

Summary of 5th National Health Policy Roundtable

Purchasing Prevention: Making every cent count

The Australian Institute of Health Policy Studies (AIHPS) 5th National Health Policy Roundtable was held on the 8th August 2006 in Melbourne. The program for the day (see attached) focused on the topic of how Australia could do a much better job of financing and funding programs to prevent ill-health in the future.

The two key points that received unanimous support during the day were that:

1. There is an urgent need to give much more attention and priority to funding and delivering effective evidence-based prevention programs in this country; and,
2. For such a significant change to occur, it will be important to seek and advocate for support from the broader Australian community, key community leaders and others.

Summary of key issues raised by presenters

From Politics to Prevention – Mr Jeff Kennett

- Do we live better in health or declining health today?

Because we are living longer and with the increasing prevalence of chronic diseases and disability, the strain on the health system is quite obvious for all to see.

- The idea of prevention is strongly supported by government in Australia regardless of politics.

There is an increasingly strong evidence base for prevention but this is not generally recognised and appreciated by government and many health leaders. The views and attitudes of politicians and health leaders will ultimately be influenced by community leaders and the electorate.

- Political leaders are willing to listen

Good relationships need to be established with key leaders including state ministers in order to advocate for change by presenting good strong quality evidence. The arguments presented need to be clear, simple and succinct, and be socially and economically responsible.

- There is already so much money spent on sickness.

If even a small proportion of these funds were spent on prevention we would have a more health and productive society.

- The government's agenda can be changed

Prevention must be made a political and community priority. This has been achieved previously in relation to other major public health challenges and more recently in relation to mental health

- We don't need more basic research

Establish networks of individuals who are able to deliver outcomes, based on evidence-based prevention strategies and approaches. Develop community-based population health programs which can deliver changes and improvements to the major lifestyles behaviours.

- We need to shift public opinion and demand

We need to develop new approaches and ideas that capture the imagination of the community, but the outcomes must still be measurable, particularly in terms of success. The message should be an improvement on the old messages and to reflect changes in society and politics.

Australia compared to US Medicare – Dr Joan Stieber

- There are common challenges facing both Australia and the United States

There are perceived disincentives to national investments in prevention. Prevention is perceived as less urgent and less tangible compared to treatment services. The timeframes commonly used to assess returns on investments are too short to capture many prevention outcomes, and there is minimal engagement of consumers. We need to establish a coordinated prevention strategy to address fragmentation and skewed incentives, and to build on evidence-based decision making models.

- There is no single authoritative source of guidance for prevention (e.g. a national prevention taskforce) in Australia – such as the US Preventive Services Task Force in the United States.
- Pharmaceuticals and medical services are seen as an *entitlement*, while *prevention* generally operates under a *begging model*. This difference in paradigm has led to under-funding of prevention and skewed financing incentives.
- In applying the principles of “evidenc based medicine” to prevention, there is a need to develop alternative models more appropriate to public health and prevention, and to generate more evidence to support all levels of prevention.
- Fragmentation in the Australian system which encourages cost-shifting between providers and funders, leaving little incentive for prevention within any one sector.

The drive for change should be multi-disciplinary, to best overcome the barriers to better health and a more cost-effective health system.

- Australia appears to be ahead of the U.S. in acknowledging the importance of intersectoral approaches to health improvement – for example, in initiatives linking health departments to the built environment, urban planning etc.

The quest for prevention co-exists within larger challenges in the health system. A better understanding of the impact of health on national productivity may be the key to shifting the view of prevention from being “optional” to “indispensable”.

Financing prevention – Mr Rob Montefiore-Gardner

“Economists are trained to believe people know what’s best for them”

- Treasury is interested in prevention due to its long term cost-effectiveness

It is more cost effective to address the underlying cause of disease rather than to treat disease once it has been diagnosed.

- Population, Participation and Productivity are linked.

Those with fair or poor health have lower rates of participation in societal activities, particularly in preventive health activities. Good health also encourages investment and reduces absenteeism, impacting on productivity. It is in industry’s best interest to take a proactive role in relation to preventive services in the workplace.

- There are many demographic challenges for Treasury and there is a need for decisions to be more than reactive.

There is a need to consider the extent to which prevention might help to take some pressure off, enhance the sustainability of the system as a whole, and most importantly bring benefits in terms of improved quality of life, labour force participation and productivity.

- There are strict rules to what you can and cannot count in health budgets.

Treasury cannot generate specific processes, unlike other health and policy units in other departments, but report to the Treasurer on evidence and evaluation provided by central agencies

- So, what sort of evidence is needed?

A problem needs to exist and it needs to be demonstrated that specific solution(s) will achieve results in a cost-effective fashion, and that the solution(s) will achieve results.

- Why isn't the message getting out?

Prevention has a very long horizon and is not a quick fix. For funding, regular evaluation is more, not less, important and organisations need to take this into account when running long term intervention studies/programs. Longer term longitudinal studies with control groups are required.

Is an ounce of prevention really worth a pound of cure? – Dr Rob Moodie

- Public health and prevention don't make money.

Economics is the most important paradigm in Australia and internationally, so we need to make more convincing arguments to be involved in public health and to fund this for the future. We need more public health economists, not just health economists. We need to provide the evidence to Treasury so they have a better understanding of the issues and problems in public health.

- There are barriers to setting up prevention programs.

Prevention needs to be re-branded as *preventive services*. People need to demand these services, as the only time that people generally take control of their health is when they actually go to the doctor. Programs are often implemented by people who don't understand their community. Also, the required knowledge and skills impact on the environment we live in and attitudes need to change so that people have to help to make these life decisions to prevention.

- Politicians need convincing, and simple, arguments for change.

There are no waiting lists for prevention. We need to be able to advocate for a newer public health. Previous experience in addressing major public health issues has demonstrated the importance of support from and change at a political level. Would a PBAC for "prevention" be a way forward in this country? Australia needs a National Prevention Taskforce or equivalent.

- There needs to be an important focus on improving workforce development and training so that programs are run more effectively and better preventive policy is implemented.
- There is a need for a greater focus on prevention by those that pay the bills, i.e. health insurance companies, as in the Transport Accident Commission model that operates in Victoria.

Making sense of evidence: opportunities for prevention – A/Prof. Theo Vos

- The spectacular health gain in terms of extension and improved quality of life from tobacco prevention and cardiovascular prevention need to be highlighted
- Despite these gains due to ageing of the population and lack of efficient prevention methods for a number of chronic disabling conditions the number of people with serious disabilities will increase dramatically over the next few decades
- Gains from smoking cessation or prevention of smoking uptake in any individual are so great that almost anything you can do in tobacco control is cost-effective. Despite large gains over the last three to four decades, we still have 2.2 daily smokers in Australia and therefore need to continue current efforts and look for additional interventions
- CVD prevention (both primary and in people with the disease) very effective but the chosen mix of methods is not very efficient. Same results could be achieved at only a fraction of the cost of current practice.
- Reasons for inefficiency: lack of investment in non-pharmacological prevention options and, importantly, a choice to prescribe expensive rather than cheaper options in drugs for blood pressure lowering and cholesterol lowering.
- There are finite resources for health and the choices made by decision-makers are generally quite predictable.
- There is increasing pressure to justify choices in expenditure in the health system, but the costs of health services are rising as a percentage of GDP.

The increase is due to expensive new technologies, new pharmaceuticals, ageing and greater demands from the consumer.

- It is important to make informed choices in health resource allocation decisions.

The evidence for health policy should reflect the size and distribution of health problems (burden of disease and projections) and the costs and impact of health interventions (disease costings and cost-effectiveness).

- The chronic conditions that are disabling such as diabetes, heart disease, chronic respiratory disease, mental health problems and neurological and sense disorders are the health problems causing an ongoing problem to our health system and their burden will only increase with an ageing population.

Although both cardiovascular disease and diabetes are very big health issues, a lot is already known about how to prevent them at an individual, community and societal level. However, this multi-level approach requires long-term and sustained lifestyle change.

- How can we achieve the most health gain given a certain budget?

We have most of the necessary tools and methods to inform a more rational approach to resource allocation decision-making in health. This requires an intensive analytical effort, but the tools to undertake this analysis are improving all the time and the data is also becoming more readily available. We can also learn a lot from our past public health success stories i.e. tobacco control, CVD prevention and injury control.

How to get more dollars for prevention – Dr Sharon Willcox

“An increased focus should be placed on preventive health measures to minimize future growth in health care costs and reduce long-term fiscal pressures.”¹

- There is a “rule of rescue” where there is more expenditure placed on treatment versus cure, due to “the sense of immediate duty that people feel towards those who present

¹ OECD Economic Survey of Australia released 31st July 2006

themselves to a health service with a serious condition” and “an ethical imperative to save individual lives even when money might more efficiently spent to prevent deaths in the larger population.”²

- Prevention has a lot of evidence, but does not have the front page stories, no parliamentary inquiries, no umpire or health insurance that can support its lobby for increased funding and to create change.
- There is evidence of the effectiveness of high level and national preventive health taskforces or committees in other countries around the world, e.g., the US Preventive Services Taskforce, the Canadian Taskforce on Preventive Health Care etc, but who is the umpire in Australia?
- The bar seems to be set higher for prevention than for what we already fund in pharmaceutical and treatment services. We need to be able to get more investment in prevention, get it onto the benefits schedule with private health funds in the long term.
- Cost effectiveness is what drives prevention in Australia, but it is difficult to marry cost-effectiveness and value for money. The higher level is the value for money, but the bottom line is cost-effectiveness.
- How do we engage with the non-government organisations? There is a need to reflect on the previous public health success stories in Australia

Non-government organisations have been quite important in this area in terms of marketing and fundraising for prevention. Also, the work of industry and organisations and that they are equally important in terms of the value of prevention activities. Mainstreaming could be an alternative way in looking for a champion in the political process.

Key points arising from Roundtable discussion following the formal presentations

We should capitalise on what is already on the COAG agenda in relation to health system reform and health improvement. There was unanimous support for new two national bodies in Australia - 1) a preventive services taskforce that would be responsible for evaluating the evidence pertaining to specific preventive services and strategies, and 2) a preventive benefits advisory committee ('PBAC II'), which would consider funding options, once a particular method or service was identified as having sufficient evidence for implementation:

- The **National Prevention Taskforce** would involve key leaders from non-government organisations, research institutions, and professional and consumer bodies. The Taskforce would have an advisory role capacity that would need to be transparent, authoritative and independent from government, but it could accept commissions for work/advice on public health matters with research assistance from external organisations.
- **PBAC II** would look at a range of financing mechanisms available to government as well as how government could leverage additional financing and also, how it might reward wellness, so that effective prevention could be delivered to appropriate scale and population coverage.

A **prevention summit** should be held to discuss strategic developments for new initiatives for prevention, such as the above proposals. The summit would provide an opportunity to both highlight and stimulate debate on a broader level, bringing together key opinion leaders from both health and non-health organisations. This summit should produce a national charter for prevention in this country and to identify who has responsibility for carrying out key tasks in relation to improved and more effective prevention services in Australia.

² Centre for Health Economics, 2000