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EDITORIAL

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Prevention pays: COVID-19 tells us it's time for a Sovereign Health Fund for disease prevention

1 | PREVENTION WORKS

COVID-19 is providing numerous case study examples of the value of prevention and early intervention. Across Australia, we have had scores of weeks of lockdowns with more to come. The cost of lockdowns in our major cities has been estimated at $1 billion per week. This does not include the cost of human suffering, loss and distress. The last 12 months have shown us how the impact of COVID-19 can be mitigated by effective prevention and early intervention.

Further investment in infection control processes and infrastructures, such as quarantine facilities, would have largely kept the island of Australia free of COVID-19 until sufficient vaccine doses became available for the entire population. While many of the lessons from COVID-19 will no doubt be applied to future pandemics and health crises, one thing is clear: prevention pays. However, there are some significant obstacles, which, if not overcome, will mean that we will not be fully prepared for the next crisis, and we will again pay dearly in dollars and human suffering for this lack of preparation.

2 | BUT WE INVEST LITTLE IN PREVENTION AND EARLY INTERVENTION

The case for health promotion, prevention and early intervention is generally well accepted. A number of disease prevention and health promotion plans and frameworks have been around for decades,[1-6] or are currently under development.[7-9] The economic and societal benefits are well established. For instance, national vaccination programs keep people out of hospital, save money and prevent deaths (although there are still opportunities to enhance the effectiveness of vaccination programs by reaching disadvantaged groups and groups with chronic health conditions).[10] Given this, one must ask: Why is progress in this area so slow? There are a least 4 fundamental reasons: philosophical, economic, political and our diffuse, federated leadership structures.

3 | DIFFERENT PHILOSOPHICAL POSITIONS ON RIGHTS AND RESPONSIBILITIES CAN STYMIE ACTION

There are inevitable philosophical tensions evoked by universal prevention programs. The tension between 'rights and responsibilities' essentially balances the individual's right to make their own health choices, with their responsibility to not hurt others because of these choices.[11] The wearing of face masks is an example. Tobacco smoking is another example of this tension. Individuals have a right to choose to smoke, but do they have a right to expose others to second-hand smoke and the costs of their expensive hospitalisation and treatment due to smoking-related illness?[12] Navigating the path between individual rights and responsibilities is where the diversity of political and philosophical views generates vigorous and important debate. Based on this balance, we currently have *compulsory* Hep B vaccinations and hand washing for health workers, seat belt and pool fencing laws, and smoke-free facilities alongside *recommendations* to be vaccinated, limit alcohol intake, swim between the flags and quit smoking. These rules and recommendations vary by occupation, age, situation, industry, state and territory. They also change over time. It is not that long ago that smoking in aircraft, restaurants and hospital wards was commonplace.

The balance between individual rights and responsibilities will soon be navigated in the form of COVID-19 vaccination certificates and passports. Already, flu vaccination is required to visit aged care and other facilities, and some organisations are making COVID-19 vaccination mandatory for staff. These questions and more will be confronted across businesses, workplaces, occupations, public places and jurisdictions in the coming months.

In addition to where policy-makers sit on the rights-responsibility continuum is the value they place on business and the wealth of the nation versus the health of its citizenry (even though they are closely connected). What COVID-19-related policy decisions across Australia and overseas show

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us is that different administrations make very different decisions based on where they sit on these continua.

4 | THERE IS A LONG DELAY BETWEEN DISEASE PREVENTION INVESTMENT AND RETURN

In promotion and prevention, you need to invest before it pays. The economic argument for investing in these areas is well developed, but not compelling. For instance, the Productivity Commission Inquiry Report into Mental Health estimated reform of the Australian mental health system would yield a $19.3 billion return per year.[13] These are not back-of-the-envelope calculations, but based on the work of a panel of experts over 2 years. Enhancements to cancer and heart disease prevention would probably be worth even more. Similarly, the number of hospital beds occupied through alcohol-caused and smoking-caused illness is staggering.[12,14] In the context of how much is spent in health treatment and rural health care in particular,[15] it makes one question why we don't invest more in preventing cancer, diabetes, mental illness, cardiovascular disease and other chronic health conditions.

Investing in health promotion and prevention requires a ‘leap of faith and a wager of action.’ Based on available evidence, health leaders invest in a program, approach or method with the hope that sometime in the future this investment will be returned, with interest. This presents a significant challenge and obstacle. In the case of COVID-19, the relationship between the investment and the return is evident within weeks and months. In the case of other health conditions such as heart disease and cancer, the gap between investment and return may be decades and possibly more than 50 years. In addition, effective investment means we *don't see* skyrocketing illness, hospitalisation or deaths. It is more difficult to justify the investment when you don't see the results. This is the other problem with health promotion and prevention: when it is done well, you don't see the damage it prevented.

5 | SHORT ELECTION CYCLES MITIGATE AGAINST LONG-TERM PLANNING

The fundamental barrier to implementing transformational reforms leading to national health, wealth and welfare benefits is the political election cycle. The immediate and most strident (mostly media) clamour is about reducing emergency department and elective surgery wait times, and the need for additional staff and hospital beds. These are all things governments can and do try to address with the hope of measurable improvements before the next election. The same is true for funding additional programs and staff to improve health outcomes in rural Australia.

Announcements of public health prevention actions don't have the same mass media or electorate impact as announcements of new hospitals or additional staff; and usually improvements will not be evident before the next election. This is why so many very good promotion, prevention and early intervention strategies remain neglected and unfunded, while hospitals and health care staff numbers continue to grow.

I remember 20 odd years ago playing in a band at a fundraising function for another country's 50 year (!) reafforestation plan. At the time, I reflected on how our electoral cycles mitigate against long-term planning for national benefit and hamper leaders' capacity to cast their eyes to a longer event horizon.

We do have some remarkable occasions when our leaders displayed the courage and vision to transcend the electoral cycle. For instance, John Howard's gun control reforms and Bob Hawke's industrial relations reforms. However, these are exceptions requiring a principled leader prepared to sacrifice short-term political capital for the long-term benefit of the nation. These reforms are exceptional because the Australian system of leadership and governance mitigates against such things.

6 | DIFFUSE LEADERSHIP AND GOVERNANCE STRUCTURES HINDER DECISIVE, UNIFIED ACTION

Under our current national governance structures is it only the courageous, powerful leaders that can make meaningful national reforms. In this context, COVID-19 has highlighted the need for new models of health leadership to guard the health of our nation. Over a year ago, in my editorial, I reflected on some leadership lessons that were emerging from COVID-19 at that time.[16] The editorial focused on the need for leadership integrity and transparency, disaster preparedness to enable rapid mobilisation and the importance of effective crisis communication. The current situation highlights additional leadership lessons from COVID-19—the need for unified health leadership for illness prevention.

The current leadership models are also prone to overlook the impact on those on the frontline. For instance, the impact of COVID-19 on hospital-based staff is alarmingly high, with average depression and anxiety scores almost twice that found in the general population.[17] For those required to work out in the community, the situation is even worse. The rates of depression and anxiety in paramedics, community nurses, child protection and police officers are even higher than hospital-based staff and 2-3 times the rate of the general population.[18] The proportion of hospital-based staff suffering

workplace exhaustion and burnout is high,[19,20] and higher (52%) in community-based essential service workers, with a significant proportion (40%) also considering quitting their jobs.[18]

COVID-19 also highlights the limitations of heroic leadership models where one or 2 individuals make key decisions on behalf of the citizenry. Leaders from the UK, the United States, New Zealand and Australia all claim to be acting on the best scientific advice of their top health experts, as do our state and territory leaders. Yet their actions are quite different, and the ramifications of a poor decision by a national or provincial leader are massive. The community rightly asks: If our leaders are all acting on the best expert advice, why are their responses to COVID-19 so varied?

This invokes another structural governance problem. As a federated country, the states and territories are both separated and connected and they have powers and responsibilities that overlap with those of the Australian Government. The Australian Government has many national health-related powers and responsibilities, but public health orders are determined by the states. The actions of one jurisdiction affect all other jurisdictions. The different approaches and the subsequent political point-scoring confuses and undermines public trust in *every* jurisdiction. COVID-19 illustrates the importance of a coordinated and unified national approach to vital health challenges. This is not achievable under our current system of government (despite the National Cabinet).

7 | IS IT TIME FOR A NATIONAL SOVEREIGN HEALTH FUND FOR DISEASE PREVENTION?

COVID-19 has demonstrated the economic and human value of the 'fence at the top of the cliff rather than the ambulance at the bottom' preventive strategy. However, due to Australia's current governance and leadership structures, progress in the area has always been, and I suggest, always will be, glacial.

Perhaps it's time to consider the establishment of a Sovereign Health Fund focused on the prevention of disease. Taking the best available advice from experts from Australia and overseas, it could sit alongside and have similar governance arrangements (such as a non-partisan board of guardians) as our $180 billion Sovereign Wealth Fund and our Future Fund. We already have a $20 billion Medical Research Future Fund. Surely, COVID-19 highlights the potential benefits of a similar fund dedicated to disease prevention. Avoiding 20 weeks of COVID-19 lockdown alone would pay for it, and it would bring added financial and human benefits by improving the health and well-being of our populace.

The board of guardians of a Sovereign Health Fund could consider available evidence and arguments to determine the best actions to enhance our nation's health and prevent disease. The fund would have the capacity to invest in those actions with the best return on investment. It could also invest in the infrastructure to help protect the country from the worst impacts of future pandemics and other health crises. Separated from politics, it could more easily get the collaboration of all the nation's jurisdictions. Most importantly, it would have the capacity to put in place initiatives for the benefit of our children, and our children's children.

8 | CONCLUSION

The COVID-19 crisis has powerfully illustrated the value of prevention and early intervention in public health. There will surely be future pandemics and unknown health crises to confront our country. We must invest in the infrastructure and mechanisms to rapidly respond to and prevent the worst effects of future health threats to our country. Yet fundamental factors such as our system of governance make it extremely unlikely that the necessary reforms will ever occur. In the meantime, we also have other clear and present health challenges to address—tobacco use, obesity, dietary risks and high blood plasma glucose for a start.[21] An estimated 38% of the total burden of disease in Australia could be prevented by reducing exposure to known risk factors.[21] Instead of putting more stress on an already over-stretched health workforce, it is time to seriously invest in disease prevention. The health, wealth and safety of our nation depend on it.

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