THE AUSTRALIAN

INQUIRER

Our hospitals are full of patients whose surgeries could have been prevented

By STEVE ROBSON

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Australians could be forgiven for thinking their health system is crumbling around them at the worst possible time. We read reports of patients dying while waiting for ambulances to arrive, or in the back of ramped ambulances queueing up outside emergency departments. The number of Australians waiting for surgery in our public hospitals has reached an unprecedented level.

Outside of public hospitals, getting an appointment with a GP is more difficult than ever. Last month, the federal Department of Health released a report predicting the rise in demand for GP visits due to diabetes, obesity and mental health problems. At that same time, the GP workforce is short 2500 doctors. This prompted Health Minister Mark Butler to issue this warning in May of last year: “If you think it’s hard to find a doctor now, in five or 10 years ... it will be a real problem.”

Because GPs manage many Australians with complex health problems in the community, and help keep them out of our overburdened hospitals, access to GPs is a major issue for the health system as a whole. “Every fail in the health system around the community,” Butler went on to say, “ends up in the emergency department, crowding out an already very stressed hospital system.”

According to the Australian Institute of Health and Welfare, almost two-thirds of all planned surgery and medical procedures occur in the private hospital system. Until recently, this has provided a safety valve for people needing care and who can afford private health insurance. Yet even the private health system seems to be buckling under pressure, prompting Butler to order a “private hospital viability check” in June of this year. The move was forced after dozens of private hospitals around the country closed their doors in the aftermath of the pandemic.

Spending on health in Australia, across all sectors, topped $240bn in the 2021-22 financial year, representing about 11 per cent of our gross domestic product. Yet despite this record investment, patients and healthcare workers alike are feeling a sense of impending doom. A 2022 report from the Grattan Institute found that every year, despite our universal health system, half a million Australians couldn't afford medications due to costs, and a similar number couldn't afford specialist care. The most vulnerable were those with chronic health problems – the group who most need care.

If a wealthy country like Australia is struggling to deal with demand for healthcare, what will the future hold? Spending as a proportion of GDP has increased almost 12 per cent over the past decade. The Productivity Commission warns us of an increasingly aged population with fewer young people to work and to provide care for the elderly and sick.

Australia is buckling under a wave of chronic illness. The recent parliamentary report into diabetes, for example, carried a stark warning: "The health costs of obesity and diabetes are very high and of significant concern in virtually every community across the country and in every age group." Rates of diabetes are catastrophic in regional and remote areas, but no part of Australia is spared.

If Australia's health system is to be sustainable in the long term, then the only option is to flip our thinking from providing care for established disease to preventing illness in the first place. While such a paradigm shift might sound logical, essential even, the obstacles to pivoting Australia's health system toward preventing illness in the first place seem formidable.

In a paper published on Friday, La Trobe University professor Alan Shiell and his colleagues highlight a number of uncomfortable truths for our health system. First, our spending on prevention is embarrassingly small compared with other OECD countries, less even than Lithuania. For most of the past decade it has hovered at about $110 per person per year, or about 1.6 per cent of total health expenditure across the country. By comparison, preventive expenditure in the cash-strapped UK is well over 4 per cent and in Canada it approaches 6 per cent.

To make matters worse, Shiell points out, there is no formal mechanism for tying the money that is currently spent on prevention to any evaluation of cost-effectiveness, as occurs with evaluation of new medicines or other medical treatments. “We cannot say ... with any degree of certainty how much is spent on what sorts of public health activity, what mechanisms are used to get the funds into the hands of the service providers, whether those mechanisms are fit for purpose or could be improved upon, or what percentage of the population has access to preventive programs of proven cost-effectiveness,” he says.

Preventing illness must become a high priority for Australia. There is no time to waste. According to the Australian Institute of Health and Welfare, waiting times for almost all planned procedures have increased compared with the pre-pandemic period. Yet it is important to understand why so much surgery needs to be done.

A good example is that of hip and knee replacement operations, of which more than 120,000 are performed every year. One of the key reasons these major operations are required is osteoarthritis. The Arthritis Foundation explains that osteoarthritis is “the result of a combination of factors, many of which can be modified or prevented. Ultimately, the best defence ... is a healthy lifestyle. Diet, exercise, sleep, managing stress and whether you smoke or drink can have a tremendous influence on the health of your joints.”

“Instead of choosing to change their lifestyle, patients want to have an operation to take away the pain,” says Victorian orthopaedic surgeon Dr Anita Boecksteiner. If Australians were more active and fewer were overweight, “it definitely would decrease the need for these operations, though it wouldn’t remove it altogether. But they could have a new knee or hip at an older age and not require a revision operation – the operation is going to last them a lifetime.”

Our public hospitals are filled with patients with preventable diseases such as diabetes, hypertension, smoking-related lung diseases and cardiovascular conditions. The AIHW estimates that more than 700,000 hospital admissions in Australia every year are for conditions that could have been prevented. One of the key reasons that emergency departments are filled to overflowing – and that ambulances are ramped outside their doors – is that hospital beds are taken up with thousands of patients with preventable conditions. This blocks emergency patients who need a hospital bed from accessing one.

“All the states are pouring billions and billions of dollars more into public hospitals, and public hospitals are the sponge that soaks up failure elsewhere in terms of healthcare,” explains South Australian Health Minister Chris Picton. “They’re the last port of call where people go when they’ve reached a critical stage of illness.”

This drift in focus away from prevention, and on to treating established disease, has accelerated over the past decade but was not always the case. Australia established a National Preventive Health Agency in 2011, with the aim of providing a “national capacity to drive preventive health policies and programs, and to strengthen Australia’s investment and infrastructure in preventive health”.

That body developed preventive policy and established partnerships across commonwealth, state, and territory governments, community health promotion organisations, industry, and primary healthcare providers. It was abolished in 2014 as part of a government cost-cutting drive. “If we had had that body over the past decade,” laments Picton, “I think that there’s no doubt we would have seen some stronger policy responses and no doubt better health of the community as a whole.”

As Shiell points out in his paper, investment in prevention in Australia is a rudderless ship at the moment. Unfortunately, there is no compass either: there has been no report on preventive healthcare spending from the AIHW for more than a decade now.

“The fact that the last report applied to the 2008-09 financial year, and was published in 2011, makes no sense to me,” says Professor Terry Slevin, chief executive of the Public Health Association of Australia. “You can’t manage it if you can’t measure it. Reporting is fundamental to making informed and intelligent decisions about investment in health.”

Slevin is brutal about Australia’s current lack of investment in preventive healthcare.

“Ultimately, it’s a fool’s paradise to continue to chase having a world class health system while ignoring the drivers that are sending people to the acute care system,” he explains.

“These things require a long-term view, and they require leadership and commitment beyond the current term of government.

“Building a sensible health system into the future requires a commitment to planning health investment that doesn’t suffer the slings and arrows of daily debate in parliament about who can be most popular for opening more hospital beds, employing more nurses, or other immediate challenges,” says Slevin.

“That’s not so say that those problems aren’t important, but that sensible investment for the long term could prove that governments can walk and chew gum at the same time.”

Picton agrees, saying that “the investment we’re seeing in the acute side of the system is massive, but we need to make sure that we’re actually trying to prevent as many people from hitting there as possible. We need to learn the lessons from successful campaigns, and how we apply them to the current healthcare challenges that we face. Because if we don’t do that, then we’re just going to have to keep building more and more hospitals, spending more and more billions of dollars, and people will be more and more sick.”

Mike Freelander, a doctor and parliamentarian from Western Sydney, chairs the Parliamentary Standing Committee on Health, Aged Care, and Sport. He was the lead author of the Parliamentary Inquiry into Diabetes that reported in July this year. “Prevention is not easy,” he says. “It has to start early, and it requires attention to all of the social determinants of health. Things like housing, education, work, family support, mental health, a whole range of measures.”

The stakes for our health system are high. “It is quite clear that the costs of not preventing illness like type two diabetes are enormous and increasing across the health system, across the economy,” warns Freelander. Yet preventive action is not easy. “Prevention is very important, but it’s complex and requires a lot of work across a whole range of portfolios. This is very difficult for governments to tackle when you’re looking at a long horizon,” he laments.

Australia has had great success in preventive health campaigns. The Slip-Slop-Slap campaign saw a generation of young people apply sunscreen and wear hats. Smoking rates have fallen dramatically with strict public health campaigns. As a nation, we have seen very successful preventive health measures deliver strong results.

Australia is in an excellent position to innovate in its approach to preventive care, and a good example is that of genetic screening to identify people at risk of disease. This week's government announcement of legislation to ban genetic discrimination should open the door for millions of Australians to seek such screening. Yet, again, we seem to stumble at what should be a low hurdle.

"Our current testing systems are failing to detect most of the people at risk of these conditions in the community," explains Dr Jane Tiller, a Monash University researcher who is both lawyer and genetics expert. "The biggest barriers have been cost and ideology. The cost of genetic testing has come down so much in the last decade that we are now at the point where it would be cost effective to screen the whole population.

"Ideologically ... genetic screening for adults hasn't been something that is seen as a priority for the government, for the health system," explains Tiller. "We need to have in the health system an ideology that we should be funding prevention. We are not focused on getting ahead and finding people before the first onset of cancer of heart disease."

Is the fact that prevention rarely captures the imagination of voters the biggest barrier? "It's rarely explicitly stated by the decision makers, but it permeates every aspect of health and policy decision making," says Tiller. "You don't get votes with prevention."

Slevin agrees. "When cuts have to be made, prevention is the easiest thing to knock off. Because preventive health takes a long-term view, politicians aren't going to lose votes if it doesn't happen next year," he says. "Those are the things that are first to evaporate out of a tight budget cycle."

"Making space for prevention has to be an ideological change, not what's done with the money that's left over – because there's never any money left over," says Tiller. "Prevention is the first thing that gets pushed off the plate and it won't buy votes immediately."

Australia's sclerotic approach to prevention will hobble our health system without urgent action. Former president of Australia's College of Emergency Medicine, Dr Clare Skinner, puts it this way: "Just as pain is a symptom of a broken bone,

ambulance ramping is a symptom of a lack of capacity and integration in our health system. We don't treat pain and ignore the broken bone. To cure ambulance ramping, we don't treat the symptom – we need to cure the system-wide problem."

Steve Robson is a surgeon and health economist. He is outgoing president of the Australian Medical Association.

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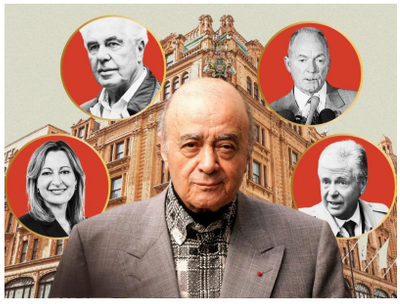

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