10. Andrew Wilson

This has been a fascinating series of presentations and in view of the time as the last speaker I am not going to use my full presentation but use elements of it to highlight some selected issues to allow time for adequate discussion.

I want to start though with something that came up in the discussions here and generally when there is a discussion of the economics of prevention. Repeatedly presenters have equated the economics of prevention with saving health care costs. Now prevention is not fundamentally about saving health care costs, it’s about preventing disease and it’s about improving health and wellbeing. Of course, there may be a benefit in that in terms of what impacts it might have on the healthcare system. But it has been well documented now that the main driver of health care costs is the volume or intensity of treatment of all diseases. We can do more and do so for just about every disease. That’s a good thing.

But if you look at the projection of $120 billion increase in costs between now and 2030, $80 billion of that cost comes from increases in the intensity of treatment (Slide 3). In fact if you look at diseases where we’re actually succeeding in preventing diseases, such as cardiovascular disease, where prevention has resulted in a reduction in incidence and mortality, the cost of treating those diseases over the forward period is still greater than at present (Slide 4). So we have to be very careful when we’re talking about the economics of prevention.

I was asked to talk about the systems approach to prevention and there’s a whole range of things that one can think about when one talks about systems approach. You can talk about the prevention system, you can talk about systems approaches to prevention, you can talk about systems’ thinking as opposed to systems construct. We haven’t got time to go through all those things today, but I do want to highlight two items.

There’s actually a tradition, a history of prevention in this country and we’ve been very successful. ANAPHA has recently released a commissioned series documenting this which is worth reading. We’ve got a good idea of some of the things that are important to that process (Slide 6, 7, 8). We know something about what some of the weaknesses of our current prevention system look like and this came out in both the National Health and Hospitals Reform Commission and out of the National Preventative Health Taskforce reports (Slides 9). The weaknesses that we primarily have in relation to prevention is that it reflects the broader health system, so prevention is fragmented, it’s loosely coordinated, it’s got multiple and discontinuous sources of funding, and it’s still largely communicable disease focused. It is also largely health system focused while lots of the issues in prevention of chronic disease and obesity require action outside the health sector. Moreover, there is a history of poor continuity of effort in prevention programs. The cancelled investment, for example, in national media for obesity control is just a recent example of this as is the complete dissolving of the community nutrition and chronic disease prevention program in Queensland.

Of course there are also some strengths in the Australian system around committed individuals and existing infrastructure and I think the way we’re currently under counting the total expenditure on costs. For example, if you look at the $12 billion that we now spend in the PBS, these are very
significant costs, over $1 billion for cholesterol lowering drugs, a prevention intervention. It is important that we demonstrate that we are using the existing resources available for prevention effectively and efficiently.

We also need to acknowledge the importance in prevention of a strong NGO sector. We've just seen some excellent examples of the sorts of things that people can do outside of government, things that are very difficult to do within governments. We've had a history of flexibility through necessity. We have both been inventive in prevention in terms of from where we've drawn our ideas but we've also been flexible and as I say, creative.

The National Preventative Health Taskforce defined some general strategies and most of these strategies go across a whole range of the most important areas of prevention. It suggested that we needed to establish a national preventative agency and as a result of that we got ANHPA (Slide 10, 11). I think if you have a quick read through what that national prevention agency was intended to do, ANHPA addresses some of those. As Louise Sylvan said, it doesn't cover the full agenda of things that are there, but it certainly is a long way from what we had. It identified a whole series of other supporting infrastructure that we needed for this social marketing, data surveillance and monitoring, national research infrastructure, workforce development and future funding models for prevention.

I think there's a really important question that at a point in time, we have to think about very carefully and that is what have we learnt from finally having a national preventative health agency and about whether its scope should be limited or broadened? (Slide 12) Given that we're in a lengthy period leading up to an election, I think we need to think about what the options might be in this space and whether we should be actually arguing for this. As a public health practitioner, it would be, I believe, a terrible backwards step if we lost it. I think we need to think about what other alternatives, given we're probably going to be faced with an alternative government, what other alternatives we might want to put in that space to offer that.

I think one of the things that we should be looking is broadening ANHPA's perspective and actually moving towards the idea of a national centre for disease control and bringing in some of those elements. I don't believe in fact it will actually cost us a lot more money to establish and operate such an agency and the benefits both nationally and in terms of our international profile would be substantial.

In the interest of time, I am going to skip over any discussion of some of the other ways of thinking about systems thinking and prevention as these are not as important to discussion of the economics of prevention (Slides 14, 15, 16).

I want to skip to make another point. Rebecca Cross gave one side of this particular argument. She addressed it, if you like, from a government perspective. But in fact the other side of it is the consumer perspective. We are constantly bombarding people with a whole range of differing social policies Slide (17). We have to think about which of these policies is important and then think about the messaging that goes with that.
Some of you will know of a report in relation to obesity by the Foresight Group which works within the UK Government. Their report, called ‘Tackling Obesities: Future Choices’, was first released in 2007. It’s a very nice piece of work and has a range of things that I would really like to see us reproduce in Australia that I won’t have time to go through today. But one of the things in it is systems map of the complex environment that drive the obesity epidemic (Slide 18). It defines all these different elements and it tries to show all the interrelationships and potential feedback loops. When I first picked this up, the first thing that it reminded me of is something that some of you will remember, which was the Knowledge Nation map, which as you know was presented by a previous Labor minister as a vision the future of intellectual capital development in Australia (Slide 19). It was an important message, but the media picked up on the relatively simple system map, lampooned it and the discussion paper disappeared almost without trace (Slide 20).

In talking about systems approaches, which I think is fundamental to understanding complex issues like obesity and like diabetes, we’ve got to be really careful about the message that we try to give to the decision makers. We need to be very clear and not feel it is necessary that the public and every decision maker or politician needs to understand the whole picture. When we talk about genomics we don’t try and tell decision makers about how you analyse DNA, we tell them how you get the messages from DNA and what makes that important. In systems analysis we’ve got to be careful that we don’t loose our message in explaining the technology or methods that we used to work it out.

Finally, some of you know that at heart, I’ve already demonstrated that despite now living in Sydney I’m a north Queenslander at heart. Probably the most distant part of Australia that you can get to from Melbourne is the Torres Strait Islands and this is a beautiful screen print by a Torres Strait Islander painter by the name of Dennis Nona from Badu Island (Slide 21). Badu Island is one of a group of islands, the most northern group of the Torres Strait Islands, just across the border from New Guinea. In fact, the nearest island about six kilometres by boat from New Guinea.

The reason I highlight this is if you’re in Brisbane and you’ve got to go to Badu Island, even the most direct flight say on the government jet takes over two hours and 45 minute journey. From Canberra add another 2 hours. By normal transport you are likely if you can make all the connections to get there in a day.

When we think about the sorts of approaches that we want to have to prevention we have to think about the context of Australia. The Torres Straits have one of the highest rates of obesity and diabetes in Australia. We’re thinking about policies and processes that are going to impact on health in Australia, we have to recognise the dimensions of this country and the special need groups within it when we do so. One approach will not fit every community and social or cultural group, and we need to learn more about what works in different circumstances. We are reasonable at documenting our successes in prevention, but we are much less inclined to document, analyse and learn from the projects that don’t work as we expected them. We need to be smarter about implementation of strategies and the scaling up of effective programs and systems thinking can help us do this better.