

Call for a National Charter for Health

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Health promotion

According to the World Health Organisation health promotion is the process of enabling people to increase control over the determinants of health and thereby improve their health. *

Determinants of health include the range of personal, social, economic and environmental factors which determine the health status of individuals or populations such as income, education, profession and working conditions. These determinants can in turn affect risk factors such as smoking, alcohol consumption, eating habits and physical inactivity.

Health promotion represents a comprehensive social and political process, it not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health.

* Reference: Ottawa Charter for Health Promotion

Effective health promotion and prevention have the capacity to improve health, manage the expenditure pressures of preventable chronic disease, enhance economic productivity, bridge the health divide between different population groups and add healthy years to life expectancy.

Despite these prospects and a growing clamour for greater attention to prevention, it has always remained on the periphery of the healthcare system. Its funding support seems at odds with the compelling evidence base and its power base often too small to influence priority setting.

Partly because of the longer lead time to achieve improved health outcomes, health promotion has been unable to extract significant financial support from funders who face more immediate political and consumer demands for treatment and hospital services. With some notable exceptions, it has also really struggled to engage stakeholders who have greater influence on the promotion of better health outcomes, such as the housing, transport, planning, education, workplace and local government sectors.

This is not the only stakeholder challenge for health promotion. Although health promotion is relevant to many beneficiaries of better health (business, health funders, governments) they have a diminished incentive to invest in population-based health promotion and prevention programs because they cannot capture all the benefits of such an investment.

These challenges prompt a host of questions that need to be addressed in the Australian context if the situation will be any different in the future. Can health promotion ever demonstrably fulfil its potential? Can it ever match the rhetoric of health promotion advocates? Can health promotion ever produce the kinds of evidence that will demand attention from those responsible for healthcare resource allocation and overcome power and system constraints to deliver such change?

The current opportunities to overcome these barriers have never been better.

In recent months, the National Preventative Health Taskforce¹, the National Health and Hospitals Reform Commission², State and Federal governments and the Council of Australian Governments³ have all released plans, position and discussion papers to chart the course of health promotion and disease prevention in Australia. There seems to be great optimism for a strengthened, systemic, and far-sighted approach to health promotion that has been lacking for decades.

This paper sets out the prospects, the evidence and the challenges for health promotion and provides effective, alternative models to tap the potential of health promotion and proposes a framework, in the form of a National Charter for Health, to guide, inform and evaluate efforts to improve the health of all Australians⁴. The National Charter for Health would set targets for improving the health of Australians and form the workplan of a National Health Promotion Agency, as well as State and Commonwealth Governments.

Health promotion offers significant opportunities for *better health outcomes*, including for those with the poorest health in our community, as well as opportunities for *benefits to the economy and reductions in healthcare cost pressures*.

This paper proposes an alternative approach that provides a framework to harness the capacity of health promotion to make a substantial contribution to healthcare efficiency, to address substantial health inequalities, to deliver broader economic benefits, and to improve the evidence base that can inform priority setting according to effectiveness, efficiency and equity parameters.

1 Preventative Health Taskforce, <http://www.preventativehealth.org.au/internet/preventativehealth/publishing.nsf/Content/discussion-technical-1>, accessed 31 December 2008

2 National Health and Hospitals Reform Commission, <http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/discussion-papers>, accessed 31 December 2008

3 Council of Australian Governments, 29 November 2008, http://www.coag.gov.au/coag_meeting_outcomes/2008-11-29/index.cfm, accessed 30 December 2008.

4 Oldenburg, B. and Harper, T. Investing in the future: prevention a priority at last. MJA 2008; 189 (5): 267-268

Better health outcomes

By international standards and according to some measures, Australians enjoy good health. Life expectancy in Australia is one of the highest in the world and has increased significantly over the past 20 years – males by six years to 78 years, and females by four years to 83 years^{5,6,7,8}, and there is the prospect that healthy life expectancy could increase by a further 10 years by 2050.⁹

Much of Australia's improved health outcomes in recent decades can be attributed to reductions in mortality due to changes in lifestyle (for example, reduction in smoking prevalence) and consequent reductions in risk factors (such as reduced incidence of high blood pressure). However, preventable biological, behavioural, social and economic factors remain a significant driver of chronic ill health in Australia.^{10,11}

Non-communicable diseases – cardiovascular diseases, cancers, mental health problems and disorders, diabetes, asthma, arthritis, nervous system disorders and kidney diseases – are now responsible for most ill health in Australia. Much of this burden is avoidable in that several different factors that contribute to the development and progression of these conditions are highly preventable.¹²

Chronic diseases were responsible for more than 80% of the burden of disease and injury in Australia in 2004 while almost 78% of all deaths have been attributed to six disease groups. A proportion of each of cardiovascular disease, cancer, injury, mental health, diabetes and asthma can be prevented, or at least have their impact reduced, through improved health promotion and prevention strategies, particularly strategies that address smoking, nutrition, physical activity and alcohol consumption.^{13,14,15,16}

For example, cardiovascular disease is the leading cause of death among Australians, despite the fact that much of the death, disability and illness caused by cardiovascular disease is preventable through better diet, quitting smoking and exercise.¹⁷ Declines in coronary heart disease (CHD) mortality rates have contributed greatly to recent falls in overall death rates in many developed countries. Since the 1970s, countries such as Australia, Canada, the United States and Portugal have seen CHD death rates fall by around 60%.^{18,19}

Much of this decline is due to changes in risk levels for disease. Approximately half the decline in US deaths from CHD from 1980 through 2000 may be attributable to reductions in major risks – cholesterol, systolic blood pressure, smoking and physical inactivity.²⁰

However, a recent analysis of the impact of obesity on longevity in the United States concluded that the steady rise in life expectancy during the past two centuries may soon come to an end due to the impact of obesity, which is forecast to reduce life expectancy by between four and nine months. This reduction would be larger than the combined effect of all accidents, homicide and suicide.^{21,22}

5 Australian Bureau of Statistics, 2005.

6 Victorian Department of Premier and Cabinet, Governments working together a third wave of national reform a new national reform initiative for COAG, August 2005, www.dpc.vic.gov.au, accessed 4 August, 2007.

7 Peeters, A, Research Summary: Disease trends. VicHealth 2007; http://www.vichealth.vic.gov.au/assets/contentFiles/research_DiseaseTrends.pdf, accessed 28 November 2007.

8 AIHW, International health: how Australia compares, Canberra, 1998.

9 Prime Minister's Science, Engineering and Innovation Council. Promoting healthy ageing in Australia, 2006.

10 Fitzgerald, V. Governments working together. Report by Allen Consulting, May 2004.

11 AIHW, Australia's Health 2004, p.55.

12 AIHW, Australia's Health 2004, p.56-7.

13 AIHW, Australia's Health 2002, Canberra, 2002.

14 Fitzgerald, V. Governments working together. Report by Allen Consulting, May 2004.

15 AIHW, Australia's Health 2002, Canberra, 2002.

16 AIHW, Chronic disease and associated risk factors in Australia 2006.

17 Fitzgerald, V. Governments working together. Report by Allen Consulting, May 2004.

18 AIHW, Australia's Health 2004, p.55.

19 OECD (Organisation for Economic Co-operation and Development) 2003. OECD health data 2003, 3rd edition: a comparative analysis of 30 countries (CD-ROM). Paris: OECD.

20 Olshansky, S. et al. A Potential Decline in Life Expectancy in the United States in the 21st Century, NEJM, 2005 352;11, www.nejm.org.

21 Olshansky, S. et al. A Potential Decline in Life Expectancy in the United States in the 21st Century, NEJM, 2005 352;11, www.nejm.org.

22 Anderson RN. U.S. decennial life tables for 1989-91. Vol. 1. No.4. United States life tables eliminating certain causes of death. Hyattsville, Md.: National Center for Health Statistics, 1999. DHHS publication no. (PHS) 99-1150-4.)

Improving health outcomes has the added potential to improve the health of populations that have the poorest health, particularly among Indigenous Australians and Australians from disadvantaged and regional socioeconomic backgrounds, who have higher rates of many preventable diseases.

Compared with areas of high socioeconomic status, the least advantaged areas of Australia have higher levels of smoking, physical inactivity and obesity; they experience higher prevalence of diabetes, heart disease and arthritis, and have higher mortality across most chronic conditions.²³

There is growing recognition that the social processes, conditions and environments in which people live their lives are powerful determinants of their health, not just as influences of how people behave, but by having a direct impact on health per se.

Determinants of health include social inclusion, freedom from discrimination and violence, and access to economic resources.

Health and the economy

Economic and health outcomes are inextricably linked: better health is good for the economy and improved economic wellbeing has the potential to improve health.

For example, improved health may improve economic productivity by slowing the rate of decline in labour force participation. Australia has an ageing population with little growth forecast in the numbers of young workers, adding pressure to future labour force participation levels.

Over the next four decades, the proportion of Australians over 65 is forecast to increase from 13.4% in 2003-04 to more than 25.8% in 2041-42, and over the same period the proportion of people of traditional working age (15-64 years) will fall. It is estimated that the aggregate labour force participation rate (LFPR) will fall from the current level of 65.2%²⁴ to about 56% over the next 35-40 years.^{25,26}

According to the Productivity Commission, "Population ageing will significantly reduce workforce participation and per capita income growth. At the same time, it will push up health and aged care expenditures, creating major fiscal pressures for governments".²⁷

The Productivity Commission has identified that while Australia's aggregate LFPR is above the OECD average, it is relatively low for some key age groups: particularly for men and women aged 55 to 64 years, and women in the 25 to 44 age group.²⁸

The observation that Australia lags behind some comparable countries in terms of labour force participation has signalled one possible avenue for alleviating the economic effects of ageing, cited in a Victorian Government discussion paper: "The rationale behind this type of policy is that, by endowing people with more human capital, through better illness prevention, detection and treatment, and more education and training, both labour demand and labour supply are stimulated. The result, it is believed, will be a higher rate of labour force participation."²⁹

It has been forecast that if, over the next 20 years, Australian participation rates were to rise towards the top of the current OECD LFPR, the level of GDP per capita could be more than 9% higher by 2041-42 than the projection in the Intergenerational Report³⁰, and most of the long term gain could be achieved by the 2020s.³¹

23 AIHW, Chronic disease and associated risk factors in Australia 2006.

24 ABS, <http://abs.gov.au/ausstats/abs%40.nsf/mf/6202.0>, 14 February 2008, accessed 19 February 2008.

25 Commonwealth of Australia, Commonwealth Budget Paper No. 1, May 2005.

26 Productivity Commission, Economic Implications of an Ageing Australia, 2005 Research Report, Canberra.

27 Riding the Third Wave: some challenges in national reform. Speech by Gary Banks, Chair Productivity Commission, Paper presented to the Economic and Social Outlook Conference, Melbourne, 27 March 2008.

28 Riding the Third Wave: some challenges in national reform. Speech by Gary Banks, Chair Productivity Commission, Paper presented to the Economic and Social Outlook Conference, Melbourne, 27 March 2008.

29 Victorian Department of Premier and Cabinet, Governments working together a third wave of national reform a new national reform initiative for COAG, August 2005, www.dpc.vic.gov.au, accessed 4 August 2007.

30 Commonwealth of Australia (2002), Intergenerational Report 2002-05, Budget Paper No. 5.

31 Fitzgerald, V. Governments working together. Report by Allen Consulting, May 2004.

The economic-health relationship may be two-way. For example, Cai and Kalb identify that employees and employers value health because health and the capacity or ability to perform a job are closely related: "Poor health is likely to have an adverse effect on work performance and leads to lower productivity. As a result, people with poor health have a lower probability of being employed under prevailing wages. On the other hand, low productivity associated with poor health decreases individuals' earning potential, the opportunity costs of leisure and therefore their willingness to participate in the labour force."³²

The link between mental health and labour force participation is of special interest because poor mental health is potentially responsible for the greatest cause of all health-related withdrawal from the workforce³³ and because the causality between mental health and labour force participation can run both ways.

Expenditure on healthcare

With forecast increases in healthcare expenditure, there will be increasing pressure on the healthcare system to demonstrate that it can deliver value for the resources it attracts.

Owens estimates that health expenditure as a proportion of GDP could rise to about 17% by 2041,³⁴ while economics Nobel laureate, Robert Fogel, predicts that Western economies will be spending 20-25% of GDP on health by 2020.³⁵

Real increases in expenditure on health care put pressure on both Federal and State levels of government (the major funders of health care) to ensure that expenditure is efficient, equitable and in accord with community expectations. It also focuses attention on the high proportion of health system resources used in providing services to people with diseases and health conditions that are known to be preventable.^{36,37}

Despite this, Australia has historically spent little on prevention. In 1994-95 only 5% of Australia's healthcare budget was allocated to 'public and community health'. However, this expenditure is supplemented by activities within and outside the healthcare system that have health promoting characteristics, such as road safety and occupational health and safety.³⁸

In 2005-06, public health expenditure by governments in Australia represented just 1.7% of total health expenditure.^{39,40,41} Health promotion constituted less than a quarter of this public health expenditure.

The situation internationally is similar: 3.2% of government health expenditures were allocated to 'prevention and public health' in the 19 OECD countries for which recent data was available.⁴²

Chronic disease is already a significant cost driver in Australia's healthcare system, accounting for almost \$34 billion, which is nearly 70% of allocated health expenditure. This is forecast to increase to 80% of allocated health expenditure by 2020.⁴³

There is some evidence that health promotion is not only a good value investment but that, in some cases, it can also be cost saving.

32 Cai, L and Kalb, G. Health Status and Labour Force Participation, *Health Econ.* 2006; 15: 241-261.

33 Productivity Commission, *Effects of Health and Education on Labour Force Participation* 2007. <http://www.pc.gov.au/research/staffworkingpaper/healthandeducation>, accessed 9 February 2008.

34 Owens, H. Productivity Commission and Melbourne Institute. *Health Policy Roundtable. Conference proceedings 7-8 March 2002.* <http://www.pc.gov.au/research/confproc/healthpolicy/healthpolicy.pdf>, accessed 28 July 2007

35 Brooks, P. Prevention, not cure, is vital in controlling ballooning budgets, <http://www.theaustralian.news.com.au/story/0,25197,22726729-23289,00.html>, accessed 12 November 2007.

36 Fitzgerald, V. *Governments working together.* Report by Allen Consulting, May 2004.

37 Brooks, P. Prevention, not cure, is vital in controlling ballooning budgets, <http://www.theaustralian.news.com.au/story/0,25197,22726729-23289,00.html>, accessed 12 November 2007.

38 Segal, L. Health funding: the nature of distortions and implications for the health service system. *ANZJPH* 1998; 22:271-73.

39 Australian Institute of Health and Welfare, *National public health expenditure report 2005-06*, <http://www.aihw.gov.au/publications/index.cfm/title/10528>, accessed 14 April 2008.

40 Australian Institute for Primary Care, *General Practice and Medicare: Options for reform*, draft report for The Victorian Department of Premier and Cabinet 2004.

41 Deeble, J. 1999, *Resource Allocation in Public Health: An Economic Approach*, A Background Discussion Paper for the National Public Health Partnership, July.

42 OECD: *OECD Health Data 2004.* Paris: OECD; 2004.

43 AIHW, *Chronic disease and associated risk factors in Australia* 2006.

A study measuring the impact of Australian public health programs in the areas of smoking-rate reduction, prevention of CHD and HIV/AIDS, and immunisation against measles and Haemophilus influenzae type b (Hib)-related diseases found that for each of these programs, the benefits exceeded the costs and for most, the benefits were many times the cost. Tobacco control programs had an estimated benefit of \$8427 million compared to a cost of \$176 million. For HIV/AIDS, the estimated benefit was \$3105 million compared to a cost of \$697 million.⁴⁴

Another complication is that, regardless of responsibility, the incentive for either level of government to invest in health promotion as a strategy to reduce the burden of chronic disease on the acute sector is diminished because of the split between the Commonwealth and the States in the funding of healthcare. Within the health care sector, savings are most likely to arise in the acute care sector through reductions in potentially preventable hospitalisations. Currently, the savings from any reduction in acute care demand as a result of one level of government investing in health promotion will be shared by both levels of government because public hospital costs are at present shared about equally between the Commonwealth and the States, so any savings in acute care will 'leak' beyond the budget of a government that increases its investment in effective disease prevention.⁴⁵

Despite the capacity of health promotion to enhance health, economic, efficiency and equity outcomes, *rigid program and intra-government boundaries inhibit the transfer of resources to health promotion programs even when these programs are demonstrably more efficient, more equitable, or more socially desirable.*

Overcoming this problem requires an approach to healthcare that allows the transfer of resources, supported by justifying economic evidence. There are numerous international examples of economic evaluation guiding such resource allocation decisions in healthcare, with a number of jurisdictions having published guidelines for economic analysis.⁴⁶

Mandatory economic assessment guidelines are now in use in Canada, Finland, New Zealand, the Netherlands and Portugal, by the managed care organisation Regence Blue Shield (USA) and by the United Kingdom's newly established National Institute of Clinical Excellence (NICE).^{47,48}

Australia's approach to the economic appraisal of drugs being considered for public funding has attracted international acclaim. The approach has been copied by many jurisdictions and has been used as a prototype for evaluation of some non-pharmaceutical economic evaluations.

Listing of pharmaceuticals on the Pharmaceutical Benefits Scheme (PBS) to be covered by dedicated public funding is subject to a highly rigorous framework for comparative cost-effectiveness analysis. The approach has been designed to address issues of technical efficiency within a specified modality of treatment and drug class.

A key to this successful use of economic analysis has been the availability of a well-developed and legislatively based framework for evaluation, linked to clearly defined responsibilities within a government program.⁴⁹

44 Applied Economics 2001, Returns on Investment in Public Health, www.health.gov.au/internet/wcms/publicat-document-roi_eea-cnt.htm, accessed 10 February 2008.

45 Woodley, P. Occasional Papers: Health Financing Series Volume 7 National Population Health Planning Branch Population Health Division Commonwealth Department of Health and Aged Care, 2001, p.31

46 Hill, S et al. Problems with the Interpretation of Pharmacoeconomic Analyses: A Review of Submissions to the Australian Pharmaceutical Benefits Scheme. Volume 283(16), 26 April 2000, p 2116-2121.

47 Hjelmgren, J. et al. Health economic guidelines – similarities, differences and some implications. Value in Health 4(3); 2001: 225-250.

48 George, B. et al. Cost-Effectiveness Analysis and the Consistency of Decision-Making Evidence from Pharmaceutical Reimbursement in Australia (1991 to 1996). Pharmacoeconomics 2001; 19 (11): 1103-1109.

49 Hailey, D. Australian economic evaluation and government decisions on pharmaceuticals, compared to assessment of other health technologies. Soc. Sci. Med. Vol. 45, No. 4, pp. 563-581, 1997.

There is no doubt that the Pharmaceutical Benefits Advisory Committee's (PBAC) approach has led to the gathering of a valuable body of cost effectiveness data that is not reflected in other healthcare sectors, including health promotion.⁵⁰⁵¹⁵²⁵³⁵⁴

The PBAC model has (in part) been replicated in the recent creation of the Medical Services Advisory Committee (MSAC).

MSAC appoints a specialist Advisory Panel chaired by a member of MSAC to assist in the assessment of each application before formulating recommendations to the Federal Minister for Health and Ageing. MSAC recommendations to the Minister generally fall into one of three categories:

- The evidence is strong and supports public funding
- The evidence does not support public funding, or
- The evidence is inconclusive but suggests that the procedure could be safer, more effective and more cost-effective than comparable procedures that attract public funding. In these circumstances, MSAC may recommend interim funding to enable data collection and further evaluation of the procedure.

Another relevant model to consider is the UK's National Institute of Clinical Excellence (NICE) which was established in 1999 with a mandate to "set standards for the use of new technologies and procedures within the NHS and to produce guidance for clinical and public health, in doing so it was required explicitly to take into account both clinical effectiveness and cost-effectiveness."⁵⁵

A hybrid model, combining the features of NICE, PBAC and MSAC, should be adopted to guide resource allocation for health promotion in Australia.

One possibility would be to extend the PBAC model to cover other modalities by broadening the use of comparators in assessing pharmaceutical and non-pharmaceutical submissions for public funding, and allowing for non-pharmaceutical submissions to PBAC. There are, however, practical barriers to such an approach.

Substantial resources are devoted by private industry to the economic evaluations considered by the PBAC – a commitment beyond the capacities of other sectors. However health promotion has traditionally not been supported by extensive government and research budgets. In addition, and partly because of that lack of support, the current level of economic evidence in most healthcare sectors does not match the rigour and breadth of economic data relating to pharmaceutical treatments.⁵⁶

For example, Carande-Kulis describes the body of economic evidence available to compare costs and returns of interventions to improve health as substantially limited in both quantity and comparability.⁵⁷

50 Segal, L. and Chen, Y. Priority setting models for health. The role of priority setting and a critique of alternative models. Centre for health program evaluation. Working paper 119, February 2001.

51 Sculpher MJ, Buxton MJ, Ferguson BA, Humphreys JE, Altman JFB, Spiegelhalter DJ et al 1991, 'A Relative Cost-effectiveness Analysis of Different Methods of Screening for Diabetic Retinopathy', *Diabetic Med*, 8, pp 644-650.

52 Robertson I and Segal L 1999, 'Management of High Blood Pressure by Drugs and Lifestyle', Research Report, Health Economics Unit, Monash University.

53 Smith R & Widiatmoko D 1998, 'The Cost-effectiveness of Home Assessment and Modification to Reduce Falls in the Elderly', *Australian and New Zealand J of Public Health*, vol 22, no 4, pp 436-440.

54 Hall J, Heller R & Dobson A 1988, 'A cost-effectiveness analysis of alternative strategies for the prevention of heart disease', *Medical Journal of Australia*, vol 148 (6), pp 273-277.

55 Pearson, S and Rawlins, D. Quality, Innovation, and Value for Money NICE and the British National Health Service, *JAMA*. 2005;294:2618-2622.

56 Hailey, D. Australian economic evaluation and government decisions on pharmaceuticals, compared to assessment of other health technologies. *Soc. Sci. Med.* Vol. 45, No. 4, pp. 563-581, 1997

57 Carande-Kulis, V. Methods for Systematic Reviews of Economic Evaluations for the Guide to Community Preventive Services, *Am J Prev Med* 2000;18(1S).

Pritchard reviewed the characteristics of all economic evaluations included in the Health Economics Evaluations Database and concluded that only 10% of all evaluations assessed preventive care.^{58,59} Another recent review undertaken by Schwappach examined the availability of economic evidence relating to prevention, focusing on primary prevention of cardiovascular disease. The study involved a literature review of journal articles published during the period 1995-2005.

A total of 195 studies were identified in the review which concluded that "the vast majority of studies (87%) evaluated measures of clinical prevention, and pharmacotherapy in particular (56%) and only a minority of the studies (10%) examined health promotion activities addressing the health behaviour of communities of people including education, advertising, or legislation."⁶⁰

A more recent analysis by Cohen et al⁶¹, which consisted of detailed abstracted information on published cost-effectiveness studies up to 2005, examined 599 articles (and 1500 ratios) published between 2000 and 2005 that discounted future costs and benefits, and contained dollars per quality adjusted life year (QALY) ratio. They found that 279 out of 1500 (almost 19%) were studies of preventive healthcare options. Despite the smaller proportion of preventive options, and the fact that the preventive options considered included primary and secondary prevention, "opportunities for efficient investment in healthcare were roughly equal for prevention and treatment."⁶²

Despite the limited nature of the available economic evidence, there is some cause for optimism on the potential of health promotion. The body of economic evidence relating to public health interventions is small in comparison to that related to healthcare, although, where it exists, it does suggest that the former can be more cost effective than the latter, even along the same disease pathway (for example, smoking cessation versus medical interventions to treat cardiovascular disease).

Responsibility for funding health promotion research, including economic evaluations, has largely fallen to publicly-funded agencies. Dranove suggests that the response from public agencies has been insufficient, blaming the response on finite financial capacity, a tendency to rely on others and to 'free-ride off the research done elsewhere', and political support for preventive research that is lower than for other forms of medical research.⁶³

Typically, health promotion interventions will have broad outcomes that can potentially affect patients, families, providers, developers of new drugs and other medical technologies, insurers, employers, governments, taxpayers, and society.⁶⁴

Effective health promotion activities typically have multiple outcomes shared by multiple stakeholders. Physical activity programs that increase numbers of employees and students cycling to work and school could ultimately reduce the risk of heart disease, osteoporosis and cancer, and may lead to lower (or delayed) demand for medical services and lipid-lowering pharmaceutical products, enhanced mental health, improved economic productivity, reduced traffic congestion and reductions in greenhouse gas emissions. Because such benefits would be shared broadly by diverse stakeholders, adopting a single agency perspective is likely to result in a partial evaluation that may exclude important costs and benefits simply because they fall on different sectors. An intervention that appears uneconomic from a single agency perspective can in fact be very valuable once all the benefits are taken into account.^{65,66}

This problem becomes relevant in health promotion because of the typically smaller budgets. While it is certainly feasible and desirable to conduct comprehensive economic evaluations that cover such a broad perspective, it is beyond the capacity of many health promotion programs. Similarly, the silo nature of healthcare (and other sectors) has not generally encouraged a collaborative approach to healthcare where, for example, medical, transport and environmental stakeholders collaborate to measure the value of an active transport initiative. In many cases, the health sector will limit studies to their costs only since the sector is concerned with allocating resources within specific budgets.⁶⁷

58 Pritchard C: Developments in economic evaluation in health care: A review of HEED. London: Office of Health Economics (OHE); 2004.

59 Schwappach, DLB et al. The economics of primary prevention of cardiovascular disease - A systematic review of economic evaluations, *Cost Effectiveness and Resource Allocation* 2007, 5:5.

60 Schwappach, DLB et al. The economics of primary prevention of cardiovascular disease - A systematic review of economic evaluations, *Cost Effectiveness and Resource Allocation* 2007, 5:5.

61 Tufts–New England Medical Centre Cost-Effectiveness Analysis Registry (www.tufts-nemc.org/cearegistry).

62 Cohen, J. et al. Does Preventive Care Save Money? *Health Economics and the Presidential Candidates*, *NEJM* 358;7 www.nejm.org 14 February 2008.

63 Dranove, D. Is there underinvestment in R & D about prevention? *Journal of Health Economics* 17 (1998) 117-127.

64 Krumholtz, H. et al. The cost of prevention: can we afford it? Can we afford not to do it? *J. Am. Coll. Cardiol.* 2002;40;603-615.

65 Pan American Health Organisation. *Guide to Economic Evaluation in Health Promotion*, 2007.

66 Hale, J. What contribution can health economics make to health promotion? *Health Promotion International*, Volume 15 (4); 341-8.

67 Wanless, D. *Securing good health for the whole population. Final report. Document prepared for the UK Treasury, February 2004.* http://www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless04_final.cfm, p.125, accessed 25 February 2004.

It is also important to consider the distribution of health gains from better prevention. For example, Culyer and Wagstaff⁶⁸ analysed the distributive implications of various competing definitions of need. Their discussion highlights how health maximisation would not necessarily lead to the treatment of those whose health status, or prognosis without treatment, is most severe. Taken further, this triage approach could lead to decisions about preventing illness in those that are currently healthy could be taken at the expense of those who are ill and require urgent treatment.⁶⁹

Economic evaluation techniques have tended to focus on the maximisation of health gains from health intervention, and distributional effects have been largely neglected in existing economic evaluations.⁷⁰

From a systematic review of empirical economic evaluations published in five sample years (1987, 1992, 1995, 1996, 1997) using electronic searches of health economic databases, Sassi concluded that “existing economic evaluations have not taken such effects explicitly into account, and they do not systematically provide the information that decision-makers would require to formulate for themselves a judgement on the desirability of alternative policy options.”⁷¹

As Sassi notes, “equity is increasingly a key concern of healthcare decision-makers, particularly at the policy level, and society is not indifferent to alternative distributions of health and healthcare among individuals and population groups. By neglecting this dimension, economic analysis loses much of its normative power and restricts itself to a relatively narrow role in supporting healthcare decisions.”⁷²

Power and influence in healthcare

While medical treatment generally involves a relatively tangible and immediate outcome for the consumer, health promotion initiatives deliver benefits to individuals who may never attribute their health to a health promotion program. Will an ex-smoker in 30 years' time attribute a case of lung cancer that never eventuated to a social marketing campaign today that prompted a decision to quit? Will a smoker in 30 years' time expect to receive treatment for a case of lung cancer or expect resources to be directed to quit smoking programs? Are governments likely to be motivated in resource allocation decisions by individuals on hospital waiting lists demanding medical attention now, or by calls to invest funds now to reduce the risk of ill health occurring well beyond the current electoral cycle, and perhaps as far as 5, 10 or 30 years into the future?

Further complicating this issue is the likelihood that the benefits of health promotion might be 'invisible' in that the program has reduced people's risk of ill-health, and therefore their need for medical health care. Medical care, on the other hand, involves the individual as a specific focus of attention, and the problem is manifest and immediate.⁷³⁷⁴

If these political challenges can be overcome, the state of economic evidence for health promotion could be developed to the advanced state of, say, that available in the pharmaceutical area. If government decision-making structures allowed the movement of resources between programs to deliver these efficiency gains, the impact on resource allocation decisions could be significant.

Challenging environments and competing interests are common in healthcare decision-making where budget holders attempt to weigh the ethical, effectiveness, efficiency and equity implications (and tradeoffs) of resourcing decisions.

68 Sassi, F, Archard, L, Le Grand, J. Equity and the economic evaluation of healthcare. *Health Technol Assess* 2001;5(3).

69 Culyer, AJ, Wagstaff, A. Equity and equality in health and health care. *J Health Economics* 1993;12:431-57.

70 Sassi, F, Archard, L, Le Grand, J. Equity and the economic evaluation of healthcare. *Health Technol Assess* 2001;5(3).

71 Sassi F, Archard L, Le Grand J. Equity and the economic evaluation of healthcare. *Health Technol Assess* 2001;5(3).

72 Sassi F, Archard L, Le Grand J. Equity and the economic evaluation of healthcare. *Health Technol Assess* 2001;5(3).

73 Eagar, Kathy, Harvey, Roy & Cromwell, David 1997, *Funding Levers for Public Health*, Centre for Health Service Development, University of Wollongong, November.

74 Woodley, P. Occasional Papers: Health Financing Series Volume 7 National Population Health Planning Branch Population Health Division Commonwealth Department of Health and Aged Care, 2001, p.18-19.

Proposal – an alternative approach to prevention and promoting the health and well-being of all Australians

An alternative approach is needed to harness the capacity of health promotion to make a substantial contribution to efficiency in resource allocation within the healthcare system, to address substantial health inequalities, to deliver broader economic benefits expected by governments, and to improve the evidence base that can inform priority setting according to effectiveness, efficiency and equity parameters.

This approach to health promotion needs to establish the capacity of health promotion to provide effective, efficient and equitable strategies to address challenges in the healthcare system. Such challenges include health and cost pressures resulting from the rising tide of preventable chronic disease, and the structural constraints of the healthcare system that limits its capacity to direct resources to more efficient or equitable alternatives.

Pooling existing health promotion expenditures of State and Federal Governments may enhance allocative efficiency by overcoming rigid program and government boundaries that inhibit the movement of health expenditures.^{75,76}

Currently, both the Commonwealth and State Governments fund programs in health promotion, however most of the service delivery infrastructure is State-based. While the States are responsible for the delivery of most population health services, the Constitution of the Commonwealth of Australia does not specify public or population health as an explicit federal responsibility, so "States and Territories might argue that, while it is their responsibility to ensure that such services are provided, the greater revenue raising power of the Commonwealth as compared with the States/Territories – known as 'vertical fiscal imbalance' – means that paying for such services is a different question".

Fitzgerald⁷⁷ has proposed that to gain the benefits of a more integrated, strategic approach to promotion and prevention, the Commonwealth and States pool such payments to develop integrated local health promotion plans.⁷⁸

Given the relatively low level of funding for specific health promotion and prevention programs⁷⁹, this funding should be supplemented with *new, dedicated health promotion funding tied to appropriate economic evaluation strategies*.

Fitzgerald advocates charging regionally based health authorities with responsibility for implementing such health promotion strategies. "By giving the long term, continuing responsibility for the health of all residents within a region to a single authority, there would be greater emphasis on improving the health status of that community, and increased capacity and incentives for continuity of quality care and service integration."⁸⁰

A similar approach was advocated by Richardson et al⁸¹, while New Zealand and UK regional authorities with budgetary, performance and organisational responsibility for the health of a catchment population negotiate contracts with primary care practices for primary care. Fitzgerald argued that such a focus facilitates a shift from traditional, individually focused general practice to a more integrated population-focused approach.⁸²

Guiding the investment of funds from a pooled model would be a National Charter for Health⁸³ that reflects agreed priorities of State and Federal Governments – the providers of funding to the pooled model.

75 Fitzgerald, V. Governments working together. Report by Allen Consulting, May 2004.

76 Woodley, P. Occasional Papers: Health Financing Series Volume 7 National Population Health Planning Branch Population Health Division Commonwealth Department of Health and Aged Care, 2001, p.49.

77 Fitzgerald, V. Governments working together. Report by Allen Consulting, May 2004.

78 Australian Institute for Primary Care 2004, general practice and Medicare: Options for reform, draft report for the Victorian Department of Premier and Cabinet.

79 Australian Institute for Primary Care 2004, General practice and Medicare: Options for reform, draft report for The Victorian Department of Premier and Cabinet.

80 Fitzgerald, V. Governments working together. Report by Allen Consulting, May 2004.

81 Richardson J. et al. 1995, Prioritising and Financing Health Promotion in Australia, Centre for Health Program Evaluation, Research Report 4, Melbourne. Monash University and the University of Melbourne.

82 Fitzgerald, V. Governments working together. Report by Allen Consulting, May 2004.

83 Oldenburg, Brian F. and Harper, Todd A. "Investing in the future: prevention a priority at last", The Medical Journal of Australia, Volume 189 Number 5, September 2008 p 267-268

Given the lag time for many health promotion interventions, it is likely that the framework would need to apply for at least five years, but preferably longer.

The Charter should stipulate desired progress on health priorities and include *a universality requirement for a minimum set of health promoting programs to be accessible by all Australians*. For example, in the area of nutrition and physical activity, it may include such programs in workplace and school settings, active transport programs to encourage greater walking and cycling, and programs to improve access to physical activity programs for disadvantaged groups. In the area of tobacco control, it may include mandated minimum levels of Quit-style social marketing campaigns and cessation assistance for population groups with high levels of smoking such as Indigenous groups.⁸⁴ In all cases, such programs would be comprehensively evaluated and updated accordingly.

Dynamic model of funding and evaluation

To achieve these goals, and to develop a stronger evidence base, there needs to be a dynamic model that allows the controlled experimentation of health promotion initiatives. For example, Richardson et al⁸⁵ advocate an aim of increasing investment in health promotion on coordinated trials to assess the effectiveness, economic efficiency and distributive impact of such investments, and to assess performance against the framework.

Such an approach should allow for the *'scaling up' of successful pilots* to overcome a common problem where numerous pilot programs are funded by governments but there are rarely the funds available to 'scale up' the promising pilots to a level that they could really make a difference.

Richardson et al proposed a funding system that pursues a form of 'dynamic efficiency' through encouragement of experimentation and progressive improvement in program efficiency. "Efficiency, in the dynamic sense, is an extension of the simple idea of allocative efficiency. It implies that there is a system which promotes information and new ideas and – equally importantly – is responsive to information about beneficial services."⁸⁶

In pursuing innovation and experimentation, Richardson et al advocated the collection of information about the costs and benefits of existing programs, mechanisms for encouraging experimentation, and supporting activities shown to be cost-effective. Such a model of innovation and experimentation, coupled with rigorous evaluation to examine the efficiency and equity outcomes of programs, would assist in addressing the deficit in economic evidence in health promotion and, potentially, could provide decision-makers with evidence leading to consideration of a broader range of interventions in resource allocation decisions.⁸⁷

Richardson et al advocate a collaborative, regional approach to health with a "coherent structure for regulation and control of health promotion activities, albeit with sufficient flexibility to provide dynamic efficiency".⁸⁸

This would overcome the scaling up challenge – it is proposed there are two broad funding streams for health promotion: one for programs with demonstrated economic efficiency and that have been proven to address equity, and a second for programs intended to develop innovative strategies for health promotion. The first category could be 'submission based' by funding programs that meet pre-determined effectiveness, equity and efficiency criteria. Both categories would be subject to formal economic efficiency and equity evaluation to assess their economic potential relative to other interventions. In this way, the current deficiencies in economic analysis would be progressively addressed.

84 Wakefield, A. et al. "Impact of Tobacco Control Policies and Mass Media Campaigns on Monthly Adult Smoking Prevalence", *American Journal of Public Health*, August 2008, Vol 98, No. 8

85 Richardson J. et al. 1995, *Prioritising and Financing Health Promotion in Australia*, Centre for Health Program Evaluation, Research Report 4, Melbourne. Monash University and the University of Melbourne.

86 Richardson J. et al. 1995, *Prioritising and Financing Health Promotion in Australia*, Centre for Health Program Evaluation, Research Report 4, Melbourne. Monash University and the University of Melbourne.

87 Richardson J. et al. 1995, *Prioritising and Financing Health Promotion in Australia*, Centre for Health Program Evaluation, Research Report 4, Melbourne. Monash University and the University of Melbourne.

88 Richardson J. et al. 1995, *Prioritising and Financing Health Promotion in Australia*, Centre for Health Program Evaluation, Research Report 4, Melbourne. Monash University and the University of Melbourne.

Addressing equity needs in health

Economic analysis in healthcare has largely focused on maximisation of health gains within resource constraints, without consideration being given to the individuals or groups that stand to benefit from such decisions. This has led to a questioning of how accurately such investment reflect social values, including those relating to equity.

Sassi made several recommendations to improve the quality of research in the area, including a commitment to expand the evidence base in relation to social values and the systematic gathering of information on the distributional implications of resource allocation decisions. Such a process would involve the systematic gathering of information about the expected distributional effects of resource allocation decisions. It would include data on the characteristics of the populations that may benefit from the health interventions appraised, and information on the effectiveness and cost-effectiveness of the interventions in different subgroups.⁸⁹ This approach would be consistent with the dynamic model proposed in this paper where economic evidence on health promotion investment would be systematically collected and continually utilised to refine resource allocation.

Economic evaluation in health promotion needs to meet the challenges of providing greater consideration of equity and efficiency. Enhancing the quality of such data provides decision-makers with better tools to begin answering the question posed by Deeble: "The question of what combination of curative and preventive measures would most improve the population's health cannot be separated from the equity issue of who has the greater 'right' to public support – people who are sick now or those whose future illness may be averted? On both sides, the answer may well be that what economists call 'process utility' can be as socially important as health outcomes per se. Health status is not the only maximand, even for the health services."⁹⁰

National Charter for Health

This paper proposes *the establishment of a National Charter for Health, an agreed framework for improving the health of Australians*.⁹¹

The Charter, issued and monitored by the Council of Australian Governments (COAG) on the recommendation of the Australian Health Ministers' Advisory Council (AHMAC) would be implemented by a national illness prevention agency.⁹² This would reflect the agreed priorities of the Commonwealth and State Governments. It should include *targets for key health indicators including behaviours such as smoking, alcohol misuse, violence, nutrition and physical activity, as well as population determinants of good health including social inclusion, freedom from discrimination and violence and access to economic resources, food security, housing and education*. Targets would be adopted for whole of population as well as priority population groups.

The approach has similarities with that proposed for the UK by Wanless, who advocated that the setting of quantified national objectives for changing the prevalence of all important determinants of health status for the medium and long term would help inform future resource planning projections and immediate decision-making. "A great deal of research, analytic thinking and consensus building is required to ensure these objectives are carefully defined and the responsibilities for delivery are understood. They would also be a major input into local decisions. And it is locally that much of the activity needs to be planned and implemented by networks of local authorities, health organisations and community and voluntary groups."⁹³

Similar to Wanless' recommendations, the proposed new model for Australia should seek advice about what should be the objectives for all major determinants of health. These objectives should be subdivided where appropriate to cover important groups within the population, for example by age, ethnicity or social class, particularly those which are key to achieving the equality objectives.⁹⁴

89 Sassi F, Archard L, Le Grand J. Equity and the economic evaluation of healthcare. *Health Technol Assess* 2001;5(3).

90 Deeble. J. Resource allocation in public health: an economic approach. A background discussion paper for the National Public Health Partnership, 2nd edition, August 2000.

91 Oldenburg, Brian F. and Harper, Todd A. "Investing in the future: prevention a priority at last", *The Medical Journal of Australia*, Volume 189 Number 5, September 2008 p 267-268

92 Moodie, R. et al. "A national agency for promoting health and preventing illness", an options paper commissioned by the National Health and Hospitals Reform Commission, October 2008. [http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/16F7A93D8F578DB4CA2574D7001830E9/\\$File/national-agency-promoting-health-illness.pdf](http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/16F7A93D8F578DB4CA2574D7001830E9/$File/national-agency-promoting-health-illness.pdf)

93 Wanless, D. Securing good health for the whole population. Final report. Document prepared for the UK Treasury, February 2004. http://www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless04_final.cfm, accessed 25 February 2008.

94 Wanless, D. Securing good health for the whole population. Final report. Document prepared for the UK Treasury, February 2004. http://www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless04_final.cfm, accessed 25 February 2008.

This is timely given the recent COAG commitment by the Commonwealth and the States to invest \$448.1 million over four years, and \$872.1 million over six years starting from 2009-10 to improve the health of all Australians through a Health Prevention National Partnership and an Indigenous Health National Partnership.

The Charter would expand on the targets identified by the National Preventative Health Taskforce (obesity, smoking, alcohol consumption and closing the Indigenous life expectancy gap) and include broader influences on health such as housing, physical activity, social security and education; and would set specific targets for groups who experience the poorest health outcomes.

Such an approach recognises the important contributions of 'non-health' portfolios in government, covering functions such as housing, social security, education and transport, for example, which are likely to have a greater impact on improving health than the healthcare system as it is currently defined.

The Charter could also identify accountability requirements such as performance monitoring and reporting, minimum standards of service and a requirement for authorities to ensure that the implementation of programs are subject to rigorous framework to assess the effectiveness, efficiency and equity of its resource allocation strategies.

In summary, the Charter would identify a common commitment to health promotion by State and Federal Governments and provide a clear delineation of responsibilities. It would detail respective contributions by State and Commonwealth Governments, establish health promotion targets, and contain a requirement to address equity issues, a commitment to the development of the efficiency and equity dimensions of economic evidence, and a pledge to foster innovation in health promotion. The delivery mechanism for this strategy would be regionally based health promotion authorities.

Potential sources of funding

The principal options for sourcing 'new funds' for this health promotion model are the re-allocation of funds within the healthcare budget to prevention and provision of 'new funding' derived from taxation. For example, the commitment to improved health could be funded through a 'creeping commitment' that increases the health promotion budget over time with new funds derived from taxes on alcohol, tobacco and possibly unhealthy foods.

For example, Brooks proposes progressively increasing investment in health promotion and disease prevention to the point where such investments comprise 20% of the health budget⁹⁵. The Productivity Commission has also raised the idea of a target of 20% of healthcare expenditure being directed towards prevention activities.⁹⁶

This approach has the advantage of being a clear social commitment to improving health and a demonstrable step towards addressing under-investment in health promotion in Australia. It would also promote community discussion on how the healthcare system, including health promotion, best addresses the needs of the community.

A further refinement of the Brooks proposal should include a continuous assessment of the contribution made by health promotion relative to other potential investments as funding is increased. For example, such an assessment could occur when health promotion reached thresholds of 5, 10 and 15% of the health budget. Only if health promotion continued to demonstrate superior economic, effectiveness and equity outcomes would funding for health promotion advance to the next threshold.

Funding the increase in health promotion funding would be by way of a reform of existing taxation arrangements. The taxation system offers a powerful tool to improve health outcomes. Many countries have adopted taxes on alcohol and tobacco products to influence consumer choices – taxes on tobacco are one of the most effective strategies to reduce consumption. For example, it is estimated that a 10% increase in the real price of cigarettes reduces consumption by approximately 3 to 5%, and reduces the number of children who smoke by 6 to 7%.^{97,98,99}

95 Brooks, P. Prevention, not cure, is vital in controlling ballooning budgets. *The Australian*, 10 November 2007. <http://www.theaustralian.news.com.au/story/0,25197,22726729-23289,00.html>, accessed 12 November 2007.

96 ABC News. Woods, M. Commissioner - Productivity Commission, <http://www.abc.net.au/news/stories/2008/03/27/2200732.htm>, accessed 16 April 2008.

97 Chaloupka, F, "Macro-Social Influences: The Effects of Prices and Tobacco Control Policies on the Demand for Tobacco Products," *Nicotine and Tobacco Research*, 1999.

98 Chaloupka, F & Pacula, R, An Examination of Gender and Race Differences in Youth Smoking Responsiveness to Price and Tobacco Control Policies, National Bureau of Economic Research, Working Paper 6541, April 1998.

99 Emery, S, et al. "Does Cigarette Price Influence Adolescent Experimentation?" *Journal of Health Economics* 20:261-270, 2001.

Similarly, alcohol consumption (and its associated harms such as accidents and alcohol-caused cancer and cirrhosis) has been shown to be responsive to movements in price.^{100 101}

Several countries have taken this one step further and hypothecated such funds into health promoting activities. For example, a 2% surcharge on alcohol and tobacco products in Thailand is redirected to the national health promotion authority, Thai Health.¹⁰²

Constructing a taxation system that applied taxes to products associated with community harm (tobacco, alcohol and some foods) would allow funds to be directed to health promoting investments. This approach would ideally tax products in a way that influenced healthier choices – lower taxes on low alcohol products and higher taxes on high fat/sugar/salt products, for example.

This approach has two advantages – the taxes themselves could influence healthy choices while the funds could be directed to other health promoting purposes and, in particular, improving the health of those who experience the poorest outcomes.

The proposed funding model includes a commitment to develop the effectiveness, efficiency and equity evidence on health promotion investments and to continue to assess the optimal level of investment in health promotion, namely where the marginal return on investment in health promotion investments is equal to or exceeds that from other potential investments.

This facilitates better decision-making by providing clearer evidence to decision-makers on the impact of expenditure at the margin on competing investments and developing an enhanced understanding of the link between expenditure and the outcome.

Conclusion

Australia faces significant challenges in healthcare.

An ageing population, stubborn (long-ignored) inequalities in health, a challenging productivity environment and continuing health pressures suggest that it is time to consider a new vision for achieving better health in Australia that embraces evidence, effectiveness, equity and efficiency. Significant change will undoubtedly be needed if health and economic wellbeing are to be improved or even be maintained, given the increasing expectations on the healthcare system, and a burgeoning chronic disease epidemic.

A new, real and sustained commitment to advancing health outcomes for society, and particularly those groups such as Indigenous communities who have long endured unacceptably poor health outcomes, is needed.

100 Kenkel, D. and Manning, W. Perspective on alcohol taxation. *Alcohol Health and Research World* 1996; 20 (4); 230-8.

101 Babor, T. et al. *Alcohol: no ordinary commodity, Research and public policy*, 2003. Oxford: Oxford University Press.

102 Thai Health Promotion Foundation - <http://www.thaihealth.or.th/english/>, accessed 11 February 2008.

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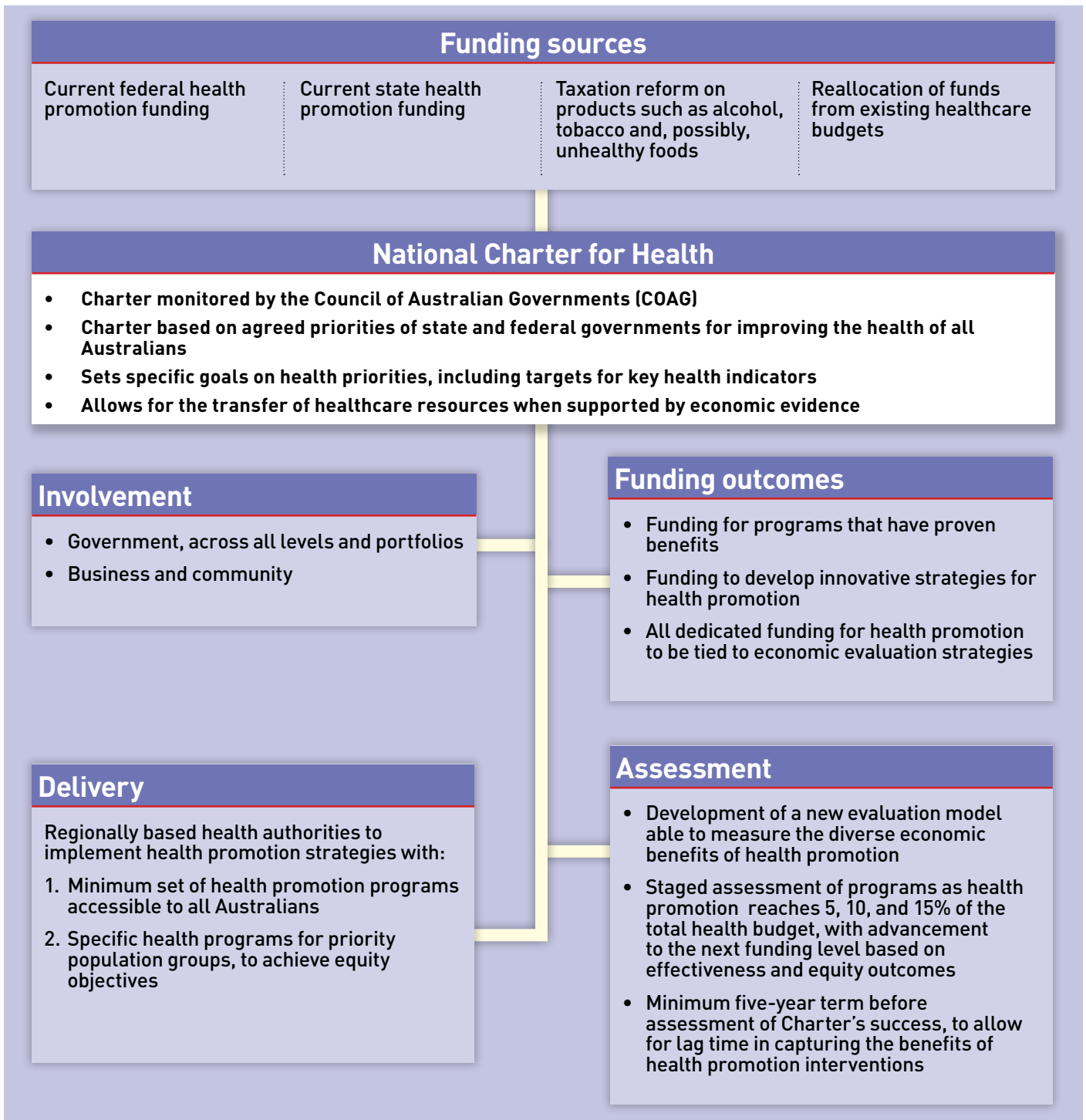


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A Charter for Health Promotion





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