

**PHAA – KEY ELECTION PRIORITIES 2013**



**Public Health Association**  
AUSTRALIA

# Election Priorities for 2013

## KEY MESSAGES:

1. Improved health outcomes for all Australians can be achieved by tackling the “causes of the causes” of poor health with a specific focus on disadvantaged sectors of our community
2. A modest increase in prevention spend now will bring substantial benefits in terms of both health and costs in years ahead
  - a. Many specific issues are raised in this submission
3. There are opportunities for raising revenue of over \$2billion per annum while playing a key role in improving long term health outcomes of individuals and the community when implemented as part of a comprehensive program

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## **PHAA – KEY ELECTION PRIORITIES 2013**

### **Overview of Election Commitments Sought by PHAA**

#### ***Continue the reform process across hospitals, primary healthcare and prevention***

The PHAA recommends to all parties that they continue the strides that have been made in health reform by the following steps outlined as ‘key commitments sought’.

#### ***Revenue opportunities with positive public health ramifications***

The PHAA seeks a comprehensive approach to improving health

- **TOBACCO REVENUE:**

- Cigarette prices in Australia are lower than in some comparable countries. An increase in excise duty of at least ten cents per stick would reduce smoking and raise approximately \$1.25 billion per annum. The PHAA welcomes the government announcement on this issue and seeks support from other parties.
- Reject all funding of political parties by tobacco companies and return any current donations

- **ALCOHOL TAXATION:**

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

- **JUNK FOOD:**

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

- **LOWER CARBON USAGE:**

- Build on the range of taxes and revenues so far introduced to lower carbon usage.

There should be a comprehensive approach to each of these areas. As an example revenue raising in relation to alcohol should fit in as part of a program that includes regulation to curb alcohol promotion, replacement sponsorship for sports, research-based health warnings and information determined by government, increased expenditure on public education, and national approaches to ensure consistent and more effective liquor licensing measures and enforcement and reductions in alcohol-caused injury, violence, domestic violence and road crashes. Similar approaches should be adopted in comprehensive strategies addressing junk food and lowering carbon usage. The government should use as a model the comprehensive approach that has been deployed by State, Territory and Federal Australian governments in dealing with the health consequences of smoking.

#### ***Ten priority areas have been identified by the PHAA.***

The broad concepts follow on the next page and detailed explanations are in the body of this guide.

## PHAA – KEY ELECTION PRIORITIES 2013

### Key Commitments Sought

- **Move prevention from 2.2% to 4% of health expenditure and fund a National Public Health Policy**
  - Increase the level of funding for prevention from 2.2% to 4% of health expenditure. At the Federal level this means budgeting for \$1.16billion. This requires additional Federal funding of around \$.522billion pa from an expected expenditure this financial year of \$.638billion
  - Fund the development of a National Public Health Policy.
- **Australian Centre for Disease Control (ACDC)**
  - Initiate an investigation into the establishment of a new Australian Centre for Disease Control (ACDC), along the lines of those in Canada and the USA. Alternatively, a body with a broader remit to include health promotion and prevention could be established either alongside or as part of the Australian National Preventive Health Agency (ANPHA)
- **Health Workforce**
  - Invest in building the competence and capacity of a national preventative health workforce who understand inequity and the social and economic determinants of health and are skilled to deliver effective preventive health services at the local level
- **Medicare Locals**
  - Maintaining the funding of Medicare Locals at a level that will allow comprehensive primary healthcare based on an understanding of the social determinants of health
- **Women’s Health**
  - Funding be provided for a National Women’s Health Policy 2010 implementation program
- **Close the Gap**
  - Retain and extend funding for the “Close the Gap” measures, including additional support for Aboriginal Medical Services and Aboriginal Health Services
  - Develop a national strategic framework (the Framework) to address food access and security for Aboriginal and Torres Strait Islander people
- **Food, Nutrition and Physical Exercise**
  - Implement rigorous legislated controls to protect children from the advertising and promotion of nutritionally undesirable or “junk” foods and improve labelling of foods with an effective interpretive system and commit to effective Health and Physical Education (HPE) in schools in the new Australian Curriculum
- **Injury Prevention**
  - Include Injury Prevention in the Australian National Preventative Health Agency’s work plan as a standalone key priority area.
- **Oral Health**
  - Retain the \$4billion commitment to “Denticare”
- **Climate and Health**
  - Establish a requirement for a Climate Impact Assessment along with a Health Impact Assessment for all government policy and program decisions
- **Tobacco**
  - Reject all funding of political parties by tobacco companies and return any current donations

## PHAA – KEY ELECTION PRIORITIES 2013

### Contents

<b>Overview of Election Commitments Sought by PHAA .....</b>	<b>2</b>
Continue the reform process across hospitals, primary healthcare and prevention.....	2
Revenue opportunities with positive public health ramifications .....	2
Ten priority areas have been identified by the PHAA. ....	2
Key Commitments Sought .....	3
<b>1. Introduction .....</b>	<b>5</b>
Public Health.....	5
The Public Health Association of Australia.....	5
Advocacy and capacity building .....	5
Election commitments for 2013 .....	5
<b>2. Preventive Health .....</b>	<b>6</b>
Raise expenditure on prevention from 2.2% to 4% of the health budget .....	6
Key Commitment Sought.....	6
<b>3. Aboriginal and Torres Strait Islander Health .....</b>	<b>7</b>
Key Commitments Sought .....	7
<b>4. Tobacco and Alcohol.....</b>	<b>8</b>
Tobacco - reduce smoking and provide funding for prevention activities.....	8
Alcohol - replace the WET Rebate with a volumetric tax rate .....	8
Key Commitments Sought .....	9
<b>5. Food, nutrition and physical activity.....</b>	<b>10</b>
A comprehensive approach is vital.....	10
Key Commitments Sought .....	10
<b>6. Communicable Disease .....</b>	<b>12</b>
Implement the recommendations of the recent JETECAR Report.....	12
Establish an Australian Centre for Disease Control (ACDC) .....	12
Key Commitments Sought .....	13
<b>7. Injury Prevention.....</b>	<b>14</b>
Fund a National Injury Prevention Plan.....	14
Key Commitments Sought .....	14
<b>8. Oral Health.....</b>	<b>15</b>
Commit to “Denticare” .....	15
Key Commitments Sought .....	15
<b>9. Gender – A Joint Submission by AWHN &amp; PHAA .....</b>	<b>16</b>
Gender: A key determinant of health and well-being.....	16
Key Commitments Sought .....	17
The Australian Women’s Health Network.....	17
<b>10. Climate Change and Health –a safe environment.....</b>	<b>19</b>
Use taxes and revenue and other levers to move to lower carbon.....	19
Key Commitments Sought – action for a safe environment .....	20
<b>11. Conclusion.....</b>	<b>21</b>

## **PHAA – KEY ELECTION PRIORITIES 2013**

### **1. Introduction**

The Public Health Association of Australia Incorporated (PHAA) is recognised as the principal non-government organisation for public health in Australia and works to promote the health and well-being of all Australians. The Association seeks better population health outcomes based on prevention, the social determinants of health and equity principles.

#### ***Public Health***

Public health includes, but goes beyond the treatment of individuals to encompass health promotion, prevention of disease and disability, recovery and rehabilitation, and disability support. This framework, together with attention to the social, economic and environmental determinants of health, provides particular relevance to, and expertly informs the Association's role.

#### ***The Public Health Association of Australia***

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

Key roles of the organisation include capacity building, advocacy and the development of policy. Core to our work is an evidence base drawn from a wide range of members working in public health practice, research, administration and related fields who volunteer their time to inform policy, support advocacy and assist in capacity building within the sector. PHAA has been a key proponent of a preventive approach for better population health outcomes championing such policies and providing strong support for the Australian Government and for the National Preventative Health Taskforce and National Health and Medical Research Council (NHMRC) in their efforts to develop and strengthen research and actions in this area across Australia.

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

#### ***Advocacy and capacity building***

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

#### ***Election commitments for 2013***

The PHAA appreciates the opportunity to offer a series of suggestions designed to improve health outcomes in the future.

## **PHAA – KEY ELECTION PRIORITIES 2013**

### **2. Preventive Health**

#### ***Raise expenditure on prevention from 2.2% to 4% of the health budget***

Prevention is better than cure. At a time of increasing demand for expenditure on tertiary care a government with a long term vision will invest in prevention.

Governmental commitment to prevention across Australia including the States and Territories currently stands at 1.9% of the health budgets (AIHW: Australia's Health 2012), much of which is dedicated to screening and immunisation programs. This is down from 2.2% (AIHW: Australia's Health 2010). While recognising the policy and funding commitments that have been made to prevention in recent years through the Council of Australian Governments (COAG) and other processes, we believe that any health program designed to improve the health of Australians must include a strategy to increase the funding allocated to prevention.

There is enormous potential for preventive programs to improve the health and well-being of the community.

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

The budget statements of the Department of Health and Ageing at Outcome 1 Population Health show an expected expenditure of \$.638b. Raising the expenditure on prevention from 2.2% to 4% would mean an annual on Outcome 1 expenditure of \$1.16b entailing additional Federal funding of around \$.522b pa.

It should be noted that government revenue estimates (Budget Paper 1, Table 6) for 2012-13 that the increased revenue from restrictions on duty free tobacco alone will raise \$.165b. Additionally, (Table 11) revenue from taxes on beer (\$2.035b), other beverages (\$.94b) and tobacco (\$5.85b) are close to \$9 billion and that there is strong public support for increases in these taxes if the funding is allocated to health-related services.

#### ***Key Commitment Sought***

- Raise expenditure on prevention from 2.2% to 4% of the health budget

## PHAA – KEY ELECTION PRIORITIES 2013

### 3. Aboriginal and Torres Strait Islander Health

Nationally Aboriginal and Torres Strait Islander health outcomes remain much worse than for other Australians. Life expectancy is 12 years less for an Indigenous man and 10 years less for an Indigenous woman than other Australians and infant mortality is 2.6 times the rate for all Australians. Health expenditure per person is only 20% higher for Indigenous Australians despite this demonstrably greater health need (AIHW Australia's Health 2010).

There are some signs of slow improvement in Aboriginal and Torres Strait Islander health, but this has been less than the greater improvement seen in the total Australian population. Importantly, the COAG reform agenda does not recognise health as a critical social determinant of developmental outcomes for the under-5s. Children who are unhealthy and malnourished do not have the capacity for a play-based learning stimulus essential for brain development. To redress this imbalance, there should be an 'across-portfolio agenda and mandate' with a clearly articulated vision informed by meaningful community consultation and specific funding. Aboriginal and Torres Strait Islander health policy and health care must meet the needs of Aboriginal and Torres Strait Islander peoples in different contexts – 30% of Aboriginal and Torres Strait Islander people live in a major city, 20% in an inner regional town, 23% in outer regional areas, 9% in remote areas and 18% in very remote areas.

#### Key Commitments Sought

- Retain current levels and build in future growth of funding for the “Close the Gap” measures
- Develop a National Aboriginal and Torres Strait Islander Social Determinants of Health Policy as a key strategy in closing the gap and overcoming Indigenous disadvantage. The policy needs to describe the social determinants, focus on social inclusion and support the provision of real opportunities in education, employment and health status, with funding tied to delivery of outcomes.
- Develop a policy for the inclusion of Aboriginal health equity and self-determination in the mandate of Local Hospital Networks and Medicare Locals. The policy should include reforms to increase the investment in culturally competent services by requiring:
  - Aboriginal community controlled health, legal and welfare services are prioritised and adequately supported
  - Mainstream services better meet the needs of Aboriginal people
- Greater investment in an holistic approach to mental health for Aboriginal and Torres Strait Islander people that supports prevention, treatment and opportunities to strengthen cultural identity, job readiness and social inclusion.
- Develop a national strategic framework (the Framework) to address food access and security for Aboriginal and Torres Strait Islander people including those living in regional and urban communities. Such a framework should identify determinants of food security, describe the burden of disease due to poor nutrition, determine the status of poor nutrition and support implementation of community driven programs.
- Greater investment in early years in health and education as a public health issue:
  - The COAG reform agenda needs to account for children who remain unwell, underweight/malnourished, undertreated (ear/eye infections, heart disease) and underrepresented in the early childhood education sector
  - The Framework needs to advocate more clearly for healthy outcomes and appropriate funding for all children as a basis upon which education follows

## **PHAA – KEY ELECTION PRIORITIES 2013**

### **4. Tobacco and Alcohol**

#### ***Tobacco - reduce smoking and provide funding for prevention activities***

Health groups believe that cigarettes in Australia should cost at least \$20 per pack of 25 and that this is achievable within the life of the current National Tobacco Strategy 2012–2018. A good first step would be an immediate increase in excise duty of ten cents per stick. This would result in an estimated 140,000 smokers quitting and raise approximately \$1.25b. This would also do more to save lives and improve health than any other measure conceivable in the forthcoming Budget.

The National Preventative Health Taskforce recommended regular, annual tobacco excise and customs duty increases “to discourage smoking and to provide funding for prevention activities...”. There is overwhelming evidence on the impact of increasing prices, with special benefits in influencing children and low-income groups. There is also strong public support for this measure, all the greater if the revenue goes back into supporting health costs. Cigarette prices in Australia are still lower than in some comparable countries, and apart from CPI there has not been a tobacco tax increase since 2010.

We applaud the Government’s determination to reduce the massive harms of smoking, and its costs to the community, particularly through its world-leading plain packaging legislation. A tax increase now would be a superb means of complementing plain packaging and ensuring a further significant dramatic reduction in smoking.

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

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

PHAA therefore recommends a tobacco tax increase as part of a comprehensive approach to reducing smoking, with revenue raised to be allocated to health funding.

#### ***Alcohol - replace the WET Rebate with a volumetric tax rate***

The PHAA supports the case put to you in a budget submission by the Foundation for Alcohol Research and Education (FARE), the submission of 29 January 2013 by the Alcohol and Other Drug Council of Australia (ADCA) and the approach taken by the National Alliance for Action on Alcohol (NAAA) <http://www.phaa.net.au/documents/101126Attachmenttosub-NAAApositionStatement-Reducingharmfromalcohol-creatingahealthierAustralia.pdf> for tax reform as part of a comprehensive approach, including the regulation to curb alcohol promotion, research-based health warnings and information determined by government, increased expenditure on public education, and national approaches to ensure consistent and more effective liquor licensing measures and enforcement and reductions in alcohol-caused injury, violence, domestic violence and road crashes.

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



## **PHAA – KEY ELECTION PRIORITIES 2013**

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

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

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

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

FARE then argued about long-term savings through preventive health measures for a small expenditure on public health measures around alcohol issues including Foetal Alcohol Spectrum Disorder.

The FARE submission is available at:

<http://www.fare.org.au/wp-content/uploads/2011/07/FAREs-2013-14-Pre-Budget-Submission.pdf>

### **Key Commitments Sought**

- **TOBACCO TAXATION:** increase in excise duty of ten cents per stick to reduce smoking, save lives and raise \$1.25 billion
- **ALCOHOL TAXATION:** Projected savings of \$849million if a volumetric tax is applied to wine and the WET rebate abolished.
- **COMPREHENSIVE APPROACH:** Tax reform should be part of a comprehensive approach designed to reduce harm associated with the use of tobacco and alcohol

## PHAA – KEY ELECTION PRIORITIES 2013

### 5. Food, nutrition and physical activity

#### *A comprehensive approach is vital*

Good nutrition is vital for growth in early life, health and wellbeing, preventing the development of chronic disease and is integral in the treatment of disease to minimise disease progression. Obesity is one of Australia's most important public health issues. Obesity increases morbidity and mortality due to insulin resistance and type II diabetes, high blood pressure, dyslipidaemia, cardiovascular disease, stroke, sleep apnoea, gallbladder disease, hyperuricemia and gout and osteoarthritis. It is also linked to cancer of the stomach, prostate, breast, uterus, cervix, ovary, oesophagus, colon, rectum, liver, gallbladder, pancreas, and kidney.

The National Preventative Health Taskforce identified that "In only 15 years, from 1990 to 2005, the number of overweight and obese Australian adults increased by 2.8 million" and "if the trends continue, it is predicted that almost two thirds of the population will be overweight or obese in the next decade". The Taskforce also identified that a quarter of our children are also overweight or obese. This is up from just 5% of our children in the 1960s. Almost a third of children do not meet national guidelines for physical activity and only about a fifth meet dietary guidelines for vegetable intake. Even moderately obese people have a life expectancy between two and four years less than those with a healthy weight, with some research indicating up to a seven year difference (National Preventative Health Taskforce Report June 2009).

A comprehensive approach is vital. As with other public health issues, some of the interventions to reduce or control overweight and obesity may bring about only modest gains when implemented in isolation, but when implemented in combination and over a long period, they can bring about substantial benefits. A National Nutrition Policy should be developed through an open, engaging and transparent process and in a manner that is linked with other policies such as the National Food Plan and other key policy areas such as physical activity, women's health, indigenous health and the national curriculum.

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

#### *Key Commitments Sought*

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

## **PHAA – KEY ELECTION PRIORITIES 2013**

program should be run or coordinated by ANPHA and should incorporate or reflect expected systems of simple and interpretive front of pack labelling.

- Implement rigorous legislated controls and active monitoring to protect children from the advertising and promotion of nutritionally undesirable or “junk” foods (those with low nutrient density and high in fat, salt, sugar or energy), with a special focus on preventing any form of promotion of these foods to children, including advertising, internet, sports/events promotion and promotions through schools.
- Improve labelling of foods with an effective interpretive system so that nutrition / health information is clear and consistent across nutrition/diet promotion activities, and impose effective controls over direct or indirect health claims for nutritionally undesirable foods.
- Commit to appropriately resourced research and implementation of effective Health and Physical Education (HPE) in schools in the new Australian Curriculum, including achievement of specified hierarchies of health and food literacies (as Achievement Standards) across the stages of education.

## PHAA – KEY ELECTION PRIORITIES 2013

### 6. Communicable Disease

#### *Implement the recommendations of the recent JETECAR Report*

The Finance and Public Administration Committee of the Senate reported on the Progress in the implementation of the recommendations of the 1999 *Joint Expert Technical Advisory Committee on Antibiotic Resistance* (JETACAR).

A series of recommendations from that Committee drive not just the issue of antimicrobial resistance but a broader approach to communicable disease. The PHAA urges all political parties to adopt the recommendations of the Senate Committee as a matter of urgency.

#### *Establish an Australian Centre for Disease Control (ACDC)*

The first recommendation of the Senate Committee is:

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

Australia is unique in being the only Organisation for Economic Co-operation and Development (OECD) country without a recognised separate authority for the national scientific leadership and coordination of communicable disease control.

There is a network of health organisations that are involved in supporting the call for an Australian Centre for Disease control. We have worked closely with a range of academics and health institutes. However, the lead role has been taken by the PHAA in partnership with the Australian Faculty of Public Health Medicine (AFPHEM) which is an arm of the Royal Australian College of Physicians (RACP).

The most important element of an ACDC is coordination and oversight. Some argue that this is being done at the moment – and to a certain extent is true. However, the nature of inter-jurisdictional relationships means that blame shifting occurs. Overall responsibility and coordination is fundamental to successfully dealing with the spread of infectious diseases. The recent confusion over the Hendra virus in Northern NSW and Queensland provides a good example.

Although interaction between different bodies in jurisdictions, departments and local government was sorted out over a relatively short time - the response to the outbreak should have immediately become the responsibility of a national body with an overall coordination plan. The reduction in public service staff across Queensland, particularly in the area of public health, reflects vulnerability in the current communicable disease control system when aspects are at the discretion of the jurisdictions. Australia's disease control system needs to be proactive, adequately resourced and nationally coordinated if we are to deal effectively with infectious disease outbreaks.

In order to have a more proactive rather than reactive approach to adverse events, the PHAA identifies the main benefits of the establishment of an ACDC as follows:

## **PHAA – KEY ELECTION PRIORITIES 2013**

- National coordination of disease surveillance. Experts in communicable disease surveillance should lead the analysis and interpretation of notifiable disease information and the coordination of scientific effort
- National leadership in communicable disease prevention programs e.g. National Immunisation Program, HIV and antibiotic resistance
- Specialist expertise in the investigation, coordination and management of nationally significant outbreaks of communicable disease or other significant related issues (e.g. adverse events following vaccination)
- Oversight and coordination of training and development of the disease control workforce; and
- Strategic contribution to the control of communicable diseases in the Australian Area of Interest (Western Pacific and Near North) in partnership with World Health Organisation regional agencies (SEARO and WPRO).

*See the joint PHAA, AFPHM (RACP) discussion paper:*

<http://www.phaa.net.au/documents/110329NationalCentreforDiseaseControldiscussionpaper.pdf>

There is some debate as to whether an ACDC should be developed as part of the Australian National Preventative Health Agency or should be established separately.

### **Key Commitments Sought**

- Adoption of the recommendations of the Senate Committee report on JETACAR
- The establishment of an ACDC
- As a first step the PHAA calls on the government to commission a study to examine the benefits and costs of establishing an ACDC.

## PHAA – KEY ELECTION PRIORITIES 2013

### 7. Injury Prevention

#### *Fund a National Injury Prevention Plan*

The issue of injury prevention has not been high on the government's agenda to this point. Injury prevention is a key priority for public health. The most notable success in this area in Australia has been with regard to motor vehicles. The PHAA believes that many of the lessons learnt from the interventions and campaigns around seat belts, speeding and alcohol related accidents have applicability in other areas where injury considerably increases the burden of disease. The PHAA has a number of injury prevention policies which illustrate the need for a comprehensive national approach. These include:

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

#### *Key Commitments Sought*

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

## **PHAA – KEY ELECTION PRIORITIES 2013**

### **8. Oral Health**

#### ***Commit to “Denticare”***

The Public Health Association of Australia (PHAA) warmly welcomes your government’s \$4 billion investment in dental health targeted at children, disadvantaged people and regional Australia. PHAA is keen to ensure that the services - and advertising associated with the package - encourage maximum uptake by those most in need. The PHAA works with five other organisations in a coordinated manner seeking government commitment on oral health. They are the Australian Healthcare and Hospitals Association, the Australian Council of Social Service, the National Rural Health Alliance, the Australian Health Care Reform Alliance and the Australian Dental Association.

The Dental Benefits Act 2008 Medicare Teen Dental Voucher scheme was targeted at low and middle income families. The second review of the scheme found that uptake was highest in areas of relatively greater advantage, peaking at 36.2% in Socio-Economic Index For Areas (SEIFA) index 10 locations. Only 19.9% of available vouchers were used in SEIFA 1 locations.

The Australian Government Department of Health and Ageing commissioned market research on the communication materials for the Teen Dental Voucher program. We recommend that these findings are taken into account when designing materials for this new package. In addition, the Teen Dental Voucher was promoted via school newsletters, ethnic press and community radio and we would support these and other measures to reach as many people as possible.

As the uptake of the Teen Dental Voucher largely did not reach those most in need we recommend that further work be undertaken to design the best ways to promote and provide the various new programs to at-risk subgroups such as Aboriginal people, who have typically experienced great difficulty accessing mainstream dental and medical services.

In designing the roll out of this new investment which will target at-risk groups, we are keen to ensure that consideration is given to not only the way in which programs are promoted, explained and implemented but also how they are delivered (patient, family and prevention centred model of care) in order to ensure they will be regularly utilised by those most in need it.

#### ***Key Commitments Sought***

- Retain the government commitment to “Denticare” and the \$4billion dollars committed by the government
- Disseminate information about the strategies that will be used to work with other Australian governments to ensure this program is widely accepted and accessed by the eligible Australian children and families to whom it is targeted.

## **PHAA – KEY ELECTION PRIORITIES 2013**

### **9. Gender – A Joint Submission by AWHN & PHAA**

This component is a joint submission with Australian Women’s Health Network (AWHN) and PHAA. Additionally, the PHAA also acknowledges and supports the submission of Sexual Health and Family Planning Australia (SH&FPA) [www.shfpa.org.au](http://www.shfpa.org.au)

#### ***Gender: A key determinant of health and well-being***

The health and well-being of women is dependent on their status in society, their incomes and opportunities for social and economic participation which, in turn, are shaped by social, economic, political and cultural factors. The consequences for women’s health and well-being of social norms that create gender stereotypes, discriminate against women and girls, uphold unequal laws, and create inequality, are critical.

Recent public debate has highlighted again the need to address the ongoing, entrenched discrimination against women in Australia, which restricts their access to financial security and leadership opportunities, and makes invisible the considerable contribution they make to the economy particularly through their unpaid ‘caring’ work. It has also shown the frustration and anger that women feel about these issues and that strong visible government leadership is needed over a considerable period to address the inequitable distribution of power and resources experienced by women.

Currently, poverty among women and their children is growing rather than decreasing. Women’s earnings remain persistently lower than men’s income. Men can expect to earn 1.5 times more than women over their lifetime from age 25 (FaHSCIA 2010) and benefit from double the superannuation balances and payouts than women (Australian Human Rights Commission 2009). The Human Rights Commission predicted the gap in superannuation to persist for coming generations and that instead of “accumulating wealth through the retirement income system as intended, due to experiences of inequality over the lifecycle, women are more likely to be accumulating poverty”. This will result in increasing demands on government funding to support a growing number of older women who will be reliant on the welfare system and spend many years in old age living in poverty (Senate Committee 2008).

Through their unpaid work as carers, women meet the physical, social, emotional and financial needs of younger and older populations, as well as family members with illness and disability. Responsibility for unpaid work has serious implications for women’s financial independence and for their health. In 2005, the annual cost of replacing unpaid carers was estimated to be \$30.5 billion (NATSEM 2004 cited by Carers Victoria 2003). While current health system reform is necessary and welcome, it is increasingly shifting the care of sick persons from institutional care to home care, thus increasing the burden on women and the reliance on their unpaid caring work.

If women’s health and population health are to be improved, health systems have a responsibility to acknowledge social relations, social factors and conditions. The purpose of a health system should be to increase health, well-being and equity, and to decrease inequities. To do this it is essential for all policy, population planning and programs to be explicitly gendered. However, the tendency of health policies and programs to be gender blind undermines those fundamental goals. Health policies, whether for cancer, heart disease, mental health, or ageing women, should provide a guide for health practice and programs by ensuring that:



## **PHAA – KEY ELECTION PRIORITIES 2013**

- health systems are responsive to women’s particular needs and work with women’s health and NGOs for information about best practice;
- strategies are developed to improve the health status and experiences of all women, particularly vulnerable and marginalised women;
- there is a commitment to expanding service, workforce and system capacity for gendering of policies and programs;
- there is accountability and outcomes for women which are measured and transparent;
- gender mainstreaming, the infusion of gender analysis, gender sensitive research , women’s perspectives and gender equity goals into policies, project and institutions, is promoted by the health sector, so that gender is embedded in policies across sectors, e.g., in social inclusion, disability and employment policies.

The current Federal government’s National Women’s Health Policy 2010 (NWHP), which was developed with input from our three organisations and many others, provides a guide for such work, but its effectiveness to date has been extremely limited as it was not accompanied by a cohesive, appropriately funded, implementation program.

The NWHP examines strategies for addressing the social determinants of health and acknowledges the significance of gender as a key determinant of women’s health and well-being. Furthermore, it identifies “an opportunity to ensure these are reflected in the health reform process, to develop a health system that is more responsive to needs of Australian women” (p.9). However, there is no requirement for other policies and program to be linked to this policy or to report against its goals and there is little evidence that it has had an impact on the development of other subsequent health policies and system reform. For example, the prevention of chronic diseases, through the control of risk factors, and mental health and well-being were both identified as priority health issues for women in the NWHP. These are important current health priority areas that the Government has made significant investment in recently, however, women’s experiences and needs are largely invisible in approaches to reducing and managing the incidences of chronic conditions and there is a conspicuous lack of gender focus in general mental health plans. This is in spite of advice provided in its NWHP and overwhelming evidence for the explicit inclusion of gender for strategies to be effective.

The AWHN Women and Health and Wellbeing Position Paper 2012 provides specific recommendations which should be included in a funded NWHP implementation program, as these would significantly strengthen its effectiveness. They include, for example, incorporating into a range of areas appropriate gender and health analysis, a call for leadership from the Commonwealth Government on gender and health issues and the provision of incentives that reward businesses which actively promote women to executive management levels.

### **Key Commitments Sought**

- As a starting point, funding be provided for a National Women’s Health Policy 2010 implementation program that incorporates the recommendations of the AWHN Women and Health and Wellbeing Position Paper 2012.

### **The Australian Women’s Health Network**

*AWHN is an advocacy organisation that provides a national voice on women’s health, based on informed consultation with members. Through the application of a social view of health, it provides a woman-centred*

## **PHAA – KEY ELECTION PRIORITIES 2013**

*analysis of all models of health and medical care and research. It maintains that women's health is a key social and political issue and must be allocated adequate resources to make a real difference.*

*It aims to foster the development not only of women's health services but of stronger community-based primary health care services generally, which it sees as essential to improve population health outcomes. It advocates collaboration and partnership between relevant agencies on all issues affecting health. To this end, AWHN coordinates the sharing of information, skills and resources to empower members and maximise their effectiveness. The coalition of groups that comprises the organisation aims to promote equity within the health system and equitable access to services for all women, in particular those women disadvantaged by race, class, education, age, poverty, sexuality, disability, geographical location, cultural isolation and language.*



## PHAA – KEY ELECTION PRIORITIES 2013

### 10. Climate Change and Health –a safe environment

#### *Use taxes and revenue and other levers to move to lower carbon*

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

A safe environment is one of the core determinants of human health along with the socioeconomic and political structure of our society, and the complex of individual and organisational factors affecting health and health services. A safe environment is one that will provide a habitat to support *Homo sapiens* and an ecologically sustainable complex industrial society.

Components of a safe environment are: a safe climate; an intact biophysical natural environment featuring complex biodiversity; functioning ecosystems which include those providing clean air, fresh water, soil and forests; intact protective features such as the tropospheric ozone. Prerequisites for maintaining a safe environment are to minimise adverse human impact on the environment by developing and maintaining a sustainable social and economic system. A sustainable human society is one that provides food, settlement, energy, transport and leisure within the ecological boundaries of the planet for the present population while allowing for future generations. Factors that assist in doing so include a population within the carrying capacity of the planet and practices that do not disrupt or overload the capacity of the planet's chemical and ecosystem cycles.

Human activity including additional greenhouse gases is driving ecosystem and biodiversity changes. Human existence and well-being depends on the living and non-living environment, which may have fundamental rights outside of the benefits and services provided to humanity.

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

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

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

## **PHAA – KEY ELECTION PRIORITIES 2013**

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

### ***Key Commitments Sought – action for a safe environment***

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

## PHAA – KEY ELECTION PRIORITIES 2013

### 11. Conclusion

PHAA seeks support from all parties and candidates to build a healthier society.

We are keen to ensure expenditure, and particularly that in the health portfolio, is as closely as possible managed in line with this submission.

Our key messages are the public health should be given a higher funding and action priority:

- Improved health outcomes for all Australians can be achieved by tackling the “causes of the causes” of poor health with a specific focus on disadvantaged sectors of our community
- A modest increase in prevention spend now will bring substantial benefits in terms of both health and costs in years ahead. We have provided a series of examples where investment in prevention will return benefits both economically and in terms of human health
- There are opportunities for raising revenue of over \$2billion while playing a key role in improving long term health outcomes of individuals and the community when implemented as part of a comprehensive program

Please do not hesitate to contact Michael Moore, in the first instance, should you require additional information or have any queries in relation to this submission.

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04 August 2013

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