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Future directions

In developing this report, extensive consultation with States and Territories was carried out. During this process, a number of problems with the scope of the NHPA process were identified. In order to finalise this report in a timely fashion and to ensure that data and information were current at the time of printing, these issues have not been addressed in this report but will be taken into account for the future development of the NHPA process and addressed in future reports.

As outlined in the introductory chapter of this report, the National Health Priority Areas (NHPA) initiative is guided by the experience of the earlier National Health Goals and Targets program. By identifying and improving the valuable components of this earlier process, while learning from the shortcomings, a strategically oriented work program a strategically oriented work program is being developed for the NHPA initiative, through the tasking of expert groups to provide advice in each of the priority areas.

A problem with the way in which earlier goals and targets activities were implemented was that activity occurred in two parallel, but not interrelated, streams:

- data development, to monitor trends in health status for the priority conditions; and
- identification of strategies designed to realise change.

Under the National Health Goals and Targets program, the extent to which the data influenced the development of national strategies, and the extent to which the strategies influenced data development were minimal. While this report details only a few examples of activity occurring across the nation in relation to the priority areas, future reports will aim to link cost-effective activity to measurable outcomes. This will not only allow determination of the level of uptake of proven beneficial activity, but will also help measure its impact upon the health of Australians. There is also the need to integrally link the development of agreed national strategies with data development and analysis activities—the two must work together, rather than as separate components of the same broad process.

Highlighted in this report are areas where it is not likely that the targets set will be reached by the year 2000, or where targets have not been set and the health status is declining. Some of these include:

- the continuing rise of suicide among young males;
- increasing levels of obesity in the population; and
- inequities in death rates due to coronary heart disease and injuries between the Indigenous population and the general population.

These and other issues are currently being addressed at all levels of the government and non-government sectors. However, in the context of the NHPA initiative, reconsideration of structures and processes is required to monitor our progress and the identification of strategies designed to create change. As part of this process, targets will be set where there are none and, where targets have already been met, consideration will be given to revising them. In due course, targets for years beyond 2000 will need to be considered.

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NHPA work program

The future NHPA work program, outlined below, is in line with this new strategy and will include:

- development of a mechanism to identify future priority health areas;
- identification of gaps in our understanding of good practice in the prevention, treatment and management of the priority conditions, and identification of appropriate activities to fill these gaps;
- identification of appropriate points of intervention for each priority area, and identification of inappropriate activity that is significant; and
- designing, validation and refinement of indicators for reporting outcomes.

Mechanism to identify future National Health Priority Areas

At their meeting on 4 July 1996, Health Ministers requested that a mechanism be developed to identify future National Health Priority Areas. To this end, a paper was prepared by the Australian Institute of Health and Welfare for consideration by the National Health Priority Committee (NHPC). The paper noted that current priority areas are defined in terms of a disease and identified that criteria for choosing a disease, which lend themselves to an evidence-based approach may include:

- the overall burden of the disease in terms of mortality, morbidity and disability;
- the potential for health gain from prevention of the disease or ameliorating its impact;
- the existence of cost-effective interventions; and
- equity issues, especially the impact on priority populations.

The use of such evidence would not substitute for professional or political judgement in the decision making process for setting health priorities, rather it would assist in informing and supporting the decision making process in a way which provided a systematic and transparent framework for the use of evidence, along with other factors such as community values and political imperatives. The quality of the evidence is another factor which the decision making process should take into account.

Looking first at burden of disease, various estimation methodologies are available. One example is the Disability Adjusted Life Year (DALY), developed for the World Bank's 1993 World Development Report. DALY calculations require comprehensive estimation of incidence and duration for major diseases and injury and use weights reflecting the social preference for devoting resources to the prevention or treatment of conditions in order to value the loss of healthy life for non-fatal conditions. An Australian burden of disease analysis would require investment of resources and a review of methodological issues relating to the assumptions underpinning DALYs. Simplified methods based on the use of data from population health surveys, such as the Handicap Adjusted Life Year developed by Mathers (1996), may provide a practicable alternative. Empirical evidence covering DALYs for established market economies and HALYs for Australia is presented in the AIHW working paper. These indicators provide generally consistent results in their ranking of the disease groups that make up Australia's current five National Health Priority Areas.

However, adoption of burden of disease indicators alone to select National Health Priority Areas would imply that health resources and action should be allocated on the

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size of the problem alone. This would overlook the opportunity for achieving additional health gain and the cost of achieving such gain. Compilation of comprehensive empirical assessments of the potential for health gain and the cost-effectiveness of potential interventions may raise resource questions that are potentially as great as for sophisticated indicators of disease impact, even though much evidence exists in particular areas.

Whether it is more productive to seek further National Health Priority Areas, or to concentrate attention on development of strategies to pursue health gain within the existing five priority areas, is not a question that can easily be answered with available empirical evidence. However, the action orientation the program is seeking may be more satisfactorily advanced by focusing attention on strategies within existing NHPAs. A parallel exercise should be exploring the determinants of health status and common themes across the priority areas.

As outlined above, utilising standard burden of disease measures, it is clear that the existing five priority areas impact significantly on society. Against this background, the initial work program of National Health Priority Areas will focus on the existing priority conditions, rather than seeking to expand the coverage of the program.

However, the NHPC has decided that further investigation is needed before it is able to respond to the Health Ministers' request for a mechanism to identify new priority areas. Firstly, it is planning a seminar on the usefulness of DALY and related methodologies for use in setting health priorities. Secondly, the NHPC is conscious that national frameworks adopted in other countries have been more comprehensive than the disease framework for health priorities adopted in Australia's NHPA initiative. Other national frameworks have taken account of environments, risk factors and health competencies or literacy, as well as diseases. Consequently the NHPC will establish a consultancy to review Australian and international experience with goal setting and health priorities and to report on options for a framework which incorporates a focus on disease, health determinants, risk behaviour and population groups. Both of these activities will be undertaken before the end of 1997.

Identifying acceptable practice

An early component of the NHPA process will be the analysis of what is known to constitute acceptable practice for each of the priority conditions. Acceptable practice should be evidence-based, or have some demonstrated positive impact. It may include evidence-based guidelines, acceptable practice information for general practitioners, or documented intervention activities with a proven benefit. The process of gathering the necessary evidence and ensuring that acceptable practice is implemented in each priority area will take some time, and may involve pilot testing intervention programs, biomedical research, or commissioning evidence-based guidelines.

Identifying appropriate points of intervention

An area of particular concern in the Australian health system is the identification of cost-effective, equitable points of intervention for conditions across the spectrum of primary prevention, secondary prevention/early intervention, management, and ongoing maintenance. With its condition-specific focus, the NHPA process lends itself to testing options for determining the relative cost-effectiveness of various interventions. However, it is important that such a measure takes into consideration

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equity issues, to ensure that the intervention has the best potential for realising change in particular priority populations.

Just as identifying appropriate activity is important, so too is identifying inappropriate activity relating to the priority areas, and considering mechanisms to discourage its utilisation. This is the philosophy behind the French document, *1995 Guide Des Références Médicales Opposables* (1995 Guide to Medical Recommendations Able to be Used as Evidence). This document outlines when particular procedures are not necessary to be carried out. For example, it states:

There is no reason, in uncomplicated mild hypertension as defined above, when control of the hypertension is satisfactory, to repeat an ECG systematically more than once a year, except where there is new symptomology.

While the development of a similar set of guidelines is not necessarily recommended at this stage, the underpinning rationale for such an approach is worthy of further consideration. As a starting point, identification of inappropriate activity for the five priority areas will be carried out and reported in future reports.

Designing suitable indicators

Further development of the indicators for reporting will be a fundamental aspect of the work program for National Health Priority Areas. Of immediate interest is the development of a suite of indicators for diabetes—an issue discussed at Chapter 6 of this report. It is important that the indicators cover an appropriate mix of health status measures, and that indicators relating to the prevention, management and maintenance of conditions are included. It is also important that the indicators reflect an understanding of activity with proven benefit or a demonstrated lack of benefit.

The National Health Information Management Group (NHIMG) has developed a Health Outcomes Framework that will help inform the development of indicators. The framework provides a mechanism to ensure that appropriate consideration is given across health streams, including prevention, management and maintenance, and that various indicator types, including process, outcome and health status measures, are considered. Further details on this framework are provided in Appendix 1.

A structure for the management of the NHPA initiative

The outcomes of the activities detailed above will not lead to the development of prescriptive work programs for each State and Territory. Rather, they will allow for each State and Territory to access information about activity that has a proven, cost-effective, positive outcome, and which may be able to be adapted for their local conditions. For this to occur, it is essential that the work program outlined above be developed in collaboration with all levels of government.

A Commonwealth/State committee has been established to coordinate the aforementioned work program. The National Health Priority Committee (NHPC) is a high-level committee with representation from the Commonwealth, State and Territory Departments of Health, the Australian Institute of Health and Welfare and the National Health and Medical Research Council. Reflecting the change in emphasis for National Health Priority Areas outlined in the introduction to this report, this group replaces the previous Better Health Outcomes Overseeing Committee.

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The latest developments, in terms of Commonwealth, State and Territory government collaboration and the development of a National Public Health Partnership (NPHP), will require close linkages to avoid duplication of effort. Given the 'whole-of-system' focus of the NHPA process, it is essential that activities relating to particular streams of health care are in line with the broader considerations of the National Health Priority Committee (NHPC).

A key consideration of the proposed management processes is the involvement of the non-government sector including experts and consumers. The role of the non-government sector should not be underestimated, and will play a major role in ensuring that the policy directions of health departments have optimum capacity to result in changed practitioner behaviour, and ultimately to result in improved health status.

The processes for involving the non-government sector are to be further developed, and will take place in consultation with relevant peak organisations. Expert forums such as the National Cancer Control Initiative (NCCI) and the Ministerial Advisory Committee on Diabetes (MACOD) have agreed to provide advice to the National Health Priority Committee (NHPC) on the priority areas of cancer and diabetes respectively. Specialist groups in other priority areas are also being requested for expert advice.

