Preventive health reform: what does it mean for public health?

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ABSTRACT

- A revitalised public health strategy offers the most sustainable way to address current health inequalities and prevent chronic non-communicable diseases.
- Success in these goals requires a whole-of-government approach and long-term investments. A sizeable proportion of this investment must be outside the health sector, in the social, economic and environmental fabric of our society.
- The benefits of the federal government's proposed prevention agenda will only be realised if there is greater clarity about what constitutes preventive health activity, who is responsible for carrying out the preventive agenda, how it is integrated and funded within the health care system, and how prevention outcomes will be measured and evaluated.

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The current Australian Labor Government has a strong commitment to health reform, driven by an approach that sees good health policy as part of good economic policy.[1] This approach leads logically to the need to tackle Australia's escalating disease burden of preventable illnesses, such as diabetes, cardiovascular disorders, and lung and bowel cancer, as well as injuries. These conditions drive demand for health services, limit productivity, reduce quality of life and account for much premature mortality.[2] The federal Minister for Health and Ageing, Nicola Roxon, says she wants to shift prevention from the margins to the centre of health care.[3]

Before the 2007 federal election, we outlined eight health challenges for action by the incoming government.[4] Several of these challenges can be addressed by fully implementing the government's commitment to prevention. These include:

- Responding to changes in demography and disease patterns as the population ages and the burden of chronic illness grows;
- Promoting the health of our children;
- Using urban planning as a vehicle to create healthier and more sustainable communities; and
- Achieving equity in access to opportunities for health and health care, especially for Indigenous Australians.

Here, we argue that the benefits of the proposed prevention agenda will only be realised if there is greater clarity about what constitutes preventive health activity, who is responsible for carrying out the preventive agenda, how it is integrated and funded within the health care system and beyond, and how its outcomes will be measured and evaluated.

The current state of preventive health in Australia

Preventive health has always been a poorly funded relative of the total health budget, and the past decade has seen the disappearance of a number of advisory groups established to address prevention and public health policy.

Funding

A report prepared for the federal government in 2001[5] claimed that public health campaigns to reduce tobacco consumption, increase childhood immunisation, tackle HIV/AIDS, and prevent road trauma and heart disease not only averted deaths and reduced the disease burden but yielded significant returns on the investment.

The proposition that "prevention saves money" leads into highly contested economic territory, not least because the benefits of prevention are often deferred for years and may be politically "invisible".[6] However, this does not explain why the level of investment in prevention activities has been so small. In the 7 years to the 2005–06 financial year, public health expenditure as a percentage of recurrent health spending did not change, remaining a tiny fraction (2.7%–2.8%) of recurrent government health expenditure.[7] This was despite high levels of community support for spending more on prevention and public health ahead of treatment of disease.[8]

In the financial year 2005–06, total government spending on public health activities was $1.468 billion. These activities included those seen as primary prevention (immunisation, school-based health promotion programs, education and control activities in relation to substance misuse) and others seen as secondary prevention (cancer screening programs, detection and treatment of sexually transmissible infections).[7] The federal government provided $797 million (54.3%) of these funds, but was responsible for only $439 million in direct expenditure. The remaining $358 million was provided to the states and territories in the form of Specific Purpose Payments, including $160 million through the Public Health Outcome Funding Agreements. In 2005–06, public health expenditure across Australia was an average of $71.40 per person, ranging from a low of $64.98 in New South Wales to a high of $284.94 in the Northern Territory.[7]

Advisory groups

The Health Inequalities Research Collaboration was established in 1999 by the then federal Health Minister, Michael Wooldridge. Its aim was to apply the findings of research about what might be done through the health system to reduce health inequalities. Several working groups were established and actions followed, but the Collaboration was abolished in 2004.[9]

The 2003–04 federal health budget included a commitment to establish a formal priority-setting mechanism to compare and rank disease prevention and health promotion interventions and to conduct an accompanying series of cost-effectiveness studies,[10] but no results of this work have been made public.

The National Public Health Partnership was established in 1996 to identify and develop strategic and integrated responses to public health priorities. It was recently disbanded and replaced by two new committees, the Australian Health Protection Committee and the Australian Population Health Development Principal Committee, that have yet to achieve visibility.[11]

In 2005, the Public Health Performance Project, sponsored by the National Public Health Partnership, concluded that the absence of an overarching national public health strategy was the major barrier to the development of clearly articulated measures of performance in public health, and linked this to the failure of the sector to attract increasing investment commensurate with its success.[12]

Current barriers to preventive health reforms

Semantic confusion

There is considerable confusion surrounding prevention both as a concept and as an activity. When faced with semantic difficulties, it is important to first rectify the language, as the National Public Health Partnership[13] recommended.

There is inconsistency about whether to use the term "preventative health" or "preventive health".[14] The federal Health Minister consistently uses the former, although the latter seems to be more common in the literature. More importantly, "preventative health" is sometimes defined in a way that excludes tertiary prevention[15] (see below).

The Australian Institute of Health and Welfare defines prevention as "action to reduce or eliminate the onset, causes, complications or recurrence of disease".[16] This definition encompasses three forms of prevention:

- *Primary prevention* limits the incidence of disease and disability by controlling exposure to risk and promoting protective health factors at the population level.
- *Secondary prevention* comprises measures that aim to reduce the progression of disease through early detection (usually by screening) and early intervention, and is limited largely to at-risk groups in the population.
- *Tertiary prevention* aims to reduce the negative impact of established disease by restoring function and reducing complications in the affected subset of the population.

However, there are other ways of categorising preventive measures (see Herriot[17] and Sindall C and Stratton J, "Perspectives on prevention terminology", unpublished discussion paper for the SNAP [Smoking, Nutrition, Alcohol and Physical activity] Implementation Group Meeting, June 2003), and there are no clear boundaries between primary, secondary and tertiary prevention. For example, while public health is defined by the National Public Health Partnership in the same way as primary prevention,[18] public health funding encompasses both primary and secondary prevention activities.

We believe that the key focus of the federal government's prevention agenda must be on a revitalised public health strategy, using a community-based approach to address the social, political, environmental and economic determinants of health. This primary health care formulation is broader than primary health prevention,[19,20] and plays a critically important role in dismantling barriers to health and health care and addressing health disparities.[21]

Primary health care is not synonymous with primary care, which is taken to mean the first point of entry into the health system, generally for someone who is sick and seeking treatment. In Australia, primary care is almost always delivered by general practitioners. While there is the potential, increasingly recognised, for primary care to provide preventive and early intervention services, this is not the same as, or sufficient for, the achievement of a comprehensive primary health care agenda.[22]

The principal instruments of primary prevention lie outside the doctor's office, and require political, social and economic action. The primary prevention of childhood obesity is a classic example of a problem that will not be solved within the medical arena.

Workforce issues

The public health workforce, on whom the organisation and implementation of primary preventive strategies might be expected to fall, is hard to define. While it is expected that these people are trained and competent in public health, many of them will not be health professionals.[23]

However, beyond the report that led to the formation of the Public Health Education Research Program,[24] no official document can be found that specifies a strategic plan for the development of Australia's public health workforce. If primary prevention is to take its place in the preventive scheme, a lot more attention will need to be directed to the size, location and competencies of the public health workforce.

In this public health vacuum, there is a growing push for expansion of the role of GPs in population health and prevention.[25] Most clinical encounters should include prevention support, and there is some evidence that brief interventions during consultations can help individuals make changes to high-risk behaviour such as smoking, poor nutrition, excess alcohol consumption and too little physical activity.[26] But there are many practical barriers to delivering these services in the primary care setting, including GPs' lack of time and specific skills, practice nurses having other responsibilities, Medicare payments that reward episodic care, patients' illness and stress at the time they present, and the fact that access to referral services is often problematic for patients because of cost, transport difficulties and waiting lists.[27]

A push for GP surgeries to be the focus for primary and secondary prevention activities will mean that many people most likely to benefit from these activities will not access them because of waiting times, out-of-pocket costs, and perceptions that they do not need medical treatment. This, in turn, will inevitably mean that the potential ability of these services to address health inequalities will not be realised and that these inequalities will widen.

What has been promised and a possible way forward

Regrettably, very few of the federal government's election commitments in the area of prevention (Box) actually fall within the definition of primary prevention or primary health care.

Moving from rhetoric to action

Four steps could be taken by the federal Health Minister in the move from rhetoric to action:

- Clarify the semantics around what is meant by "preventative health" (and, having done that, ensure that all aspects of prevention — primary, secondary and tertiary — are covered).
- Sort out, among the plethora of commissions, taskforces, advisory groups and working parties currently proposed, their responsibilities, inter-relationships and reporting lines with regard to prevention.
- Determine the functions and size of the workforce needed to best deliver the new emphasis on public health, and ensure that the new national prevention strategy includes workforce planning and capacity building.
- Seek guarantees from the Prime Minister that primary and secondary prevention (public health) activities will be given the funding and political leverage they need.

The Labor government's election commitments in the area of prevention

Establishment of a National Preventative Health Taskforce, which will be charged with developing a National Preventative Health Strategy. The initial focus will be on obesity, alcohol and tobacco.

Establishment of a National Preventative Health Care Partnership with the states, and inclusion of prevention in the Australian Health Care Agreements.

Provision of additional funding for the National Tobacco Strategy ($15 million over 3 years).

Obesity

- Making obesity a National Health Priority;
- Introducing a Kitchen Garden Pilot Program to teach primary school children to grow, harvest and cook produce;
- Developing and distributing guidelines on healthy eating and physical activity in early childhood; and
- Evaluating successful community initiatives on obesity, and sharing information with other communities.

Indigenous health

- Closing the 17-year life expectancy gap between Indigenous and non-Indigenous Australians within a generation;
- Halving the death rate in children aged under 5 years within a decade; and
- Providing comprehensive child and maternal health services.

Maternal and child health

- Providing health checks for 4-year-old children; and
- Providing support for breastfeeding mothers.

Reform of the Medicare Benefits Scheme

- Providing incentives to encourage general practitioners to practise quality preventative medicine. ◆

Ensuring a sound, long-term investment

As the federal government moves to reduce the number of Specific Purpose Payments to the states and territories by rolling the Public Health Outcome Funding Agreements and other health-related Specific Purpose Payments into the next set of Australian Health Care Agreements,[28] there is a serious risk that the current low levels of investment in public health could decline even further.

It will be crucial to ensure that the rollover of these public health funds into the Australian Health Care Agreements comes accompanied by a set of sound, national key performance indicators, with penalties for failing to report on and reach the agreed outcomes.

Tackling the priority issues

The federal Health Minister has said that the National Preventative Health Taskforce, whose establishment was announced on 9 April 2008, will focus initially on obesity, alcohol and tobacco.[29] There is little to quibble about with this choice: the annual direct and indirect costs to society of obesity and obesity-related diseases, smoking and alcohol misuse total almost $70 billion[30,31] — equivalent to the total cost of the health system.

All three of these priority issues require a whole-of-government, multi-faceted approach and instantly highlight the need for a focus on prevention and public health that extends well beyond the health portfolio. In developing effective policy responses, the Taskforce will need to grapple with the social, economic and environmental dynamics that contribute to these problems.

Indigenous health

The Rudd government has committed to closing the 17-year gap between Indigenous and non-Indigenous life expectancy by 2030, to halving the Indigenous infant mortality rate by 2018, and to ensuring that Indigenous people have the same access to health services as the rest of the population by 2018.[32] In Indigenous communities, public health services will be as important as primary care in addressing the inequalities.

Despite the preparation and distribution of preventive care guidelines specifically tailored to the Indigenous population,[33] improvements in the delivery of preventive services to well adults have been particularly difficult to achieve.[34] A study of remote communities in the NT showed that, on average, only 40%–50% of preventive services were delivered in line with the guidelines current at the time.[35]

Specific needs for the delivery of primary prevention services to Indigenous communities include a trained Indigenous health workforce, a consultation program, culturally sensitive programs and information sources, and a set of performance indicators that enable accurate reporting and assessment of programs. The case has been cogently made that we need public health professionals to engage in creating a more compassionate society.[36]

The role of GP Super Clinics in the delivery of preventive care

The new federal government has committed to establishing "GP Super Clinics" to bring together the services of GPs, allied health workers, nurses and some specialists in communities where workforce shortages make health services difficult to access. The policy paper that outlines how GP Super Clinics will work[37] places considerable emphasis on prevention of chronic illness and highlights the need for a greater focus on health promotion and illness prevention in primary care. The policy paper seems to indicate that doctors and other health professionals in these Super Clinics who are engaged in primary and secondary prevention activities will be reimbursed through Medicare on a fee-for-service basis.

The increased role for GPs and practice nurses in primary and secondary prevention and the use of Medicare funds to reimburse for these services, which are currently funded through Specific Purpose Payments from the federal government and by the states and territories, raise a number of important issues. These include workforce flexibility, GP and practice nurse training, dual delivery pathways for health promotion and screening services, and effective targeting of these services and the Medicare funds used to support them.

What is the evidence about what works?

There is now an awareness of the importance of social and economic conditions as determinants of the health status of populations,[38] but there is limited knowledge of the way in which inequalities in health develop and about which policies, programs and services can be used to effectively address widening health inequalities. This is why National Health and Medical Research Council funding support for research in this area, combined with mechanisms to facilitate public awareness of the findings of this research, will be increasingly important.

In the United Kingdom, health must be included in the regulatory impact assessments that accompany all new legislation. This approach is important, given that key determinants of health

are found in the social and physical environments in which people live and work.[39] However, these environments are shaped by policies that are often developed and implemented without regard to their health implications.

A number of countries have recently taken a bold approach to ensuring that preventive health gets the emphasis it needs, by separating out the public health function from the administration of the rest of the health system. For example, Sweden has a Ministry for Public Health and an independent Institute of Public Health. This is backed by a national public health policy and a legislative requirement that the public health impacts of all political decisions be considered.

Conclusion

In its rhetoric, the Rudd government holds out the potential for the development of a comprehensive prevention strategy for Australia that will tackle the great pandemics of non-communicable disease and address health inequalities. Experiences in the UK and Sweden, which have taken up the challenge of addressing primary prevention, public health and primary health care as a whole, highlight the decades-long agenda that a truly preventive approach to health requires and the substantial level of commitment at all levels of government that is necessary for its implementation.

In 2005, Corbett called for an Australian "Ministry for the Public's Health", with a budget and an accountability to parliament separate from the Health Minister.[40] He argued for this new Ministry on the basis of the need for a whole-of-government approach to address issues such as obesity, better stewardship of public health infrastructure (which is currently dispersed across government), effective partnerships inside and outside government to deal with issues such as the environment, and better targeting and benchmarking of funding. We commend this approach for discussion as Australia moves forward with health reform.

Competing interests

None identified.

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