

Australia's health 2008

The Hon. Dr Neal Blewett

ADDRESS TO THE AIHW CONFERENCE 2008

Twenty years ago this month the Board Chairman of the AIH, Professor Karmel, forwarded me the first report on Australia's health in what was intended to be a biennial series. At that time the Institute, at least as a statutory authority, was in its infancy, a little over twelve months old. Today the present Commonwealth minister will launch the eleventh biennial report from an institution which has achieved an international reputation. In these few remarks this morning I want to reflect on the early history of the Institute and to compare both in format and substance the first and the eleventh reports.

The Institute was brought into being as a result of the abysmal state of national health statistics in this country, a weakness underlined dramatically in my first month as minister by the fact that the federal department of health did not know in March 1983 that Australia's first case of AIDS had been diagnosed four months earlier. Numerous parliamentary committees and Commissions of Inquiry had highlighted this flaw in the national health system over the previous decade and in 1986 the Better Health Commission Report argued that a national health data base was essential for health advancement in countries around the world. A World Health Organisation study of national health statistical collections of 16 developed societies placed Australia near the bottom of the pile; its hospital statistics were the worst.

The Government had already acted setting up the first Institute of Health within the Commonwealth Department of Health in 1984 with the intention of collecting national health statistics. But this first incarnation was a flawed solution because the collection of national statistics in the health field was very dependent on the States, the chief providers of health services, and also the private health funds, a major source of health cover. Yet the Commonwealth Health Department was frequently in adversarial relationships both with the States and the Funds. Not only were many of the statistics politically sensitive but they could also be personally sensitive given that they dealt with the health of individuals. Furthermore, if we were to attract first class researchers and provide long term perspectives we had to divorce the Institute from the bureaucratic and immediate concerns of the Commonwealth Department of Health. Hence the establishment of the Institute as a statutory authority twenty-one years ago.

The poor quality of national health statistics in this country at that time should not surprise us for health has only become a major national priority over the last generation. The Constitution allotted health responsibilities to the States and though following the

Second World War considerable financial authority in the health field accrued to the national government this took the form of Commonwealth supervision of over a hundred private medical and hospital funds, with national government back-up provision for the less well-off. This highly fragmented system characterised by a hands-off governmental approach reinforced the relative low priority given to health in national affairs. And this situation was of course not conducive to good health statistics. The relatively lowly status of health in national priorities is reflected in the fact that it was the Social Security department not the Health department that was given the responsibility for the introduction of the Medibank scheme in the 1970s. And we do well to remember that only in 1987 did the Federal Minister of Health cease being a junior minister and become a regular member of the Commonwealth cabinet.

In its twenty-one years the Institute has established an outstanding publications record. In those twenty-one years on the health side alone it has produced over 1200 publications. They range from broad surveys of hospitals and health expenditures (the two being closely related) to a social health atlas of Australia, to authoritative assessments of many of the innovative technologies developed by modern medicine to my favourite report 'Injuries Involving Magpies'. The flagship publications in the health area are, of course, the biennial surveys of Australia's health.

I want now to turn to the first of these flagship biennial reports - that of 1988 - and compare it with that of 2008 - the eleventh, which the minister will launch this morning. Superficially they look very different animals. The 1988 is a pale little beast, its cover in muted colours and quite slim in line - a mere 244 pages; 2008 has a cover in glorious technicolour and is a massive beast - nearly three times as large at 614 pages. 2008 has a sixty-page appendix of statistical tables which has no parallel in the earlier number. The glossary has expanded from eight to sixteen pages. Things not dreamt of in 1988 - at least not by the health minister of the day - turn up in 2008: angioplasty, campylobacteriosis, post-traumatic stress disorder. This glossary explosion is mainly due to the vast increase in the detailed coverage of disease in the latest report.

This much greater detail relates to what is perhaps the one most obvious difference between the two reports - the vast increase in the range and depth of health information now available to governments. I come away from the 2008 morbidity and mortality tables with all my hypochondriac tendencies alerted. It appears as though the diseases from which Australians suffer have quadrupled in number since 1988. This is, of course, an illusion created by the detail and sophistication of the material supplied through the disease registers and the Medicare statistics. Hospital statistics possibly reflect the biggest expansion in information in any one area. The jibe that Australia was at the bottom of the list as regards national hospital statistics is no longer applicable. Apart from any other reason one should be thankful to Medicare for the contribution it has made to national health statistics both for disease and for services. And then there are all those wonderful indices developed since 1988 for measuring the burden of disease - the DALYs, the PYLLs, the YLDs, and the YLLs.

Other differences reflect changes in fashion, emphases and technology in the past twenty years. One gets the impression from the 1988 report that dentistry was not really a part of the health system – the only mention I could find of dental health in 1988 concerned the number of caries in Aboriginal children. By 2008 it had come in from the cold, statistically speaking at least. Similarly in 1988 mental health was seen as a State responsibility not a national one, and received only cursory attention. It too has come in from the cold statistically speaking. And a whole range of preventive services, some not available in 1988, are now assessed – the various cancer screening programs for example.

Yet these differences are essentially superficial, relating to the appearance and the content of the reports, rather than to their structure. When structure is examined the beasts are of the same species; they have the same DNA. The model that lies behind the 2008 report may be more sophisticated but in all essentials it is identical with that which lies behind the 1988 report. The 1988 report came at the end of a decade of radical rethinking about the nature of human health and the structure of the first report was very much influenced by this rethinking: the WHO commitment to defining health as ‘a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity’; the pioneering Lalonde committee in Canada with its emphasis on health as conditioned by a wide range of social and environmental factors and the new public health with its stress on prevention.

The model put forward in the original report and refined but not fundamentally altered over twenty years consists of four elements or tiers: firstly the health status of individuals and by extrapolation that of the whole community; then the determinants of that status very broadly conceived (generic and biological disposition, life style, physical environment, cultural and social-economic factors); followed by the health services as a response to the health status of the community; and finally the financial, research and manpower resources which determine the quality and extent of the health services.

Perhaps the most important strategic development in the twenty years has been the focus on particular population groups and age cohorts to illuminate the determinants of health status. Showing considerable prescience the 1988 report gave a chapter to a case study of the health status of the Aboriginal population, concluding that while ‘the impact of the infectious diseases has been markedly reduced’ this had been offset by ‘a worsening of the non-infectious life-style diseases’ and as a consequence while ‘infant and childhood survival [had substantially improved] ...adult mortality had deteriorated’. This approach has now been extended to a range of population groups: Aboriginal and Torres Strait Islander people, socioeconomically disadvantaged people, people in rural and remote areas, prisoners, overseas-born people, Australian Defence Force Members and veterans. Such analyses provide invaluable internal comparisons of the impact of the environment, lifestyles, and cultural and socio-economic factors on health status. Similarly the statistics on how health status varies with age throws another light on these issues with a specific emphasis on generic and biological determinants.

The determinants themselves have been much elaborated in the past twenty years and the focus on them is much clearer than in 1988. For example vague references in

1988 to environmental determinants have now been replaced by references to food quality, food borne infections, air pollution, water quality and supply, climate change. Lifestyle determinants were there in 1988 but a reading of the comparable sections in the two reports suggests how far we have come in our understanding these factors even if, apart from tobacco, we have yet to significantly improve them. Noticeable too is the much greater weight now given to statistics on what might be called the bio-medical transmission routes between determinants and health status - such things as blood pressure, cholesterol levels, and body weight.

Another important advance, reflecting developments here as well as overseas, is the greater use of international comparisons. One measure of this is that figures and tables embodying international comparisons have more than doubled between the two reports. One disappointment here is that the international comparisons are all on the health status and its determinants side. The services side of the model is almost totally bereft of international comparisons. If I were minister this is certainly a challenge that I would like to see taken up by the Institute.

The most significant and ambitious feature of the 2008 Report is the attempt in the final chapter to assess the overall performance of the Australian health system. This is a courageous venture given the great complexity of the system, well-captured in a diagram on page 9, a diagram which fully deserves its commendation in the preface to the report. Building on the work of the National Health Performance Committee in the early years of this century the assessment seeks to answer the question 'Where are we improving and by how much?'

First a number of measurable outcome indicators are set out for health status e.g. changes over time in the incidence of heart attacks, changes over time in life expectancy, changes in potentially avoidable deaths. Similarly a number of measurable outcome indicators are set out for the determinants of health status e.g. changes over time in adult smoking rates, income equity, fruit and vegetable intake. Where the data is adequate a trend – favourable, no trend, or unfavourable – is recorded. Where possible these are accompanied by internal population and international comparisons.

For the health services, performance indicators have been used to assess the system across nine dimensions: effectiveness, efficiency, appropriateness, responsiveness, accessibility, safe care, continuous care, capable care, sustainability. For some of the dimensions there is a breadth of indicators, e.g. for effectiveness a total of nine indicators which cover both prevention and treatment. They relate to unsafe sharing of needles, teenage purchase of cigarettes, cervical cancer screening, breast cancer screening, childhood immunisation, influenza vaccination, potentially preventable hospitalisations, survival following heart attacks, and cancer survival. For other dimension, however there are many fewer measures. For responsiveness only one, waiting times for elective surgery; for capability only one, accreditation in general practice. Again where possible trends are identified.

However the single indicators for some of the dimensions raise issues of adequacy while there are questions too over the nature and scope of the indicators used. In some cases the meaning of the data for the indicators is unclear: for example, what constitutes a favourable trend as regards appropriateness, more or less hysterectomies, more or less caesarean sections? It should be noted too that the statistics available for assessing the system tend to use much shorter time frames than those for health status and the determinants of that status. Moreover, as noted before this part of the assessment is without international comparisons. As the report itself concludes 'the picture is much less clear in relation to the 25 indicators that aim at capturing the health's system's performance' than it is for health status and health determinants.

This chapter deserves to and will no doubt generate wide debate. Indeed it deserves a conference of its own. It will probably make the report a best seller. I have found it invaluable in constructing the last section of this talk which addresses the substantive question as to what the two reports tell us about the changes in Australia's health over twenty years.

In the last twenty years, despite all the allegations of crises in the Australian health system, Australia has become in terms of health status, both absolutely and comparatively, a much healthier nation. Since the mid-1980s life expectancy at birth has risen by four years for men and five years for women. On this measure Australian men come second in the developed world, only Japanese men ranking above them. Australian women come fifth behind Japanese, French, Italian and Swiss women. The increases in life expectancy at 65 have been even more dramatic. At age 65 Australian males can now expect to live to about 83 years and women to about 86. This puts men equal first with Japan and women equal second with France. On infant mortality we do not do so well. Although the rate has been nearly halved since 1986 and although it is better than the OECD average we still come among the worst third of the OECD countries and our comparative position has dropped back since 1986 with nearly every European country now doing better.

On diseases the picture is again impressive. The incidence of heart attacks appears to have declined by 10% this century, continuing a distinctly favourable trend that developed over the last generation. The incidence of cancer, however, has moved in the other direction and is now distinctly higher than in the 1980s, and places us close to the bottom of the OECD countries. Another worrying feature is the increased prevalence of diabetes, the rate having doubled since the 1980s, though to what extent this prevalence rate is the result of greater awareness, better detection and better surveillance is hard to say.

Deaths from major diseases present a far more favourable picture and are perhaps an indication of the responsiveness of the health services to particular diseases, in the case of cancer, for example, the expansion of screening and early detection. Despite the high incidence of cancer in Australia death rates per 100 000 have fallen from 212 in 1986 to 182 in 2005 and we rank in the top half of OECD countries. Again for coronary heart disease death rates per 100 000 of the population have fallen by 36% since 1996

and this places Australia near the very top of the OECD rankings. Much the same is true of deaths from injuries – 10% fall in the rate in the first half of this decade which puts us in the top third of OECD countries. On the other hand Australia's comparative ranking for deaths from respiratory diseases and diabetes has fallen somewhat in the last twenty years.

On the determinants of health status the picture is more mixed. The reduction in the use of tobacco represents probably the most dramatic achievement of any health prevention program, certainly the most successful of Australian drug initiatives. The falls in the proportion of people smoking is among the best in the developed world. From a middling ranking in the 1980s we have moved to the top of the OECD countries. On the other hand there appears to have been little change in alcohol drinking habits. In terms of litres per alcohol per person we were plumb in the middle of the OECD rankings twenty years ago and we are plumb in the middle today. Similarly various measures of physical activity suggest little change in the last twenty years. In terms of obesity the change, though small, has been in an adverse direction across all age groups. Comparatively we are distinctly better than the USA, much the same as Britain and Canada, but decidedly worse than France and Japan.

I noted earlier that one of the most significant advances in The Institute's biennial reports on Australia's health was the material provided on particular populations and age groups. This has now made possible a column 6 in the tables assessing the Australian health system, a column which compares the health status and the determinants of health of the indigenous population with that of the general population. Column 6 makes for disturbing reading. I merely go down the column quoting:

Heart attacks: 'Rate three times as high as for other Australians'

Cancer: 'Overall cancer rates lower than for other Australians, very low incidence of melanoma. Rates higher for lung cancer, other smoking-related cancers, and cancers of the thyroid, pancreas, oesophagus, liver and gallbladder'

Core activity limitation: 'Rates twice as high as in other Australians'

Life expectancy: 'About 17 years lower than for all Australians'

Potentially avoidable deaths: 'Almost 4 times the rate of other Australians'

Infant mortality: 'Rate 2.5 to 3 times that for other Australians'

Deaths from coronary heart disease: 'Rate 3 times that for other Australians'

Deaths from cerebro-vascular disease: 'Rate twice that for other Australians'

Deaths from all injuries: 'Rates 2.5 times that for other Australians'

Suicide: 'Rates twice that for other Australians'

Children exposed to tobacco smoke in the home: 'Rate 1.5 times that for other Australians'

Adult smoking: 'Rates double those of other Australians'

Obesity: 'Rates twice those of other Australians'

Low birth weight babies: 'Rates more than twice those of babies of other Australian mothers'

High blood pressure: 'Rates 1.6 times those of other Australians'

I have left out about half a dozen measures where there is little difference between Indigenous and other Australians such as risky alcohol use, deaths from falls, fruit and vegetable consumption, physical activity, overweight. These however are but dust in the balance of this litany of shame. We should be grateful to the Institute for once again bringing to our attention in so powerful and uncompromising a fashion the greatest failure of the Australian health system.

Finally I turn to health system performance indicators. In essence these assess three things: one, the treatment outcomes of the services system; two, the preventive outcomes of the services system; and three, the resources going into the health services - though the coverage of this last aspect is skimpy. On resources I think an opportunity has been missed to incorporate some of the material from chapter 8, 'Expenditure and Workforce', into assessing the capacity and sustainability of the system. Moreover, as I noted earlier, there are no international comparisons so that it is difficult to judge the distinctiveness of the trends, favourable and unfavourable, that are identified. Are the favourable or unfavourable trends identified part of an international pattern or are they distinctively Australian achievements or failures? I therefore propose to simply summarise the favourable and unfavourable trends.

As with most other aspects favourable trends tend to outnumber the unfavourable, in this case by eight to two. In terms of effectiveness three positive trends are recorded: decline in teenage purchase of cigarettes, and as noted earlier, survival rates following heart attacks and survival rates for cancer patients. In terms of efficiency reduced lengths of stays in hospitals. In terms of accessibility increased rates of bulkbilling. In terms of safety the advance of electronic prescribing and the computerisation of clinical data in general practice. And in terms of continuity enhanced primary care services and increased health assessments by GPs. The two adverse trends are first that perpetual bugbear of the hospital system - the blowing out of waiting lists for elective surgery; and secondly and more worryingly the sustainability of the health workforce, given the ageing of that workforce and low levels of recruitment particularly in medical services and nursing.

I apologise for the critical note that may have crept into my comments on this courageous first attempt to assess overall health system performance. It is a minor reflection of the intellectual excitement generated by so bold a venture. I look forward to its growing sophistication in biennial reports to come. I understand the COAG is at work on a new and broader set of health performance indicators.

The whole report provides a wealth of authoritative information on the health of Australians. In conclusion let me echo the report: 'Health information is fundamental to developing evidence on which health policies and programs are based'. I envy contemporary health ministers with access to this cornucopia. Indeed all of us - politicians, practitioners, patients and people - should be grateful for this fine report on the health of Australians in 2008.