services, unable to be reinvested in further preventive programs. Shared risk-reward funding models are needed to reinforce alignment of all entities with a common goal. The workforce must also be enabled to work to the top of their scope of practice, and this will require payments to reflect the outcomes achieved, rather than scaled as they currently are to reflect the higher fees of certain professions despite the same service being provided and outcome achieved.

Further investments in physical infrastructure, data enablement, IT architecture, workforce development and the development of local models of care, are needed to enable the shift. The long-term health reform principles identified in the National Health Reform Agreement addendum that provide for joint planning and funding at a local level, e.g. with Local Hospital Networks (or equivalent) and local government councils, and paying for value and outcomes (Council on Federal Financial Relations, 2020), mean that Primary Health Networks (PHNs) are well-placed to reorientate primary health care towards prevention. However, they must be given the authority and resources to do so and be enabled by national infrastructure and policies.

4. BOOSTING ACTION IN FOCUS AREAS

Where should efforts be prioritised for the focus areas? (page 19)

AHHA recommends that focus areas are needed that go beyond discrete risk factors for chronic and infectious diseases. Given the influence of social determinants and climate change on health, and the interconnected nature of mental and physical health, efforts in these areas need to be identified as priorities. Social determinants have been discussed in previous sections of this submission, with climate change and mental health discussed below.

Climate change

Tackling climate change has been identified as the greatest global health opportunity of the 21st century and yet adequate recognition of the importance of preventive climate action and resilience building activities is absent from the Strategy's consultation paper. In 2017 the Climate and Health Alliance (CAHA), together with over thirty health and medical organisations, developed *The Framework for National Strategy Climate, Health and Wellbeing for Australia,* which identifies the need for an environmentally-sustainable health sector that prioritises prevention to deliver economic, social, and environmental benefits for Australians (Horsburgh, Armstrong and Mulvenna, 2017).

While the consultation paper for the Strategy acknowledges the impact of 'changing weather patterns and different strains of infectious disease' on health, as well as identifying that 'healthy environments support healthy living' (Department of Health, 2020), it neglects to adequately recognise the risk multiplier effect of climate change and the role it plays in exacerbating pre-existing vulnerabilities (Armstrong, 2020).

Adverse climate-related events intensify inequality and place a disproportionate burden of adversity on already vulnerable populations (Armstrong & Capon, 2020). This has been highlighted by both COVID-19 and the 2019-20 bushfires, which have highlighted pressing need for action that targets the social determinants of health, and the need to reduce inequity and build community resilience (WHO, 2020).

The negative impacts of rising unemployment and the economic recession triggered by COVID-19 have been most acutely felt by low wage earners, people with low educational attainment, young people, women, people who live in low socioeconomic areas, renters, people experiencing poor general or mental health, and people with disabilities (Wilkins, 2020). Furthermore, there has been a higher proportion of people contracting the virus from minority groups, and people in insecure or casual employment (Purtill, 2020).

The health impacts associated with bushfire smoke have also proven more likely to be experienced by vulnerable populations such as the young, the elderly, people with chronic conditions, and people in low income, poorly insulated housing (Armstrong, 2020; Johnson, 2017; Vardoulakis, 2020).

With climate change set to disrupt the predictability of our environments, it is essential that preventive action is taken to tackle the interconnected nature of inequality, health, and the

environment. The Strategy must prioritise the social determinants (e.g. employment, housing, and food insecurity), and explicitly recognise the importance of a multi-faceted prevention approach that actively targets the conditions in which people live, work and play (WHO, 2020.)

Mental health

The interconnected nature of mental and physical health (Prince et al. 2007) is not well recognised in the consultation paper for the Strategy. The identified focus areas reinforce a long tradition of prioritising physical health indicators over mental health. Therefore, while actions such as increasing physical activity and reducing alcohol and other drug related harm will go some way to enhancing Australia's mental health, the impact will be marginal compared to the beneficial impacts of these activities on physical health. Recognising the importance of primary prevention that targets psychological risk factors within the Strategy, such as childhood trauma, bullying, racism, homelessness and poverty, is likely to have significant benefits on both mental and physical health (Carbone, 2020).

The social, economic and health conditions created by COVID-19 have increased the prevalence of mental ill health in the Australian population. Mental Health telephone support services have reported the demand for services increasing by approximately 30 percent (Ponniah, Angua and Babbage, 2020), and modelling reveals a 'best case scenario' of a 13.7 percent increase in suicide deaths in the wake of COVID-19 (Atkinson et al. 2020). It is therefore essential that mental health is at the forefront of any national prevention agenda. The Strategy must recognise that 'there is no health without mental health' (WHO, 2005).

The lack of focus on mental health within the Strategy consultation paper is also out of step with the broader Australian government agenda, which in recent years has increasingly prioritised action on mental health. The establishment of the National Mental Health Commission, the 2017 Fifth National Mental Health and Suicide Prevention Plan, and a significant funding allocation for mental health related measures in the 2019 budget, all demonstrate a commitment to action that prevents and mitigates the adverse impacts of mental ill health (AIHW, 2020; National Mental Health Commission, 2017). Failure to emphasise the importance of mental health primary prevention in the Strategy would be a lost opportunity to consolidate a cohesive cross-sector health reform approach.

Alignment is needed across the breadth of government health reform strategies to ensure focused, coordinated action that improves the long term physical and mental health of Australians.

5. CONTINUING STRONG FOUNDATIONS

How do we enhance current prevention action? (page 20)

It is important that the Strategy denotes responsibility for more than the Health Portfolio. There needs to be involvement and KPIs for all relevant portfolios (e.g. in social services, education, environment, mental health, transport, infrastructure, energy, population, cities, agriculture and regional development). Embedding an approach to ensure multiple portfolios are involved must be done from the outset.

This could be facilitated through a Health in All Policies and cross portfolio approach. Health can be the custodian, but it must be across departments.

It would be appropriate to aim for a ten-year program of work with annual evaluation and performance published annually and made publicly available. This should include indicators for short-term, medium-term and long-term measures of progress that use standardised metrics (and can help stakeholders demonstrate how they are contributing to the Strategy).

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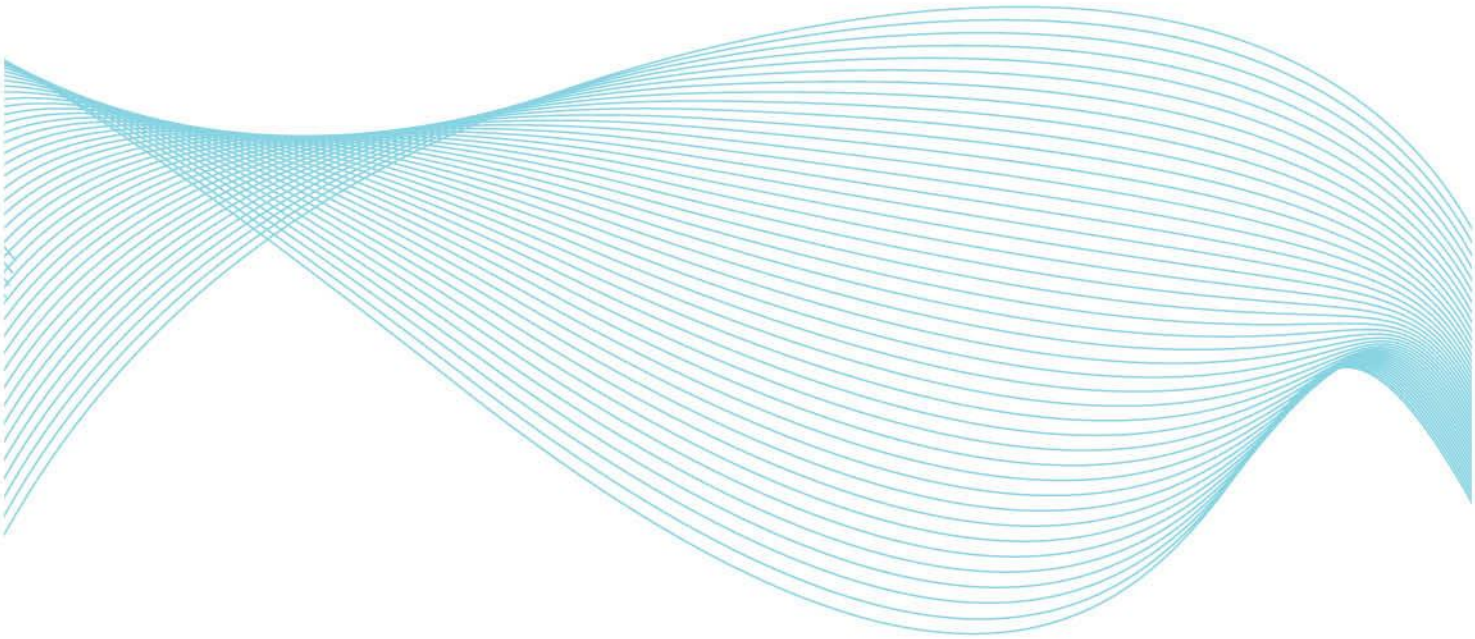

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