Heart Foundation

# BEATING HEARTS

## Cardiovascular policy proposals to save lives and money

Submission on the 2018–19 Federal Budget from the National Heart Foundation of Australia

CARDIOVASCULAR DISEASE ACCOUNTS FOR ALMOST 30% OF ALL DEATHS

CARDIOVASCULAR DISEASE AFFECTS 4.2 MILLION AUSTRALIANS

CARDIOVASCULAR DISEASE COSTS $8.8 BILLION EACH YEAR IN DIRECT HEALTHCARE EXPENSES

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# Foreword

## Submission on the 2018–19 Federal Budget from the National Heart Foundation of Australia

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This pre-Budget submission advances a suite of good, practical policy proposals that plug significant gaps in the nation's current approach to preventing, treating and managing a leading killer of Australians – cardiovascular disease.

Cardiovascular disease (CVD) comprises a number of individual diseases, including coronary heart disease, stroke, heart failure, arrhythmias, congenital conditions, hypertensive disease and peripheral vascular disease.

While mortality rates have been in decline for several decades, cardiovascular disease:

- accounts for almost 30% of all deaths
- is a leading cause of the total burden of disease (15% of the total burden)
- costs $8.8bn each year in direct healthcare expenses
- is the most costly disease to treat, accounting for 11.1% of total spending on admitted hospital patients, or $5bn each year.[1 2 3 4]

## Where are the gaps?

While Australia generally does well by international standards when it comes to cardiovascular prevention and care, there are gaps in the current approach that, if addressed, could significantly improve outcomes for patients and help contain costs for government.

**PREVENTION:**

While Australia is a global leader in some aspects of prevention, large gaps remain in the current approach, with under-investment in many areas, such as overweight/obesity, and missed opportunities to better detect and manage the 1.4m Australians at high risk of heart attacks and strokes.[5]

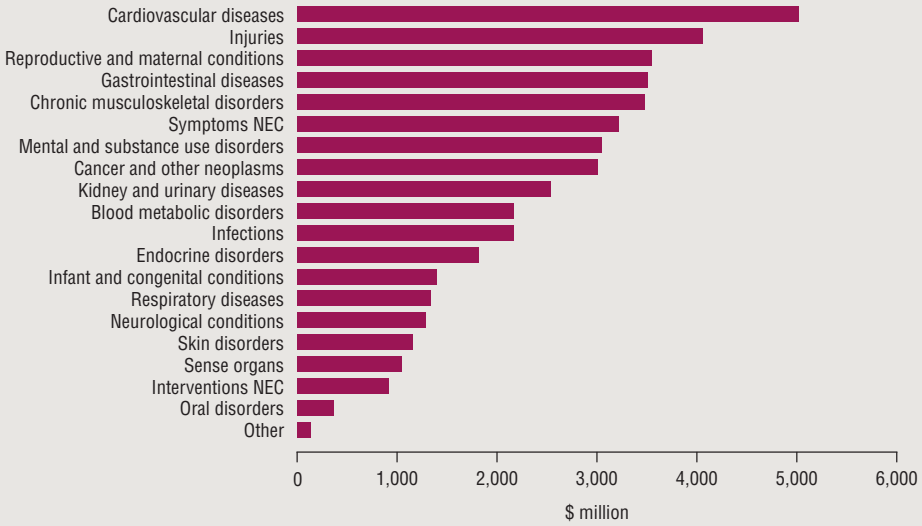
**SUPPORT AND CARE:**

There are significant variations in the care of patients when treated for cardiovascular disease.[6] Treatment times need to be nationally reported to drive improvement, as does referral and completion rates for access to life-saving cardiac rehabilitation programs. Better data will drive better outcomes.

**RESEARCH:**

Investment in cardiovascular research is highly cost-effective. Funding from the National Health and Medical Research Council and the Medical Research Future Fund should reflect the burden CVD imposes on the community.

DISEASE EXPENDITURE GROUP




Australian Institute of Health and Welfare 2017. Australian health expenditure – demographics and diseases: hospital admitted patient expenditure 2004–05 to 2012–13.

## What can be done?

The good news is that many of these gaps can be addressed with cost-effective, or even cost-saving interventions.

This Budget submission presents a series of low-cost, high-value proposals that can prevent heart disease from occurring in the first place, better identify and manage those at risk, and improve quality-of-care for those living with disease.

These proposals:

- support the Government's long-term health plan and its commitment to reduce potentially preventable hospitalisations
- implement the National Strategic Framework for Chronic Conditions
- align with the WHO non-communicable disease targets and global action plan
- build on existing Government programs and approaches to better tackle chronic disease and plan for an ageing population
- are evidence-based, cost-effective and easy to implement.

This submission also suggests revenue measures that could raise an estimated $3.3bn a year which, in turn, would enable the Government to increase its investment in healthcare, prevention and research.

Investment in heart health is an investment in life.

But it is also an investment that has benefits well beyond heart health, embracing gains across multiple chronic diseases, helping Australians lead longer, healthier, happier and more productive lives.

Adj Prof John G Kelly AM
**CEO Heart Foundation**

# THE FACTS ABOUT CARDIOVASCULAR DISEASE

MOSTLY PREVENTABLE

COSTS
**$8.8 BILLION**
EACH YEAR IN DIRECT HEALTHCARE EXPENSES

AFFECTS
**4.2 MILLION**
AUSTRALIANS

A LEADING CAUSE OF TOTAL BURDEN OF DISEASE
**15%**

MAJOR CAUSE OF AVOIDABLE HOSPITAL ADMISSIONS

A LEADING CAUSE OF DEATH AND DISABILITY

# Beating Hearts summary

## NATIONAL ACTION PLAN

### Develop a national heart and stroke action plan

**$150,000**

Develop a heart and stroke action plan to address key gaps in the current approach to cardiovascular disease prevention and care. This would support the National Strategic Framework for Chronic Conditions and aligns with the Government's long-term health plan.

## PREVENTION

### Build a comprehensive approach to prevention

**LOW INITIAL COST**

Build a comprehensive preventive health program. This should include measures to: expand physical activity investment through the national sport and physical activity plan; encourage walking; and reduce smoking rates, especially for Aboriginal and Torres Strait Islanders and other population groups with high smoking rates.

### Detect and manage those at risk

**LOW COST**

Detect and manage those at high risk of heart attack and stroke by supporting the Integrated Health Check.

### Renew absolute risk management guidelines

**LOW COST**

The absolute risk management guidelines developed by the National Vascular Disease Prevention Alliance are now due for review. Funding should be provided to ensure this takes place as soon as practicable.

## SUPPORT AND CARE

### Support women and heart disease campaign

**$4M A YEAR OVER THREE YEARS**

Support a national women and heart disease awareness campaign to save lives and reduce the suffering caused by a lack of awareness of the need for women to have their heart health checked.

### A long-term commitment to end rheumatic heart disease

**LOW ADDITIONAL COST OVER FORWARD ESTIMATES**

Make a long-term commitment to end rheumatic heart disease as a major public health issue confronting Aboriginal and Torres Strait Islander people.

### Boost uptake of life-saving cardiac rehabilitation

**$1M EVERY TWO YEARS**

Fund a biennial national audit of cardiac rehabilitation to improve uptake of this life-saving service for people who have had a coronary event, especially those living in regional, rural and remote communities.

## RESEARCH

### Ensure funding for CVD research reflects the burden the disease imposes on the community

**NO ADDITIONAL COST**

Ensure disbursements for disease specific research from the National Health and Medical Research Council and the Medical Research Future Fund are commensurate with the burden these diseases impose on the community.

Support the second National Health Measurement Survey – via the Medical Research Future Fund.

## REVENUE MEASURES

A health levy on sugary drinks ($400m/year) and much needed reform of alcohol tax (both examples of 'corrective taxes') could raise $3.3bn a year and reduce excessive consumption and harm while providing a source of revenue for preventive health and research.

# Develop a heart and stroke action plan

**THE PITCH**

- **Problem:** There are major gaps in Australia's approach to prevention and control of cardiovascular disease
- **Solution:** Develop a national heart and stroke plan to plug the gaps
- **Impact:** Lives saved, reduced costs, fewer avoidable hospital admissions

While prevention, treatment and on-going management of people with cardiovascular disease in Australia is generally good, and sometimes very good, there are some alarming gaps. There are gaps in our approach to prevention, early detection, treatment, on-going management and research.

There are, for example, 1.4m Australians at high risk of having a heart attack or stroke within the next five years, yet nearly a million of these are not getting the required medication.

These gaps cost lives and money.

The recent development of the National Strategic Framework for Chronic Conditions provides an opportunity for the Government to ensure it has a comprehensive and integrated approach to the major chronic disease groups.

While there are strategies and action plans to address a number of chronic diseases, such as diabetes and asthma, and key risk factors, such as tobacco control and alcohol, there remains no national action plan for cardiovascular disease – a disease group that causes almost 30% of all deaths and is responsible for 15% of the total disease burden, second only to cancer (19%).[7]

This is a conspicuous gap in Australia's overall approach to chronic disease.

From a government perspective, a well-targeted heart and stroke action plan has the potential to curb future costs. The scope for improvement is large. The direct healthcare cost of cardiovascular disease amounts to $8.8bn a year, the most costly of all disease groups.[8] Of this, the in-hospital cost of cardiovascular disease is $5bn a year.[9]

A heart and stroke action plan should focus on:

- preventing premature death
- improving quality of life
- cutting avoidable hospital admissions, and
- reducing the immense economic and social burden cardiovascular disease imposes on the health system and the community.

The plan should be developed by convening a small group of experts and consumers with tight terms of reference that focus on the identification of gaps in the current approach to prevention and care, and the development of cost-effective measures to address them.

The resulting action plan, to be endorsed by health ministers, should complement and build on existing frameworks and broader, long-term plans.

It should also reflect priorities and 'best buys' as identified by the World Health Organisation as part of the Global Action Plan on Non-Communicable Disease.[10]

The need to better tackle cardiovascular disease was acknowledged when it was designated as a national health priority area in 1996. Subsequently, all health ministers agreed to a National Service Improvement Framework for Heart, Stroke and Vascular Disease in 2005.

While that Framework sets out critical intervention points and priority areas, no implementation plan was developed, and no funding provided to ensure the proposed outcomes could be achieved.

A decade has passed since the Framework was agreed, but there is still no action plan to reduce risk, improve early detection and outcomes for patients, even though such a plan would help contain future costs for government.

The concept of a national heart and stroke action plan already has strong support from stakeholders including state and territory governments. The Review of Cardiovascular Disease Programs (Birch Review) commissioned by the Federal Department of Health and Ageing and released in 2011, found: *"There is strong support across jurisdictional and non-government stakeholders for the formulation of a national action plan for CVD."*

The need for an action plan is supported by the United Nation's commitment to implement the outcomes of the 2011 High Level Summit on Non-Communicable Disease, of which Australia is a signatory. It is also a goal of the Mexico Declaration, adopted by the world's leading cardiovascular groups in 2016.[11]

A heart and stroke action plan should be quick to produce, easy to implement, highly cost-effective or cost-saving, and will result in significant reductions in preventable hospitalisations, in line with the Government's long-term health plan.

**"We have a once-in-a-generation opportunity to avoid millions of premature deaths and save lives by orchestrating a coordinated response to the heart disease and stroke pandemic across the globe. In order to achieve this, we must work together to support implementation of the *WHO Global Action Plan 2013–2020* for NCD reduction, focussing specifically on heart disease and stroke."**

*World Heart Federation's Mexico Declaration. June 4, 2016*

# Build a comprehensive approach to prevention

**THE PITCH**

- **Problem:** Lifestyle behaviours are fuelling preventable chronic disease
- **Solution:** Build a comprehensive preventive health program
- **Impact:** Reduce avoidable hospital admissions and primary care costs

While responsibility for prevention is shared across all three spheres of government in Australia – federal, state/territory and local – there is no firm process for coordinating, prioritising, funding and evaluating public health measures and campaigns. Investment in prevention is also low by OECD standards, with only 1.7% of total health expenditure allocated to public health, comparing poorly with countries like New Zealand (7%) and Canada (5.9%).[12 13]

This results in ad hoc, uncoordinated measures, which could, if better coordinated and scaled up, have a much greater impact on health outcomes.

The Australian Government should lead the way to develop a much more robust, coordinated, longer-term approach to public health in partnership with other spheres of government and the non-government and consumer sectors.

The need for such an approach was highlighted in the 2017 report, Public health: How much does Australia spend, and is it enough?[14] The report concludes:

*"England stands alone among the countries we examined as having institutional structures in place both for assessing the cost-effectiveness of preventive interventions… and for monitoring the effectiveness of spending on prevention through Public Health England's Public Health Outcomes Framework. … The feasibility of transferring such initiatives and adapting them to the Australian context also warrants examination."*[15]

In addition to developing a stronger, more sustainable approach to public health, the Government should also strengthen its own investment in prevention. Four specific proposals are suggested.

## A national sport and physical activity plan

A single national plan that brings sport and physical activity together would help Australia be a more active, healthier nation by offering numerous pathways for people to move more and sit less.

Since 2001, the number of Australians doing very little or no exercise has continued to increase. Two in three (66.9%) Australians aged 15 and over are sedentary or have low levels of exercise, and eight-in-ten children do not meet physical activity guidelines of 60 minutes a day.[16 17 18]

Physical inactivity is a major chronic disease risk factor that costs the health budget an estimated $1.5bn a year[19] and causes an estimated 14,000 deaths a year.[20] Physical inactivity also contributes 21% of the cardiovascular burden and 5% of the total burden of disease in Australia, placing it among the top modifiable risk factors.[20 21]

A national sport and physical activity plan could expand on the Government's investments in physical activity to date and support community participation in physical activity as a part of everyday life.

An agency that has national leadership and oversight for increasing physical activity through the plan – modelled on Public Health England – could facilitate a whole-system approach to foster national partnerships across, and between, government, health agencies, NGOs, schools and the private sector to build national partnerships that encourage physical activity at the local level. We believe the revenue streams outlined later in this submission offer an opportunity for government to fund this work in a cost-neutral manner.

## Renew and strengthen Tackling Indigenous Smoking

Almost a decade has passed since dedicated funding was allocated to reduce Indigenous smoking rates.

Recent data shows that Indigenous adult smoking rates have dropped 22% over the past two decades. The proportion of Indigenous adults who smoked has decreased significantly, falling from 55% in 1994 to 45% in 2014–15. The number of Indigenous people aged 15–17 years who smoked has also declined significantly, from 30% to 17% over this time.[23]

The proportion of Aboriginal and Torres Strait Islander people aged 18 years and over who have successfully quit smoking has increased significantly from 24% in 2002 to 36% in 2014–15.[24] The 2016 National Drug and Household Survey also reported that daily smoking rates for Indigenous Australians has dropped from 35% in 2010 to 27% in 2016.[25]

The $116m funding for the current round of Tackling Indigenous Smoking expires at the end of June 2018. The Heart Foundation asks that the Government renew and strengthen funding for the Tackling Indigenous Smoking initiative.

## A national statement on walking

The Harvard Medical School says walking is "the closest thing we have to a wonder drug in terms of health benefits".[26] Walking for just 21 minutes a day has been shown to reduce the risk of heart disease by 30%, and lower the risk of diabetes, cancer, hypertension and cholesterol levels.[27]

Walking improves cognitive function, elevates mood and is an important great way to build social connections.[28] It is also the most popular form of physical activity for Australian adults.[29]

If increased physical activity through walking was thought of as a medication and its adult dose as 30–60 minutes a day, there is scarcely anything else that would provide such comprehensive physical, mental and community health benefits.

A statement on the benefits of walking by the Government would send a strong message of leadership to state, territory and local governments, health leaders and the community on the importance of being physically active and benefits of regular walking. It also supports the Prime Minister's comment at the launch of the Healthy Hearts Initiative that: "The next big challenge is to get Australians to be more active, to reduce obesity, and walking is a great way to do that."[30]

The US Surgeon General's *Step It Up!* initiative provides a successful framework for promoting walking and walkable communities.[31] Launched in 2015, *Step It Up!* made a compelling case for walking as a public health strategy through a public education campaign with online resources and support materials that encouraged people to walk and civic leaders to make communities more walkable.

## A national nutrition strategy and action plan: A three-step plan to healthy eating

Much work has been done already by the Government to develop a national nutrition strategy. This work should be completed. This is particularly important as dietary factors have been assessed by the Australian Institute of Health and Welfare as contributing 7.2% to the total burden of disease in Australia, second only to tobacco use at 9%.[32]

In addition, the Government should develop and implement an action plan to put the strategy into practice.

Funding should be provided to implement plans that are being developed under the Government's *Healthy Food Partnership*, particularly those that support:

- a national food reformulation program
- a portion size program, and
- engagement with the food services sector.

A program should also be developed to put the Australian Dietary Guidelines into practice and promote the consumption of core food and healthy eating patterns. This should help all Australians access, choose and prepare healthier foods. A partnership should be developed and supported to scale up current evidence-based programs which help the community choose and prepare healthier foods.

# Detect and manage those at risk

**THE PITCH**

- **Problem:** Some 1.4m Australians aged 45-74 have a high risk of a heart attack or stroke in the next five years
- **Solution:** Modify MBS items to support uptake of the Integrated Health Check.
- **Impact:** Reduced health care costs through fewer avoidable hospital admissions and more effective use of PBS medications

Over 100,000 Australians have a heart attack or stroke each year, taking an immense social and economic toll on the community.[33]

And yet, much of this toll is avoidable if people at high risk are detected early enough and are then well-managed.

Disturbingly, some 1.4m Australians aged 45–74 have a high risk of a heart attack or stroke within the next five years. But almost one million of these are not receiving the recommended treatment.[34]

Tens of thousands of premature deaths could be averted if people aged 45–74 had a absolute cardiovascular risk assessment (heart health check) and those at high risk were well managed according to existing guidelines.[35]

Well-established, National Health and Medical Research Council (NHMRC) approved-guidelines call for general practitioners to conduct assessments for eligible patients to detect those at high risk of having a heart attack or stroke.

The Australian Health Policy Collaboration paper, *Heart Health*, identified absolute cardiovascular risk assessment as a major opportunity to prevent and reduce premature morbidity and mortality through primary care.[36]

The World Health Organisation also recommends an absolute risk approach for the control of hypertension (high blood pressure), describing it as one of the 'best buys' available to governments to support interventions for people who have had a heart attack or stroke or are at high risk of a cardiovascular event.[37]

Because heart disease often co-exists with type 2 diabetes and kidney disease, and shares many risk factors, it is recommended that a cardiovascular risk assessment be done concurrently as part of an 'Integrated Health Check (IHC)'. The check combines an absolute risk assessment for heart disease and stroke, a type 2 diabetes check and a kidney disease test. It is considered best practice as it consolidates the necessary checks a patient can request from their doctor.

However, relatively few GPs routinely conduct these checks for eligible patients, missing the opportunity to ensure people at high risk are managed to help them stay alive, stay well and stay out of hospital. The IHC should be explicitly supported by the Medicare Benefits Schedule.

The Government is developing a Quality Improvement Incentive (QII) payment by consolidating a number of existing Practice Incentive Payment schemes into a single program.

Undertaking Integrated Health Checks and ensuring on-going management of patients at risk should be incorporated into the proposed QII payment.

The QII payment should be linked to Primary Health Networks. The Networks should promote uptake of the Check, develop systems support, create linkages with relevant prevention services and report via quality improvement audits.

**"A full cardiovascular risk assessment allows therapy to be targeted to those who would most benefit from it. Not only is this good clinical practice, it makes sound economic sense."**

*Prof Emily Banks, National Centre for Epidemiology and Population Health, Australian National University, May, 2016*

# Renew absolute risk management guidelines

In 2009, the National Vascular Disease Prevention Alliance (NVDPA) developed *Guidelines for the Management of Absolute Cardiovascular Disease Risk*. These were funded by the Government and approved by the NHMRC in 2012. They support best practice approaches in primary care and focus treatment in the clinically appropriate areas.

Since the guidelines were developed, new evidence has emerged that has led to some confusion among health professionals.

New Zealand has also recently developed a consensus statement to provide health professionals a synopsis of the best available evidence on CVD risk to help them provide patients with the predictions of likely outcomes.

It is therefore important that the Australian guidelines are renewed as soon as practicable.

There is strong evidence that using guideline recommendations in practice leads to improved health outcomes for patients.[38 39] Research shows that guidelines are effective in changing clinical practice, improving quality of care and achieving better health outcomes that help optimise value for money.[40 41]

# Support women and heart disease campaign

**THE PITCH**

- **Problem:** Heart disease in Australian women is a leading killer yet only 3 in 10 women consider heart health personally relevant
- **Solution:** A national awareness campaign to educate women on heart disease
- **Impact:** Save lives and reduce the suffering caused by heart disease

Heart disease is a leading killer of Australian women, killing more women than breast cancer and diabetes combined. In 2016, coronary heart disease was responsible for the death of 8,207 Australian women – almost one every hour.[42] As a primary and associated cause of death, heart disease is a factor in the death of one in five Australian women.[43]

In 2016, approximately 70,000 women had their first cardiovascular disease hospital admission. Tragically, close to 3,400 suffered a sudden and fatal cardiac event without ever reaching a hospital.[44] The estimated cost of hospitalisations for women due to cardiovascular disease consumes $3bn of the healthcare budget.[45]

For women over 40, the chance of developing heart disease is one in three. In a recent study, 40% of women who had a heart attack did not experience chest pains, had low awareness of the non-chest pain symptoms and were more likely to call a family member or friend than Triple Zero.[46] This delay has serious consequences. The health outcomes following a heart attack are often worse for women than for men, and women are more likely to die from a repeat heart attack than men.[47]

Women who are Aboriginal, on low incomes or live in rural and remote areas fare much worse. Aboriginal women are 30% more likely to have a chronic cardiac-related condition and those living in remote communities are 20% more likely to die from heart disease.[48]

A lack of awareness and action are primary factors contributing to the significant impact of heart disease on Australian women. Less than one in three women are aware heart disease is a leading cause of death and only one in eleven are aware high blood pressure is a major risk factor.[49] Women are also less likely to have heart health checks, with only one in three reporting they have had a heart health check, and have spoken with a health professional about the key risk factors.[50]

The Heart Foundation has been leading the women and heart disease space since 2008. We have a strong evidence base, a profile with women and a strong alliance of researchers, community champions and leaders to advise on a national awareness campaign on women and heart disease that would:

- *Improve awareness* – so that Australian women are aware heart disease is a leading cause of death and the key risk factors associated
- *Drive knowledge* – to highlight what women should do to reduce their risk of heart disease
- *Change behaviour* – to increase the number of heart health checks and Australian women who know the warning signs of a heart attack and take prompt action to call Triple Zero.

The Heart Foundation has estimated the cost of a three-year campaign, including development, evaluation and monitoring costs, to be $11.6m.


24 AUSTRALIAN WOMEN DIE EVERY DAY FROM HEART DISEASE.
#womenshearts
INVISIBLE VISIBLE
invisiblevisible.org.au

# A long-term commitment to end RHD

**THE PITCH**

- **Problem:** Indigenous Australians are 20 times more likely to die from rheumatic heart disease
- **Solution:** End rheumatic heart disease as a major public health issue
- **Impact:** No new cases of rheumatic heart disease among Indigenous Australians by 2031

Rheumatic heart disease (RHD) is considered a deadly condition mostly experienced in low income countries. However, it is persistent among Aboriginal and Torres Strait Islander communities in Australia, which experience disease rates among the highest in the world.

RHD is caused by untreated acute rheumatic fever (ARF) arising from childhood group A streptococcal infections of the throat, and probably also of the skin. Untreated, RHD involves damage to heart valves, potentially causing heart failure or leading to arrhythmias, stroke, endocarditis and complications in pregnancy.[51]

Globally, there are 33m people living with RHD with more than 300,000 deaths a year.[52] In Australia, RHD affects one in 43 Aboriginal people living in remote and rural areas. Indigenous Australians are 20 times more likely to die from RHD than their non-Indigenous peers – and, in some areas, such as in the Northern Territory, this rate rises to 55 times higher.[53]

Fortunately, Australia has a multi-faceted National Rheumatic Fever Strategy, funding for which was renewed and strengthened in the May 2017 Federal Budget.

It includes a national coordination centre and support for register-based control programs in South Australia, Northern Territory, Queensland and New South Wales, which have improved the detection of RHD, levels of treatment compliance, and awareness and knowledge among healthcare professionals.

The impact of the strategy has been significant. For example, the control programs in the Northern Territory and Western Australia have doubled the number of patients receiving 80% or more of the required medication as part of secondary prophylaxis treatment.

But more can be done. In particular, we believe there is an opportunity for the Australian Government to work with its state and territory counterparts to make a long-term commitment to end RHD as a public health threat to Indigenous people. This should align with the 'Close the Gap' commitment to end the life expectancy gap by 2031.

The Heart Foundation is working with the AMA, the National Aboriginal Community Controlled Health Organisation, RHD Australia, Aboriginal Medical Services Alliance Northern Territory and the END RHD CRE to amplify acceptable and appropriate interventions for RHD control.

Importantly, this will also align with the development of a resolution on RHD to be considered by the World Health Assembly in Geneva in May 2018.

Ending the threat of RHD in Australia is a feasible target. Control of RHD has been achieved in Cuba and the French Caribbean. A national campaign in New Zealand is also showing promising results, particularly following significant investment by the NZ Government with a focus on primary prevention, measurable targets and community engagement. These have contributed to a decline in first episode hospital admissions for ARF by 23% over five years.

There is much to be gained by making a longer-term commitment in Australia. While RHD is largely forgotten in the general community, it remains a major health challenge to Indigenous Australians. There is no reason why this should remain the case.

Apart from eliminating a major cause of premature death and disability, the Government would also benefit from health savings associated with the transportation and hospitalisation of those with RHD from regional and remote locations to receive specialist cardiac treatment in the major cities.

In 2016, the Heart Foundation was pleased to support the development and release of the Australian Medical Association's 'call to action' to prevent new cases of RHD in Indigenous Australia by 2031. The *2016 Report Card on Indigenous Health* made recommendations to achieve this through:

- All Australian governments committing to a target to prevent new cases of RHD reported among Indigenous people by 2031.
- Australian governments committing to a sub-target that no child in Australia dies of ARF and its complications by 2025.
- Australian governments working in partnership with Indigenous health bodies, experts, and key stakeholders to develop, fully fund, and implement a strategy to end RHD as a public health problem in Australia by 2031, comprising:
  - an interim strategy (operational from 2016–2017 until 2021); and
  - upon the 2020 receipt of the final report of the END RHD CRE, a comprehensive 10-year strategy (operational from 2021–2031).[54]

# Boost uptake of life-saving cardiac rehabilitation

**THE PITCH**

- **Problem:** Attendance rates for cardiac rehabilitation programs are as low as 11%
- **Solution:** Develop a national data set of referral, attendance and completion rates for this life-saving program for those who have had a heart attack or have heart failure
- **Impact:** Drive up cardiac rehabilitation attendance rates for eligible patients, improve patient quality of life and reduce avoidable hospital admissions

For heart attack survivors, cardiac rehabilitation is an important step in their journey of care.

While there is strong evidence that attending a program of cardiac rehabilitation can dramatically reduce the chance of a further cardiac event, attendance rates for cardiac rehabilitation programs are as low as 11–31%.[55]

Getting more eligible patients to participate in cardiac rehabilitation should, therefore, be a high priority for all Australian governments.

Given that more than one-third of hospital admissions for heart attack are repeat events, this is particularly true.[56] Moreover, the number of hospital separations due to heart attacks has increased, rising by 15% between 2003–04 and 2013–14.[57]

A recent audit of cardiac rehabilitation in one Australian state using public hospital data from 2013–15 found:

- 60% of patients do not participate in a program
- Of the 40% who did attend, about 35% participated in face to face programs and 6% in a phone program
- Death rates at 12 months were up to 50% lower in patients who participated in a cardiac rehabilitation program.

The need to increase cardiac rehabilitation referral and completion rates has been highlighted by the Heart Foundation's *Heart Attack Survivor Survey*. It found less than one-in-two patients discussed cardiac rehabilitation with medical staff before they left hospital.

### The Heart Foundation's Heart Attack Survivors Survey 2016

| Attended cardiac rehabilitation | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|
| Yes | 39% | 43% | 45% | 50% | 44% |
| No | 57% | 53% | 53% | 48% | 50% |
| Can't remember | 4% | 3% | 2% | 2% | 6%* |

*Statistically significant change from previous year

| Completed all the cardiac rehabilitation sessions | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|
| Yes | 83% | 81% | 82% | 89% | 84% |
| No | 17% | 16% | 15% | 10% | 13% |
| Can't remember | 1% | 3% | 3% | 1% | 4% |

A Victorian study reported a 25% increase in five-year survival rates among patients who attended cardiac rehabilitation.[58] Other recent research also indicated that $227m worth of economic and social benefits could be made from increased cardiac rehabilitation participation over a 10-year period in Victoria alone.[59]

In the UK, an annual audit of cardiac rehabilitation has led to a better understanding of referral and completion rates, and helped drive improvements across the system.

A national Australian audit, like in the UK, would present a detailed and complete picture of cardiac rehabilitation services that could drive service improvements.

Currently, there is no mechanism to determine how many patients are referred to, or complete, cardiac rehabilitation. These areas also lack consistent definitions and measures making it currently impossible to monitor and evaluate services.

Developing a national data set for cardiac rehabilitation programs would be a significant step in driving improvement in participation rates. Much of this data is collected by state jurisdictions already, but not publicly available in an accessible way.

Funding a biennial national audit of cardiac rehabilitation services in Australia would also assist in identifying opportunities for driving service improvement, monitoring progress over time, and sharing good-practice.

People living in regional, rural and remote communities will also benefit through reduced inequity as a result of improved access regardless of where a patient lives.

Aboriginal and Torres Strait Islander people could particularly benefit because, at present, their participation in cardiac rehabilitation programs is less than 5% and significantly lower than the general population.[60]

# Ensure funding for CVD research reflects the burden the disease imposes on the community

**THE PITCH**

- **Problem:** Disbursements from the NHMRC and MRFF do not reflect the disease burden attributable to CVD
- **Solution:** Match NHMRC and MRFF disbursements to Australia's disease burden so that the community benefits directly from research in CVD prevention, treatment and care
- **Impact:** Cardiovascular disease research returns $9.80 for every $1 invested

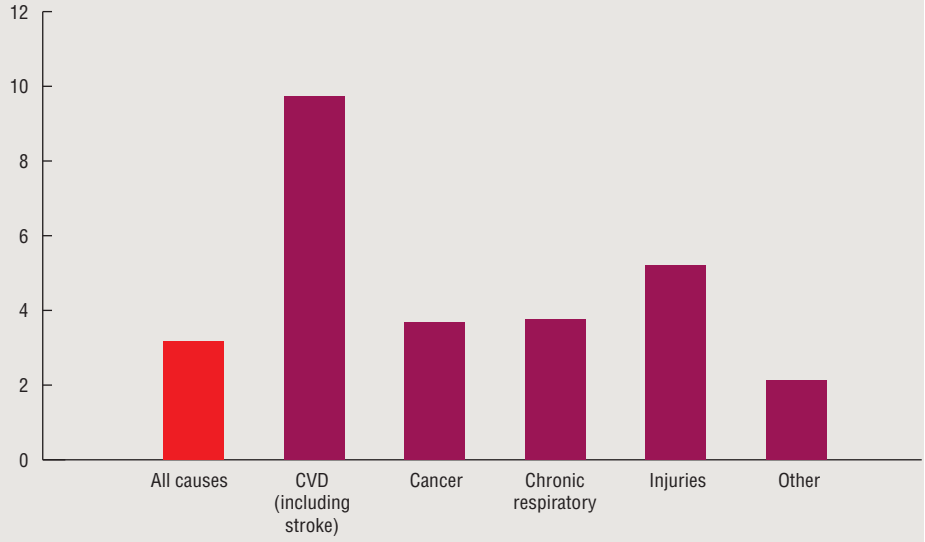
Health and medical research is an investment that reaps enormous social and economic benefits and drives improvement in healthcare quality and outcomes. Heart disease is the largest killer of Australians[61] and the most expensive disease in terms of direct health care costs. Cardiovascular disease is also responsible for the second highest burden of disease, accounting for 15% of the total burden in Australia.[62]

It is critical that disbursements from the National Health and Medical Research Council (NHMRC) and Medical Research Future Fund (MRFF) be allocated to reflect Australia's disease burden if we are to address the social and economic cost of CVD. In fact, the *Medical Research Future Fund Act 2015* states that funding priorities must take into account the burden of disease on the Australian community.

Cardiovascular disease research is an investment in the social and economic well-being of the nation that returns $9.80 for every $1 invested.[63] It also offers the potential to address obesity-related illness through blue-sky innovation and improve linkages between knowledge generation and health outcomes.

The community benefits directly from the application of evidence-based research in CVD prevention, treatment, care, and rehabilitation because many advances in cardiovascular health have had their foundation in health and medical research discoveries. Populations with special needs especially benefit from research that helps address disparities in heart health for all Australians. Like the government, the Heart Foundation is committed to health equity and research in areas of special need, such as Aboriginal and Torres Strait Islander people and people from other vulnerable groups.

BENEFIT COST RATIO OF RESEARCH WORKFORCE RETURNS, DETAILED CAUSES, 2000–2015




Deloitte Access Economics calculations

## National Health Measures Survey

The biomedical survey is a key component of the Australian Health Survey in which critical biomedical data is collected from a representative sample of 11,000 volunteers.

Australia cannot effectively or efficiently tackle the growing burden of chronic disease if it does not have detailed data to monitor progress and evaluate interventions. You simply can't manage what you don't measure.

A disbursement from the MRFF could fund this critical biomedical component of the Australian Health Survey.

The cost of the biomedical survey – around $12m – is insignificant compared to the human and economic cost of chronic disease burden. Failure to invest in the survey, especially the biomedical component, will lead to sub-optimal investment of resources (waste and inefficiency) and poorer health outcomes for Australians.

It is important that the National Health Measures Survey to be undertaken every five to six years, because it provides researchers, decision-makers and health professionals, among many others, with the data to understand the health of the nation, this status and impact of key risk factors and the effectiveness of interventions. Without this data, we are, to a great extent, flying blind.

# Revenue measures

**THE PITCH**

- **Problem:** Australian investment in public health falls well behind other OECD nations, at only 1.7% of total healthcare expenditure
- **Solution:** Alcohol tax reform and a health levy on sugary drinks could raise $3.3bn a year while providing funds for preventive health measures and research
- **Impact:** Achieve public health benefits through reduction in excessive consumption and fund public health interventions.

The Australian Government could raise $3.3bn a year with two popular, evidence-based revenue measures: alcohol tax reform ($2.9bn) and a health levy on sugary drinks ($400m). These measures could not only raise much needed funds to off-set new public health interventions, but would also achieve important population health benefits in their own right.

It's important to note that Australia lags well behind other OECD nations when it comes to investment in public health, with government funding amounting to just 1.7% of total healthcare expenditure. New Zealand leads the OECD at 7% with Canada on 5.9%.[13]

## Alcohol tax reform

With new tobacco tax measures in place, the Government should act on alcohol tax reform. The Foundation for Alcohol Research and Education (FARE) calls for reform to:

- bring wine and cider into line with other alcohol products, and
- apply a 10% increase to all alcohol excise, which would alter the cost of a standard 375ml can of beer by less than 10 cents.

This would raise $2.9bn annually to achieve a 9.4% reduction in alcohol consumption.[64] FARE further calls for indexation of alcohol excise rates to average weekly ordinary time earnings, rather than the CPI, to ensure that the cost of alcohol does not reduce relative to personal income.

The Productivity Commission's *Shifting the Dial* report recommended the Australian Government move towards an alcohol tax system that removes the current concessional treatment of high-alcohol, low-value products – primarily cheap cask and fortified wines.[65] This could be achieved through a uniform volumetric tax rate for alcoholic beverages, calibrated to reflect the health impacts of alcohol consumption.

*Shifting the Dial* also estimates that high risk alcohol consumption affects 1.8m Australians, identifying it as one of the key drivers of chronic disease – along with smoking, poor nutrition and physical inactivity – therefore making it an important target for preventive health action in Australia.[66]

FARE states, among alcohol harm prevention policies, alcohol taxation is the most effective as it not only reduces consumption and related harms, but also provides revenue to contribute to services addressing alcohol-related harms. Surveys indicate that 71% of Australians believe that the alcohol industry should pay for reducing alcohol harms and 51% support an increase to the tax on alcohol.

Excessive drinking and binge drinking can lead to stroke. Other serious problems include foetal alcohol syndrome, cardiomyopathy, cardiac arrhythmia and sudden cardiac death.[67]

## Health levy on sugary drinks

As noted above, The World Health Organisation has recommended that governments place a levy on sugary drinks as part of a comprehensive approach to reducing sugary drink consumption. This strategy is aimed at improving diet and mitigating the deleterious effects of poor dietary habits on health and chronic disease.

This approach was a recommendation of the WHO Commission on Ending Childhood Obesity, and has now been embraced by 36 jurisdictions including Mexico, some parts of the United States, Saudi Arabia and the UK.[68]

A recent Australian study estimated that increasing the price of sugary drinks by 20% could reduce consumption by 12.6%.[69] Mexico introduced a levy of 10% on sugary drinks on January 1, 2014 and evaluation data demonstrated a 12% decline in consumption by December that same year. There was also a 4% increase in the amount of untaxed beverages purchased, mainly driven by the purchase of bottled water.[70]

Sugar-sweetened beverages are now the greatest contributor of added sugar to the Australian diet.[71] Australian Bureau of Statistics data, released in 2016, reveals that while the median amount of sweetened beverages consumed on the day prior to interview was around the size of a typical can (375ml), the top ten per cent highest consumers of sweetened beverages consumed more than one litre on the day, peaking at 1.5 litres for males aged 19–30 years. The average intake for males aged 14–18 years who consumed sugar-sweetened beverages was 16 teaspoons, or 68 grams.[72]

A 12.6% reduction in consumption has the potential to generate a decline in the prevalence of obesity of 2.7% among men, and 1.2% among women, and could reduce the number of cases of type 2 diabetes by 800 a year. The study estimated that the levy could raise more than $400m a year, even after accounting for reduced consumption as a result of the levy.[69]

The UK Government expects to raise £1bn a year from its taxation of sugar sweetened beverages with the money raised allocated to school sports.[73] Similarly, revenue raised in Australia could be invested in public health programs, like a national obesity prevention strategy.

The Australian public strongly supports increasing the price of sugary drinks with research into the attitudes of Australian grocery buyers showing that 69% of participants supported a health levy if the revenue was used to subsidise healthy foods.[75]

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