Chronic diseases in Australia: The case for changing course

A Mitchell Institute policy roundtable
Tuesday 25 November, 2014
What should we be doing now to make a difference?

Professor Rob Moodie,
School of Population & Global Health,
University of Melbourne

mitchellinstitute.org.au
Figure 1.4:

Milestones in reducing smoking in Australia 1980–2007

- No bulls campaign
- Phase out smoking in federal workplaces
- Pack health labelling regulations introduced
- Male 18+
- Female 18+
- 1st QUIT Campaigns
- Smoking banned on domestic airlines
- 4 rotating pack health warnings
- Tobacco banned in print media
- In excise duty
- Federal bans on tobacco sponsorship of sports & arts
- Age for sale of cigarettes 16 to 18
- Health warnings on packs
- Remaining tobacco sponsorship removed (exc. Significant International events)
- POS advertising bans
- National Tobacco Campaign
- C/W implement tax by stick
- Smokefree dining
- Gaming venue bans
- NRT available for sale in Australia
- MCG smokefree

Source: The Cancer Council of Victoria 2009
Figure 1.5:

Road fatalities in Australia 1968–2008

- Mass media advertising campaigns
- Mobile speed cameras introduced
- ‘Booze buses’ deployed

- Compulsory wearing of seat belts
- Random breath testing began
- Use of hand-held radar speed cameras
- Mandatory helmet wearing for cyclists
- ‘Wipe off five’
  Public education and expanded enforcement
- 50 km/h residential streets

Source: Transport Accident Commission 2009
Assessing Cost-Effectiveness in Prevention

ACE–Prevention

September 2010

Theo Vos¹, Rob Carter¹, Jan Barendregt¹, Cathrine Mihalopoulos¹, Lennert Veerman¹, Anne Magnus², Linda Cobiac¹, Melanie Bertram¹, Angela Wallace¹

For the ACE–Prevention team
Figure 8.5: Recurrent spending on health goods and services, 2009–10

Source: AIHW 2011a.
Despite its importance, prevention seems to be underestimated by decision makers.

(a) Includes patient transport services, aids and appliances and administration.

Source: AIHW health expenditure database.

Figure 4.1: Proportions of annual growth in health expenditure, by area of expenditure, constant prices, 2007–08 to 2010–11 (per cent)
Why have we made so little progress since the Preventative Health Task Force in obesity and alcohol related diseases?

- Partisan politics and policy discontinuity (tearing down each others programs) – the most recent example
- Media interests, some times also very partisan - and their reliance on advertising
  - Active co-option of major sports in Australia
- Lack of cohesive community coalitions
- Lack of critical mass of individual and organisational “champions”
- Very smart moves of the part of the unhealthy commodity industries e.g. AFGC code of conduct....
The Policy Making Process and Tobacco Industry Interference

1. **Policy idea**
   - Scientific Research

2. **Draft legislation**
   - Scientific Research

3. **Public hearings**
   - Front Groups
      - Making friends
      - Delay & weaken

4. **Plenary**
   - Front Groups
      - Making friends

5. **Higher body / Committee / Cabinet**
   - Front Groups
      - Making friends

6. **Highest body / Approval**
   - Front Groups
      - Making friends
      - Delay & weaken
      - Complain

7. **Implementation**
   - Front Group

8. **Seek a seat**
   - Pro Industry version

9. **Deceiving the public**
   - Discrediting advocates

10. **Avoiding economic Regulation**
    - Subverting the law

**Source:** WHO WPRO
Overcoming obesity: An initial economic analysis

Discussion paper
“Even if a particular intervention is neutral for the bottom line or is highly attractive, companies are caught in a prisoner’s dilemma—taking unilateral action that may put market share at risk would undermine companies’ obligations to their shareholders.

There is evidence that current commitments are not being followed through by all players, and that some in the industry may therefore need government help in a more concerted approach.”
Why has investment in public health decreased?

- Lack of a “waiting list” for prevention
- No votes
- Long time frame
- Apathy
- Prevention “fatigue”

- The rise of the *not-wrong-but-only-half-right* rhetoric of personal responsibility
  - Seen as
    - anti business
    - anti individual rights
    - Nanny state interference
What have been the fundamentals of success?

- Bi/non partisan political and bureaucratic support
- Support of the media
- Broad community coalition – willingness to “hold the line”
- Individual and organisational champions
- Policy continuity (not tearing down each others programs)

- Capacity to minimise barriers/opposition – industry, community groups
What more do we need?

- Much greater influence
- Much greater presence in the corridors of power
- Working much harder at non-partisan political support
- Greater reinforcement of the science, and the evidence
What more do we need?

- New partners
  - Major insurance companies
  - Health insurers
  - Banks
  - Major consulting firms e.g. McKinseys, PwC, KPMG, E & Y
  - Human services, education services
  - Environmental services renewable energy industries
New ways of thinking....

➢ Prevention at every step of the pathway
The three Ps

"When nothing seems to help, I go and look at a stonecutter hammering away at his rock, perhaps a hundred times without as much as a crack showing in it.

Yet at the hundred and first blow it will split in two and I know it was not that last blow that did it, but all that had gone before."

Jacob Riis

We need... Persistence, Persistence, Persistence
Opportunities for secondary and tertiary prevention within a population health approach

Dr Erin Lalor
National Stroke Foundation
Approaches to prevention

Wilcox, 2014. Chronic diseases in Australia, the case for changing course
Mortality

Underlying cause of death
- CVD, diabetes, CKD
- All other causes

Underlying or associated cause
- CVD, diabetes, CKD
- No association
Prevalence and comorbidity

Prevalence and incidence
NVDPA

• Explores ways of working together and reaching consensus in areas of mutual interest, such as:
  ▪ guideline development and implementation for management and prevention of vascular and related disease,
  ▪ vascular and related disease prevention programs, and
  ▪ advocacy issues for people affected by vascular and related disease and any other related purposes.
Approaches to prevention

Wilcox, 2014. Chronic diseases in Australia, the case for changing course
## Integrating our approaches

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Actions</th>
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<tr>
<td>Community based, easily accessible and wide reaching</td>
<td>AusDrisk used to assess risk of developing type 2 diabetes and expediting access to lifestyle modification programs. Programs to <strong>promote awareness and detect risk levels</strong> requiring clinical investigation</td>
</tr>
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</table>
| Clinical – general practice & Aboriginal health services | **Integrated health checks** within general practice which include:  
  - Diabetes – AusDrisk (+/- blood glucose tests)  
  - CKD - Serum creatinine and urinary albumin  
  - Absolute CVD risk assessment  
Management of risks including medication and referral to behaviour change programs. |
| Prevention pathways to programs that promote behaviour change | **Condition appropriate programs** designed to reduce risk factors and prevent disease progression. |
Benefits: ACE prevention

Very cost-effective and large health impact:
• Tax alcohol, tobacco and ‘unhealthy food’
• Regulation of salt content in bread, cereals and margarine
• Treating blood pressure and cholesterol .... but doing this more efficiently than we currently do
  ▪ using cheaper drugs
  ▪ better targeting who needs to be treated
What is the most cost effective approach?

**Table 4 Lifetime costs, health gain and cost-effectiveness of cardiovascular disease prevention in Australia**

<table>
<thead>
<tr>
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<th>Lifetime health gain (QALYs)</th>
<th>Lifetime intervention costs to Government (S billion)</th>
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<td>Current practice</td>
<td>270,000 (220,000 to 310,000)</td>
<td>$12 ($12 to $12)</td>
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<td>-$3.4 (-$4.4 to -$2.4)</td>
<td>$41,000 ($34,000 to $52,000)</td>
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<td>Existing single risk based guidelines</td>
<td>180,000 (120,000 to 240,000)</td>
<td>$7.4 ($5.1 to $9.9)</td>
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NB. All values are rounded to two significant figures. Health gains and costs are presented as mean and 95% uncertainty interval, and cost-effectiveness ratio as median and 95% uncertainty interval. Costs are presented in 2008 Australian dollars. QALY – quality-adjusted life year. A value of $50,000/QALY is often considered a threshold for cost-effectiveness in Australia.

Cobiac et al, 2012 BMC
## Costs of our current practice

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Cobiac et al, 2012 BMC
How do we do

• Australia
  - 6% WPHC
  - 22% APHC
  - 30% high AR, but low BP treated
  - 36% high AR, low cholesterol

• New Zealand
  - over 90% of all eligible PHOs
  - 80% nationwide had risk assessment
Secrets to NZ success

• One nationally agreed approach to CVD risk assessment and management
• Online tools integrated in patient management system
• Aspirational national target for risk assessment (one of only 6 national primary care targets)
• Personal interest by the Minister of Health
• National primary care performance program
• Incentives
• Public accountability
Our challenges

Figure 5.1: Relationship between CVD, diabetes and CKD

AIHW 2014 Cardiovascular disease, diabetes and chronic kidney disease — Australian facts: Prevalence and incidence
Why are we stuck?

- Disease specific approaches
- Complex and conflicting messages
- Integrated tools
- Poor use of existing programs for risk reduction
What approaches to measurement would best promote positive change?

Professor Maximilian de Courten, Director, Centre for Chronic Disease
Outline

• On measuring chronic diseases
• Measurement and positive change
• Personal recommendation
25x25 Target

25 % relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases

1. Unconditional probability of dying between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases

2. Cancer incidence, by type of cancer per 100 000 population
Global Monitoring Targets

UN Member States formally adopted the global monitoring framework, including nine global targets and 25 indicators, as part of a comprehensive "Omnibus" Resolution at the 66th World Health Assembly in May 2013.
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Causes of Chronic Diseases

...the causes behind the causes
Education as a Determinant of NCDs and Health
NCD Countdown 2025: accountability for the $25 \times 25$ NCD mortality reduction target

on policies
Tobacco use

Harmful alcohol use
Unhealthy diets

Physical inactivity
HPV immunisation

Health systems

Measuring results

No  Partly  Yes

Beaglehole R., Lancet. 2014 Jul
What approaches to measurement would best promote positive change?
Margaret Chan
WHO Director General

“What gets measured, gets done”

“the robust and courageous actions” taken by Australia...
Global NCD Framework Campaign

- **Accountability**
  - Global Monitoring Framework

- **Action**
  - Global NCD Action Plan 2013-2020

- **Coordination**
  - Global Coordination Mechanism

Foundations of the global NCD architecture
Recent progress in understanding of chronic disease

From...

“The World Health Organisation needs to help sick people, not be a nanny. Dr Chan must cure the agency's addiction to noisy campaigns against obesity, smoking and other non-infectious ailments... Many of these afflictions arise from personal choice, and are not contagious

*The Economist, 2006*

To

“It is not that there is not enough data, not enough information and not enough knowledge as a basis for addressing the prevention and control of NCD. The problem has been how to raise the issue to a high enough level in the political agenda and maintain it there, as without that there will be no material progress.”

*Sir George Alleyne, 2011*
Personal Recommendations

• Resist excessive discussion on outcome/indicator measurement
• Standardise and join existing data collections
• Utilise progress monitoring to:
  – Integrate existing health systems
  – Advocate to ensure commitments are made and met
  – Engage multiple sectors and stakeholders across Whole of Society
  – Strengthen capacity: at health sector and other sector level, at communities and civil society organisations
• Establish a high level Accountability Commission on Chronic Diseases with cross sector representation to monitor commitments
Chronic diseases in Australia: The case for changing course
Barriers to Change and how to address them

On behalf of the PHAA I would like to acknowledge the traditional owners of the land, the Wurundjeri people of the Kulin nation, and pay respect in particular their elders, past and present.

Michael Moore
• CEO PHAA
• VP/Pres Elect World Federation PH Associations
• Adjunct Professor, Health Policy and Governance, University of Canberra
• Former Health Minister (ACT)
Barrier 1 – Cultural / Political

- It is always done this way!
- What kind of Australian are you?
- All about personal responsibility!
- Responsibility shifting from government

The level of public support counters “tradition”
Cancer Council of NSW
- 73% support for banning junk food marketing to kids (13 June)
- 75% current regulation not strong enough
  - Government responsibility
- Clare Hughes shows the way

Action
Simple message
Kids Health
Barrier 2 - DIGRESSION

Diets and Fads
- Personal Responsibility

Physical Fitness
- Personal Responsibility

Jobs, jobs, jobs

Food and Health Dialogue
- Not a policy forum
- Focus on reformulation
  - Self-regulation (govt guided)
  - Industry Responsibility
- Active Transport
  - Government responsibility
- Sensible regulation
  - Government responsibility

Action
Simple message
Kids Health
Barrier 3 – Industry profits

The Shareholders

Profit
• High in energy
• Low in nutrients
  • Many cheaper fast and packaged foods

Jobs, jobs, jobs
• The food industry accounts for 46% of all retailing turnover
• food, drink, grocery manufacturing industry employs more than 288,000 people.

Industry seeks to be a policy player

Protection of jobs – Labor
Protection of profits - Liberal

The challenge:
• Alternative healthy food can make jobs and profits

The Lancet
• The Lancet NCD Action Group
  • Moodie, Stuckler, Neal et al “unhealthy commodity industries should have no role in the formation of national or international NCD policy”

Action
Simple message
Kids Health
Barrier 4 – ‘Cure is better than prevention’

Lapband (bariatric) surgery

Diets and Fads

Sustainable business
- “Weightwatchers” return business

Bariatric surgery does have a place
- Based on ill-health
- The weight-loss and fitness industries
  - Can also drive a political agenda

Action
Simple message
Kids Health
Barrier 5 – Complacency

The boiling frog

.... democracy is not cheap .... Everybody’s involved with assisting political parties .... We need to keep these people in place to have the democracy we have today .... Yes, it costs money. (John Thorpe - Australian Hotels Association)

Evidence

We are willing to take our chances of cholera and the rest (rather) than be bullied into health by Mr. Snow..... Every man is entitled to his own dungheap.

London Times, 1851

"But, on the whole of evidence, it seems impossible to doubt that the influences, which determine in mass the geographical distribution of cholera in London, belong less to the water than to the air."

The Scientific Committee for Scientific Enquiries in Relation to the Cholera Epidemic of 1854

More than evidence

• Relationships, anecdotes, persuasion
• What is the next? Tax on sugary beverages?
Finally

Take the easy way out

There always seems an easy way
- Eating
- Politics
- Academics
- Change management
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