Delivering quality care more efficiently inquiry

Questionnaire response 59

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Participant background

1. For the purposes of this consultation, which of the following best describes you:

   I am an interested community member

2. Which of the following care sectors will your feedback relate to? Please select all that apply.

   Health

3. What kind of care supports, services and programs do you have experience with, and in what jurisdictions?

   The participant did not respond to this question.

1. Reform of quality and safety regulation to support a more cohesive care economy

1. To what extent do differences in quality and safety regulation make it costly or complex to provide or access care services?

   The participant did not respond to this question.

2. What are the reasons for your answer?

   The participant did not respond to this question.

3. To what extent should quality and safety regulations be more aligned across the different care service sectors and jurisdictions?

   The participant did not respond to this question.

4. What are the reasons for your answer?

   The participant did not respond to this question.

2. Embed collaborative commissioning to increase the integration of care services

1. What is your experience with collaborative commissioning

   The participant did not respond to this question.

2. What are the benefits of pursuing greater collaborative commissioning?

   The participant did not respond to this question.

3. What are the barriers to collaborative commissioning, and do you have any suggestions for solutions that would lead to better collaboration in the commissioning of care services?

   The participant did not respond to this question.

3. A national framework to support government investment in prevention

1. What are the main barriers to governments investing in evidence-based prevention programs across the care economy?

Australian traditions of Ageism and lack of recognition of the carer and voluntary sectors of the economy.
This is a cultural as well as demographic and economic matter which requires deep social thinking as well as socioeconomic measuring.
Australia as, in some respects, a "New World" and immigration society - a strong emphasis on youth, little awareness of tradition (eg no political party has ever adopted the name "Conservative") , and a popular reluctance to have older leaders of major political parties - a contrast to Western Europe, North East Asia and the US.
More generally, limited respect for elders in families and in society. That is quite clear to anyone who has also lived in Asia as I have done.
This leads on to the general question of age cut off dates for screening in several areas - breast, bowel and prostate.
Several contexts and implications need to be reviewed.
1. Rising life expectancy. Despite the recent blip (which may or may not be temporary) life expectancy has grown by around 11 years for men and 9 years for women since the early 1970s.
That poses the question of more years of useful, productive and fulfilling lives, both in the workforce and in care and other sectors.
A related factor is the emergence of flexible working days and hours which may facilitate increased opportunities for older people - except for the media we no longer refer to people in their sixties as "elderly".
There is also a health and quality of life aspect, not just a measure.
Early cut off dates for screening based on a "life years gained" formula may take too little account of quality of life and human suffering - I knew a fit and active man in his mid 80s, who had been diagnosed with prostate cancer in his late 70s. Except he did outlive its transition from low grade to metastasis to the bones with very painful consequences and death the result.
We need to review the cutoff dates for prostate, breast and bowel cancer screening given the demographic and cultural factors discussed above.
In summary we need to recognise that "OBs", "Old Buggers", are citizens too, people with potential, as we transcend ageist prejudices and medical/institutional habits towards them, which are in fact discriminatory.
Culture vs Evidence. We need to recognise that very often implicit and a priori cultural stereotyping actually informs apparently evidence based processes and conclusions.

2. What are some examples of successful prevention programs (this could include discontinued programs)?

Successful and unsuccessful.
Bowelscan
Approximately 40% return of Bowelscan tests. A national disaster - the numbers not screened.
1. Do we know the social class, region, age and ethnicity demographic patterns of returns ? If not how can this information be obtained? Are postcode SES economic measures a small beginning?
2. How can we address this gigantic hole in effective screening?
Not by TV advertising - already used, with limited success.

My recommendation for increasing Bowelscan returns is an incentive scheme.
That is a dollar amount eg $100 or $200 to up to three recipients 1. A cancer research fund 2. A cancer support fund. 3. The return person's bank account.
This should be a simple options box on the Bowelscan form.
Cost vs Benefit. Minimal cost at the screening stage will bring personal, health and economic benefits - contrast the hospital, specialist and treatment costs - and the human suffering, productivity loss and death costs - of latter stage bowel cancer.

3. How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?

Bowel screening - addressed in response 2 above.
Dental screening and basic treatment. Most of the earlier arguments apply.
However there is a specific aspect. A two pronged approach could address our great failure in dental care, which has implications for overall health (including the cardiovascular system and nutrition) as well as teeth and gums.
1. Dental therapists are trained in basic checkup skills and do checkups under the supervision of a dentist
2. Dental therapists do basic dental treatment (simple fillings) under the supervision of a dentist.
We know that there are complications (the cost of dental equipment, the economics of a small business, and the politics of dentists' self-interest) but these measures might make a difference in a country with unnecessarily high levels of dental decay..

CONCLUSIONS

This analysis suggests that we need to consider fundamental arguments about life expectancy, quality of life and contributions to society and culture as well as to the economy by all of the society.
That includes the many people who are missed by screening in general and the specific group (the "old buggers") who miss screening due to several age cut off dates.
It is myopic, in social, cultural and quality of life terms, to pursue this government false economy of "saving on screening" due to numerical measures without social context.
It is also myopic in health as well as budgetary terms.

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Cover sheet: Supporting document #1

Dr Stephen Alomes
Preface to Submission on Preventative Screening

I write as a social historian and a health policy researcher.
My focus is on the big picture of fundamental social, health and demographic changes as they impact on health and quality of life and productive contributions to the economy, including the informal care and voluntary economies.
I am conscious that Australians have been good at gathering statistical information, from the First Muster of settlers in 1800, to the several volumes of Timothy Coghlan's *Labour and Industry in Australia*, from 1918, to the ABS' work, including the Census.

Have we been less good at understanding fundamentals, including social and cultural causes and results, and quality of life questions?
If we ask the wrong questions, due to a priori assumptions, even when the evidence seems clear it may not address the fundamentals.
The historian Manning Clark criticised 'mere measurers', invoking the Biblical lines about Jesus removing traders and money changers from the table, upsetting the latter's tables. (Matthew 21:12).

The change in life expectancy has been dramatic. When the age pension was introduced (from 1908-10) for men at 65 and women at 60, life expectancy was 55 for males and 59 for females. Only 4% of the population were over 65. https://www.nma.gov.au/defining-moments/resources/age-and-invalid-pensions

In my submission I argue for a big picture assessment of the benefits of extending public health screening cutoffs, recognising several quality of life and social productivity benefits, especially if the life expectancy of older adults increases, following the approximately 10 year improvement over the last half century.
"Years gained", "health years gained" and "quality of life and productivity years gained" need ongoing review.