The Folly Of Preventative Healthcare

Publish Date:

December 2012

This article from the December 2012 edition of the IPA Review is written by President of Private Doctors Australia and author of 'Problems in Health Care Delivery: Governmnet as Cause not Cure', Brian Bedkober.

Commencing with Otto von Bismarck (and some would say even earlier) the role of the state in protecting its subjects from various risks has been steadily increasing. A great many of these protections are now provided under the heading of 'health care.' In providing for the health care of the nation, however, government has run into a number of serious difficulties. One of these difficulties is how best to allocate resources between curative, hospital-based services and preventative, community-based services—and at a deeper level, precisely what curative treatments to make available and what particular preventative measures to promote.

The expense associated with high-technology treatment (particularly in-patient treatment), has led governments to believe that preventing the emergence of disease rather than simply treating it when it presents itself is the best financial strategy for the future. Rather than increasing hospital

bed numbers government has decided to emphasise the funding of the many preventative health measures that it believes will lead to a healthier and more cheaply serviced population.

There are, however, a number of reasons to doubt the ‘better and cheaper’ tag attached to the preventative care banner. Jeremy Sammut of the Centre for Independent Studies, for example, has drawn attention to a 2002 crosscountry analysis of thirteen OECD countries that shows that ‘more spending on higher cost curative care, rather than less spending on lower cost ‘preventative care’ appeared to have produced better health outcomes.’

Obviously, people who live ‘healthy’ lives do not become immortal but eventually succumb to conditions that may be more expensive to treat (often in hospital) than those resulting from poor lifestyles. And while it might be expected that increasing the quality of preventative care in people with established disease would lead to lower costs through such factors as better diagnosis and fewer treatment errors, as Sammut has also pointed out, these effects appear to be neutralised by the increased costs associated with the identification and management of previously unmet needs.

Even in those who are currently disease free, the costs must include not only those involved in screening a large number of people who are ostensibly well (checking, for example, their blood pressure, their prostate, their cholesterol and their breasts), but also those associated with dealing with individuals who have been worried into inappropriate attendance by exposure to scary preventative health messages. And then there are the costs associated with building GP Superclinics and providing access to the public purse to an increasing number of nurses and other allied health care practitioners, providing many of the additional preventative health care services.

While the costs of an increased emphasis on preventative care may be higher than anticipated, the benefits may also be lower—as individuals generally find it hard to sustain long-term behavioural change. Different people also have different views about what changes are desirable and many are prepared to exchange a shorter and more pleasurable life for a longer one.

Furthermore, not only is it a costly process when nationwide preventative programs are directed towards people who do not want them or are unaffected by the problem being targeted, but when the messages are delivered indiscriminately to the masses, legitimate targets are able to rationalise that the message was meant for somebody else. Health messages are also more readily ignored in an environment in which many of them are clearly exaggerated.

Another significant reason for the failure of so many of the preventative activities of the state is that the evidence base supporting their implementation is so very poor. Unfortunately, the problems associated with grant selection and the inadequate or absent evaluation of the results of government-funded programs mean that taxpayers’ money is frequently frittered away on ineffective campaigns and those programs that work are often underfunded and those that don’t are over-funded. It has proven virtually impossible to defund ineffective programs.

So, whether or not to spend vast sums of taxpayers’ money on preventative health measures rather than curative care is a question with an uncertain answer. The prevalence of obesity and other predominantly lifestyle-related chronic conditions, despite decades of escalating expenditure

on preventative health care, shows that government has been largely unsuccessful in delivering results in this area. And the redirection of funds to preventative care has been a significant contributory factor in the failures of the public hospital system.

The (predictable) response to government's preventative failures has been to suggest that more would have been achieved if only more had been spent. Along with an injection of further funds, we can also anticipate the more widespread use of legislative and regulatory restrictions against the principle of free choice. Government is already increasing the frequency with which it uses Medicare refunds, incentive payments to doctors and various welfare payments as tools to achieve its political ends.

It has also been suggested that if individuals want to benefit from taxpayer funded health care they ought to be obliged to adopt healthy lifestyles. Hospital admission, for example, could be denied to individuals who continue to smoke (or they could be placed lower down on public waiting lists) and subsidies could be declined or lowered for the treatment of injuries and illnesses that result from unapproved choices.

The difficulty for these approaches is that the Australian health care system cannot be said to provide 'universal' care once it incorporates sticks and carrots into its operations. Admission to public hospitals cannot be both 'free' and conditional. And what can it mean to have a conditional 'right' to health care? The idea that a citizen has a 'right' to any welfare program is damaged by the attachment to it of any conditions.

Many of the failures of the current system in delivering timely and effective health care are related to the fact that government chooses between prevention and cure and between different preventative and curative measures in a political process. Under this process, access to care is considered a 'right' and services are delivered, in government's traditionally wasteful way, on a collective basis. We would all be much better off if we were able to make these decisions for ourselves—if, that is, we were free to choose the appropriate balance between preventative and curative expenditures and if we were personally responsible for managing many of the risks from which government tries to protect us. We all have particular information relating to our personal circumstances and desires that government is in no position to address. And if we make a bad choice then we will learn from it and the damage done will be limited to us alone.

Since the state can only operate at the level of the collective, when it gets things wrong the damage is widespread. And if an individual is not held personally responsible for the management of a particular harm (such as obesity), there will be an increase in the incidence of that harm. Patient confidentiality and the patient-centred approach to care are also casualties in a system where third parties with a vested interest in the decisions made must be admitted into every consultation.

Good intentions notwithstanding the system we have just doesn't work very well—and preventative health is not the panacea it is made out to be.