Australia confronts the challenge of chronic disease

It is time for debate to become policy

RECOGNITION IS GROWING WORLDWIDE that chronic, non-communicable disorders (often, but not exclusively, associated with ageing) and hidden disability are acting in concert with burgeoning technologies to make healthcare more expensive. As communicable diseases are controlled, and social and economic conditions develop to support longer life expectancy, the challenge of preventing and managing chronic disease grows greater. A recent report of the Australian Institute of Health and Welfare confirms that Australia is facing an increasing economic and social burden because of chronic diseases and their associated risk factors.[1] Twelve chronic diseases and conditions accounted for an estimated 42% of the total disability-adjusted life years (DALYs) lost in Australia in 1996, and all such diseases and conditions accounted for about 80% of DALYs.[2]

The report noted the difficulties of defining chronic disease, and concluded that "...though open-ended, it is usually defined by a minimum duration (for example diseases lasting 3 or 6 months, continuously or intermittently, may be termed chronic)".[2] Illustrating the semantic divide, a recent report of the United States Institute of Medicine focused on the inadequacy of care of chronic conditions, and defined a chronic condition as one which "... requires ongoing medical care, including monitoring, treatment, and coordination among multiple providers, limits what one can do; and is likely to last longer than 1 year."[3]

In the mid-1990s, the National Health Target strategies were developed by the Australian government, following the Better Health Commission's report in 1987. Since then, much more has been written on the need for more efficient and better-coordinated policies for preventing and managing chronic conditions in Australia.

A range of viewpoints, disease targets and high-level overviews have emerged in proposals by the National Health Priority Action Council, the National Public Health Partnership, the Department of Health and Ageing Sharing Care Initiative in the 1999–2000 Budget, the Rural Chronic Disease Initiative, the Strategic Research Development Committee of the National Health and Medical Research Council, and advisers forging the next Australian Health Care Agreements.[4]

US leaders in the development and evaluation of integrated models of care for people with chronic illness, such as Kaiser Permanente, and Group Health Cooperative of Puget Sound, have shown that the burden of chronic disorders can be reduced by informed primary care practitioners and patients working together, supported by evidence from modern information technology.[5] Yet in 2003, when other nations have moved beyond talk into detailed proposals for reforming the prevention and management of chronic conditions, Australian governments still debate.[3] Gaps in our health policy research into preventing chronic illness and managing and financing chronic care are wide, confirming the lament of a recent editorial in this Journal.[6] Three of these gaps deserve special mention.

First, while some prevalence rates and use of hospital resources have been estimated, accurate data are lacking about how the total direct costs of managing chronic conditions vary with age, number of risk factors or number of comorbidities. Recent US research provides the first indications of the increases in direct costs as the number of risk factors increases. The increased costs are pronounced for prescribed drugs, and less so for hospital and medical services.[7] Disability is a major driver of the direct and indirect costs in an ageing population.[8,9] Five conditions (mood disorders, diabetes, heart disease, hypertension and asthma) accounted for 49% of direct healthcare costs in the United States in 1996, and for 42% of illness-related indirect costs.[10]

To obtain more accurate projections of future care costs, we need new coding systems that measure comorbidities, and linked data sets provided by all care providers and payers.

Second, better data about the costs of the prevalent risk factors listed in the Australian Institute of Health and Welfare report[1] are essential. The World Health Organization has laid out the empirical rationale for such a campaign against risk factors.[11] With these cost data, the economic case for their prevention can be opened to public debate. Economic incentives to the community to reduce their risk and look after their health have not been conspicuous in Australia. Health economists have generally argued against investments in public education and information that might modify demand for healthcare in favour of government regulation of the supply side. They may wish to adapt their arguments in the light of evidence on the impact of demand-side strategies in US chronic disease management trials.[12]

Third, there is no clear evidence of the success of initial attempts to organise and pay more efficiently for the management of chronic conditions. The first trials of coordinated care in Australia were not designed, managed or funded adequately to demonstrate significant achievements in health and functional status, or cost reductions compared with usual care. The findings from the evaluations of these trials reflect these limitations[13] and contrast with the results of the US Medicare Coordinated Care Demonstration[14] and with US evaluations of integrated care models, such as the Program of All-Inclusive Care (PACE) for the frail elderly,[15] a small subset of the chronically ill. In Australia, the second set of trials of coordinated care is under way. Unfortunately, private health insurers are not much involved. In fact, there is no incentive in the current Reinsurance Pool for private health insurers to provide coordinated care for their members with chronic disorders. This pool reimburses funds whose members receive high cost, lengthy hospital care, while extracting payments from funds with lower cost members.

Some state governments, most notably the New South Wales government through the work of the NSW Health Council, have declared an interest in managing several chronic conditions, such as diabetes, chronic respiratory disorders and heart failure. Regrettably, current funding mechanisms and political timidity prevent anything as radical as cashing out all federal payments to allow the states to implement risk-rated capitation funding allocated to the continuum of care needed by chronically ill people.

It is time to bring the private healthcare sector into the policy review process. The recent report of the US Institute of Medicine identified the need to make best use of all resources, public and private, in a mix of new types of care, using adequately funded demonstration projects that had the appropriate mix of information technology, evidence-based clinical practice guidelines, coordination of care by multidisciplinary teams, and linkage of universities into the learning process.[3]

The US government policy review strategy for coordinated care differs markedly from the Australian strategy in one other respect. In July 2000, the lead US government agency sought public comment on both the contents of its proposals and the design features of the proposed demonstrations of coordinated care before it announced awards for 15 new trials in 2002. Most comments identified how the fee-for-service payment system of US Medicare would thwart the program objectives, and, as a result, the payment system for the new trials is a monthly all-inclusive rate covering coordination with community-based services, transportation, drugs, non-covered home visits and medical equipment.[13]

In Australia, we have achieved reductions in heart disease mortality since the mid-1960s with a combination of prevention and treatment. This should inspire us to believe that we can do well in the future care of patients with chronic disease. Tobacco control, nutrition policies, cancer screening and preventive treatment for those with established cardiovascular disease are examples of what we have achieved to date. We now need larger injections of political will. The early prevention and better coordinated management of chronic conditions will require changes in the methods of financing and paying for healthcare, inspired and supported by strong leadership from our politicians.

Paul F Gross

Chairman, Health Group Strategies Pty Ltd, Sydney, NSW

Stephen R Leeder

Director, Australian Health Policy Institute at the University of Sydney

Milton J Lewis

Senior Research Fellow, School of Public Health
University of Sydney, Sydney, NSW

1. Australian Institute of Health and Welfare. Chronic diseases and associated risk factors in Australia, 2001. AIHW Catalogue No. PHE 33. Canberra, AIHW, 2002.
2. Mathers C, Vos T, Stevenson C. The burden of disease and injury in Australia. AIHW Catalogue No. PHE 17. Canberra, Australian Institute of Health and Welfare, 1999.
3. Committee on Rapid Advancement Projects: health care finance and delivery systems. Fostering rapid advances in health care: learning from system demonstrations. Washington DC: Institute of Medicine, National Academies Press, 2002.
4. Gross PF. Chronic illness: “we need detailed funded policies, not more words”. *Healthcover* 2003; 13: 43-45.
5. Wagner EH, Austin BT, Davis C, et al. Improving chronic illness care: translating evidence into action. *Health Affairs* 2001; 20: 64-78.
6. Van Der Weyden MB. Australian health policy research and development: where is it? [editorial]. *Med J Aust* 2002; 177: 586.
7. Anderson G, Krickman JR. Changing the chronic care system to meet people’s needs. *Health Affairs* 2001; 20: 146-160.
8. Foote SM, Hogan C. Disability profile and health care costs of Medicare beneficiaries under age sixty-five. *Health Affairs* 2001; 20: 242-253.
9. Cutler DM. Declining disability among the elderly. *Health Affairs* 2001; 20: 11-27.
10. Druss BG, Marcus SC, Olfson M, et al. Comparing the national economic burden of five chronic conditions. *Health Affairs* 2001; 20: 233-241.
11. The World Health Report 2002: reducing risk, promoting healthy life. Geneva, WHO. 2002.
12. Weingarten SR, Henning JM, Badamgarav E, et al. Interventions used in disease management programmes for patients with chronic illness — which ones work? Meta-analysis of published reports. *BMJ* 2002; 325: 925.
13. Berenson R, Horvath J. Confronting the barriers to chronic care management in Medicare. Health Affairs. Web Exclusive, 22 January 2003. Available at: www.healthaffairs.org/WebExclusives/Berenson_Web_Excl_012203.htm (accessed Jan 2003).
14. Blecher M. Beyond managed care. *Hospital Health Networks* 2001; 15: 50-53.
15. Master RJ, Eng C. Integrating acute and long-term care for high-cost populations. *Health Affairs* 2001; 20: 161-172.

❑