

Questioning Prevention

Health Policy Priorities for an Ageing Australia



Aims and Problems

- **Long-term SUSTAINABILITY.**
- Unprecedented situation facing Medicare.
- Ageing population: quarter of population over-65 by 2040s.
- Impact of baby boomer bulge hits mid-2020s.
- Health spending as high as 20% GDP



Intergenerational Challenge

- High cost of medical revolution.
- High-tech advances - diseases associated with ageing.
- High expectations – demanding baby boomers access to latest medicine.
- Huge cost-burden on smaller proportion of younger working age population.



Short to Medium-Term

- **'TAKE PRESSURE OFF PUBLIC HOSPITALS'.**
- HOSPITALS ALREADY BEARING THE BURDEN OF AGEING.
- Cause: Increasing admissions by 'very old' patients, aged 75 plus.
- Effect: Endemic overcrowding or Access Block.
- Reason: Lack of staffed available beds created by average occupancy >90%.



Solutions?

- **Evidence-based policy.**
- Challenges are too great for ad hoc measures and political fixes.
- Need for 'structural reform' to 'get the structure of the health system right'.



3 Claims

- **Three dominant claims of current reform debate.**
- Too much focus on expensive hospitals.
- Not enough on cost-saving Prevention.
- Spend more on 'cheaper primary care'.



Key Idea

'Investing' in prevention – especially preventive primary care – will contain anticipated growth in health costs by reducing prevalence of lifestyle disease.



Catch-phrases

- 'Wellness'.
- 'Sickness model'.
- 'Focus on curing illness not promoting health'.
- 'Focus on demand not supply side'.
- 'Preventive care to stem lifestyle disease epidemic'.
- 'Keep people well and out of hospital'.



Catch-phrases

- 'Alternative models of care'.
- 'Community-based care'.
- 'Coordinated primary care'.
- 'Better management of chronic disease'.
- 'Care in more appropriate setting to keep frail and elderly patients out of hospital'.



Voices

- Guiding principles of current reform agenda.
- Endorsed by, among others...

Australian Chronic Disease Prevention Alliance.
Centre for Policy Development.
Australian Health Care Reform Alliance.
Australian General Practice Network.
2020 Summit.
National Health and Hospital Reform Commission – First Report, 2008.



Furious agreement

- **BUT...**

Assertions/assumptions rarely subject to scrutiny and analysis.



Question

- Evidence-based policy?

A POLICY LOOKING FOR AN EVIDENCE-BASE?

(3 examples: Stronger Primary Care, Preventive Care, and Coordinated Care.)



Policy Making

- Bid:
'A wealth of international evidence shows that health systems oriented towards primary care achieve better health outcomes for a lower overall cost than systems focused on specialist or tertiary care. The international trend is moving away from hospital care.'
J. Doggett, *A New Approach to Primary Care*, Centre for Policy Development, 2007.



Rationale for GP Super Clinics Policy

- Response:
'There is now international evidence to demonstrate that health systems focused on primary care and preventative health care achieve better health outcomes, including lower death rates from chronic diseases like heart disease and cancer, and lower overall cost than health systems which are focused on acute hospital care.'
Rudd and Roxon, *New Directions for Australia's Health*, 2007.



Outcome

- 'Investing more in primary care services in local communities to keep people in good health and take pressure off public hospitals.'
Nicola Roxon, 'ALP Offers the Healthier Option,' *The Australian*, 28 August 2007.
- 2008 Federal Budget allocates \$275 million for start-up of initial 31 of national network of multidisciplinary GP Super Clinics designed to deliver 'preventive primary care' and 'coordinated chronic disease care'.



Prevailing assumption

That stronger primary care – because the setting 'most suited to early interventions, such as lifestyle modifications ... to prevent chronic disease advice' (Doggett) – has a preventive effect that reduces lifestyle disease and health costs.



The international evidence?

- Mainly US studies and comparative studies of OECD countries.
- Studies that show higher provision of primary care produces better health outcomes *contain no evidence that receipt of preventive care actually prevented chronic illness.*
(Denmark & England & Heart-disease)



Counter-Assumption

- Advocates of 'stronger' primary care confused traditional role and benefits of primary care – timely diagnosis and referral to secondary treatment – with alleged effects of preventive care.



Balance

- Studies also admit that improved health outcomes...
- Depend on 'appropriate balance' between primary and secondary care.
- That 'international comparisons and studies within the United States point to this conclusion.'



OECD

- For example, 2002 cross country analysis of 13 OECD countries actually revealed...
- That countries with relatively weaker primary care system – including Australia – that spent more hospital care achieved better health outcomes *than those with health systems more strongly oriented to primary care.*



International comparisons

- **Do not** show that countries with stronger primary care and 'less focus on specialist/hospital care' achieve better health outcomes at lower cost.
- *They show that countries that spent more on higher cost hospital care achieved better health outcomes.*



Preventive Care

To question prevention means asking what are The Limits of Prevention.



Prevailing assumption

More spending on prevention/preventive care' to educate people to make already well-known healthy lifestyle choices will tackle obesity, reduce chronic disease, and lower health costs 'in the long run', as *if this is a sure and seamless process.*

- **Bi-partisan:** Governments, politicians love to be seen to be 'helping' people:



Howard Government

'We need to continue to prepare for the health care we want in the future, and ensure that health spending is as efficient and effective as possible. For example, promotion of healthier lifestyles can prevent many health problems and reduce overall health costs over time.'
Intergenerational Report 2007.



Rudd Government

'Preventative health care needs to be made more accessible to ordinary Australians struggling to find the time in their busy lives to look after their own health. We can't expect people to take better care of their health if we won't help provide the health services they need to make this a reality.'

Rudd & Roxon, *New Directions for Australia's Health*, 2007.



BUT ONLY IF IT WORKS

- Prevention is better than cure...
- **Key question always glossed over in the endless talking up of health and cost benefits of more spending on prevention.**



'Slim' evidence-base

- 40 years of public health promotion policies targeting risks associated with poor diet and lack of exercise.
- Healthy lifestyle message well and truly 'out there'.
- Promoted both by governments and range of media and social pressures.



Results

- Not as universally successful as hoped – mixed results.
- Increasing obesity and lifestyle disease.
- Some people heeded and practiced – more in middle classes – and some – more in lower income groups – have not.



Evidence

- Aust 2004: *Returns on Investment in Public Health*.
- An estimated \$810m spent by Australian governments on CHD programs results in \$557m 'saving' on health expenditure
- UK 2004 – Wanless Review of public health policy
- Finding: failed to improve the overall health of the population.



Identical Conclusions

- Almost identical language:
- 'there was little change in the amount of physical exercise taken and the proportion of overweight persons increased.' (*Returns on Investment*)
- 'levels of physical activity have remained relatively stable over the last decade, [and] obesity levels have been rising.' (Wanless)



Wanless

- 'Very poor information base' and 'lack of conclusive evidence for action'.
- 'Generally little evidence about the cost-effectiveness of public health and preventive policies or their practical implementation'.
- 'There is little evidence about what works among disadvantaged groups to tackle some of the key determinants of health inequalities'.



Qualifiers

- ACDPA also admitted the evidence of effectiveness and cost-effectiveness is 'limited' and 'scare'.
- Review by Monash University Health Economics Unit (2005) pointed to 'critical gaps' in evidence, the 'poor quality of evidence', 'particularly in relation to retention of behaviour change.'



Why?

- Obesity/lifestyle disease not an 'epidemic' governments have failed to control.
- No way of passively protecting people.
- Not same thing as contagious disease and immunisation and regulating water, air, and food supply.



Individual Responsibility

- Governments can try to induce people to protect and promote their own health
- But ultimately governments have limited authority to control individual behaviours that cause and can prevent lifestyle disease.



Lifestyle modification is hard

- Different to quitting smoking.
- Requires changing and sustaining changes to complex series of 'sticky', unhealthy, but often pleasurable behaviours.



Success depends on personal qualities

- Will, self-discipline, impulse control.
- Public health policies cannot instil in those who don't possess them already.



Presumption

This is why Prevention runs up against the LIMITS OF PREVENTION



Public health discourse

- Policy-making based on following thinking.
- Tacit admission not as successful as hoped – ‘knowledge not put into practice’.
- But always suggest evidence doesn’t show what works.
- **Limits of Prevention** never examined.



Instead

- Individuals are absolved of responsibility.
- Lifestyle disease epidemic blamed on government failing to provide preventive care.
- **Thinking behind Super Clinics policy:**
‘Ordinary Australians’ can’t take care of own health without government help and Medicare- funded ‘wellness’ services.



New model of ‘wellness’ care

‘The lifestyle changes associated with obesity and physical activity can be facilitated by ongoing collaboration by a multidisciplinary workforce – most notably dietitians/nutritionists, and nurse educators working with fitness therapists/lifestyle coaches ... by fitness trainers, lifestyle coaches, counselors, and a range of complementary therapists.’

Dr John Stafford, *Wellness Centres Revisited*



Does it work?

- Same story as community-wide health promotions campaigns.
- Studies of high-intensity multidisciplinary lifestyle interventions show low impact on key behaviour - long-term retention of lifestyle modification. (2003 US Preventive Health Service Task Force report)



Implication

- Not ‘evidence-based policy’.
- **‘A policy looking for an evidence base.’**
Anderson, ‘Obesity Prevention and Management—Evidence and Policy,’
Journal of Human Nutrition and Dietetics 18:1 (February 2005), 1–2.



'Hit and Hope'

- Must 'do something' – make Medicare into weight-loss counselling service.
- Replicate standard GP care and advice.
- Crowd out private providers.
- Expensive structural feature of health budget.
- Won't make Medicare more sustainable.
- Pay more for ineffective preventive care for limited health and cost benefit.



Coordinated Care

Assumption because rising numbers of elderly patients with complex chronic conditions are presenting at overcrowded emergency departments, conditions better managed in a multidisciplinary GP Super Clinic.



Battle of the 'Anecdotes'

- 'Anecdotal' reports elderly chronically ill patients who could be treated by GPs are using emergency to access primary care for ongoing conditions. (Booze Allan Hamilton, Key Drivers of Emergency Demand, 2007)
- Yet some emergency specialists suggest rare to find acutely ill elderly patient whose admission could have been prevented by better care in the community



Assumptions and evidence

Where is **the** 'patient of the future' best treated?



Second Round ACCT

- Mainstream trial targeted the key demographic .
- 'Very old' and chronically ill patients.
- Coordinating the care of patients did not produce a significant reduction in hospital use compared to control group continued usual GP care.
- Patients receiving coordinated care used more hospital services at the beginning, end, and throughout the trial on average than control group.



More community-based care?

- Range of existing Commonwealth and State services providing care for elderly in the community.
- Booze Allan Hamilton Report suggests programs are working well.
- Elderly are well enough to remain in community longer.



BUT!

- Are entering 'high care' nursing homes older and sicker.
- Are more likely therefore to need referral to hospital.
- Are almost always true emergency cases.
- Almost always require admission to a ward bed.



Appropriate

Other studies also suggest use of emergency departments by elderly mostly appropriate and unavoidable.



Journal of Gerontology, February

- Examined the patterns of use of emergency departments by elderly patients during a 4 year period.
- Found elderly patients were high users of emergency departments,
- But very few visits avoidable – majority 'high-intensity' reasons.
- Diverting elderly to more 'appropriate' primary care would not relieve overcrowding.



The BIG question about Prevention

Less focus on hospitals,
and more on prevention –
or the other way round?



Paradox

- **The problems in hospital are due to the success of better (easy) prevention.**
- Longevity.
- Falling rates of heart attack and stroke – medication and lifestyle change.
- Reduced use of hospitals beds by 65-74 in 1990s.
- Rising use of hospitals beds by 75 plus age group in 2000s.



Delayed Demand

- People who once would die in 50s and 60s now living to very old age.
- Inevitably get acutely ill due to onset of conditions linked to age, genetic, and hereditary factors.
- Hospitals face an unprecedented tsunami of demand for hospital care from 'very old' patients.

(Is the hospital sector ready?)



Continuing Crisis

Due to decades of beds cuts, based on planning assumption that beds and bed numbers are 'less important' (AIHW), public hospitals already unable to cope with rising demand.

- Australia doesn't have an internationally (OECD) comparable 3.9 acute beds.
- 1.3 beds – 33% of the national total – in private hospitals and most not used for emergency patients.



Public acute beds ↓ one-third

- Bed numbers have fallen from 6.2 per 1000 head of population in 1983 to 4 per 1000 today.
- At present, approximately 2.6 public acute hospital beds per 1000 - down from 4.8 per 1000 in 1983.



The 'Hospital Crisis'

- Public hospitals operate at above average 90% occupancy to reduce elective waiting lists.
- Access block occurs when occupancy is >85%, regular bed shortages when occupancy is >90%, and emergency always operate in crisis mode when occupancy is >95%. (Bagust, BMJ)



Overcrowding

- Lack of available, staffed beds is why (mostly elderly) patients wait a long time on trolleys in emergency corridors. (ACEM 2004).
- Reason why over one-third of admitted emergency patients wait longer than eight hours for a hospital bed.



Cuts, Rationing, & Maximum 'efficiency'

THE QUEUE FOR 'FREE' HOSPITAL CARE NOW FORMS IN EMERGENCY DEPARTMENT CORRIDORS.



Priorities?

- Can it be said that problems in public hospitals due to too much focus on hospitals and not enough on prevention?
- **Hospital crisis appears due to success of prevention, and failure of public hospital sector to cope with the consequences.**



Only 2%

Oldenburg and Harper, MJA 2008, increase funding for prevention to 10% of national health budget by 2015.



'High cost' of obesity

- Obesity costs \$58 billion? (Access Economics/Diabetes Australia 2008)
- Knock out the \$49.9 billion non-financial opportunity cost of lost wellbeing, and other non-health systems costs,
- Health systems costs \$2 billion a year
- 1% of the \$300 billion Commonwealth budget
- 3% of government health spending.



RIGHT PRIORITY FOR AN AGEING AUSTRALIA?

- AMA - cost of 3750 beds to prevent access block and operate hospitals at 85% average occupancy - \$3 billion a year.
- PREVENTION, OR CRISIS IN HOSPITALS ASSOCIATED WITH 1500 PREVENTABLE DEATHS PER YEAR? (Richardson, 2008)



'Denial' and 'Avoidance'

- Betting on prevention means don't have to talk about:
- Role of bed-phobic governments, rationing and bed cuts in a 'free' system in 'crisis'.
- Addressing public hospital monopoly and inefficiencies.
(\$26Billion – 65% real increase last decade.)



Realising Reform.

- Maximizing use of capacity in private hospitals.
- Ending 'double dipping' -10% – capping private patients in public hospitals.
- Addressing the real issues in aged care – bonds for 'high care' – enable delivery of sub-acute care out of hospitals.

