PLAN, PREVENT, CHECK, TREAT
Time to tackle chronic disease
Time to tackle heart disease & stroke

Submission on the 2015-16 Federal Budget from the Heart Foundation and the National Stroke Foundation
The Challenge

With an ageing population and more prevalent risk factors, the Australian Institute of Health and Welfare acknowledges that chronic disease is ‘Australia’s greatest health challenge’.

To successfully meet the chronic disease challenge, Australia must do more to tackle its biggest - and most costly - component: heart disease and stroke.

This submission puts forward cost-effective proposals to meet the chronic disease challenge, save lives, ease pressure on health budgets and reduce avoidable hospital admissions.

Together, the proposals should form the basis of an effective national action plan for heart disease and stroke.

These measures will address big gaps in our current approach to the prevention, detection, treatment and on-going management of our biggest killer.

The Facts

Cardiovascular disease (mostly heart disease and stroke):

- is the most costly disease group at $7.7bn a year, or 10.4% of direct healthcare expenditure including $4.5bn on hospital admissions and $1.65bn on pharmaceuticals¹
- is highly prevalent, with 3.7m living with cardiovascular disease²
- is a major cause of avoidable hospital admissions
- causes around one-third of all deaths (30%)³
- contributes to 55% of all deaths⁴
- is a leading cause of the total burden of disease (14%)⁵ and 23% of the fatal burden of disease⁶
- is largely PREVENTABLE.
We all agree.

It’s time to tackle chronic disease.

It’s time to tackle CVD.

Ms Ley should prioritise addressing chronic disease in her new role as Health Minister. “There’s no rocket science there. I think it’d be great if she can support us and everyone in the health industry in our region tackling chronic disease, because diabetes, obesity, arthritis, heart disease, they are costing the country an absolute fortune," she said.

Roz Menzies, former director at the Broken Hill GP Super Clinic

*Sydney Morning Herald*, December 23, 2014

“There must be high-level discussions about chronic disease management, public hospital funding, Commonwealth/State relations, prevention, and medical training …”

A/Prof Brian Owler, AMA Federal President, December 21, 2014

Chronic disease is already the leading cause of illness, disability and death in Australia. ... It is expensive to treat, particularly because the current arrangements result in many unnecessary and avoidable admissions to hospital, which is the most expensive setting for health care.


What causes 20% of all hospitalisations? One in five of all hospitalisations in Australia were associated with cardiovascular disease, diabetes and chronic kidney disease in 2012–13.


There is substantial evidence on the impacts of chronic diseases on individuals, families, communities and the economy. They are the major cause of death and disability in Australia and a significant driver of health system utilisation and costs, generating billions of dollars in avoidable health expenditure each year.

Mitchell Institute for Public Health, December 2014
# The Solutions

## 1. Plan

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<th>Number</th>
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<tr>
<td>1.1</td>
<td>Develop a national chronic disease strategy for Australia with a comprehensive national cardiovascular disease action plan as a core component</td>
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**Investment**

- $250,000 for development of a CVD action plan

## 2. Prevent

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**Investment**

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<th>Description</th>
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<td>Low cost to plan</td>
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<td>Restore funding levels</td>
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## 3. Check

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## 4. Treat

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<tr>
<td>4.1</td>
<td>Reporting of treatment times for heart attack and stroke</td>
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<td>4.2</td>
<td>Fund 4,000 public access defibrillators in sport clubs, venues</td>
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<td>4.3</td>
<td>National audit of cardiac rehabilitation services</td>
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<td>4.4</td>
<td>New national support system for heart attack survivors</td>
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<td>4.5</td>
<td>Fund a review of vital heart failure guidelines</td>
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<td>4.6</td>
<td>New clinical guidelines for stroke management</td>
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<td>4.7</td>
<td>National online resource to support health professional adherence to stroke guidelines</td>
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<td>4.8</td>
<td>Fund national rollout of StrokeConnect</td>
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1. Plan: Getting the strategy right

Australia’s next chronic disease plan: we must get it right

**Recommended action:** Develop a comprehensive national action plan for cardiovascular disease as an integral part of a new national chronic disease strategy. Investment: $250,000 for the development of a national CVD action plan.

All Australian governments have agreed to revise the National Chronic Disease Strategy. The existing strategy was signed off by all health ministers in 2005. The development of a new strategy is a positive move.

But Australia cannot risk developing another document that sits on shelves for a further decade and makes little impact on addressing Australia's greatest health challenge.

While working closely with state and territory governments, the Australian Government must take a leading role in the development of a meaningful document that can drive real and lasting change as the Australian population ages and the chronic disease challenge grows.

This is critical to Australia’s future social and economic prosperity.

It is also critical that a comprehensive national action plan for cardiovascular disease be developed and included as a vital component of the new chronic disease strategy.

While Australia has an existing, well developed national service improvement framework for heart, stroke and vascular disease, there has never been a funded implementation plan to put this plan into action.

This has been one of the most significant short-comings of Australia’s approach to chronic disease over the past 15 years.

As all Australian governments move to develop a new approach to chronic disease, now is the time to ensure our leading killer and the most expensive disease to treat is a core component of the nation’s efforts to reduce premature death and suffering from chronic disease.
WHO recognises CVD as a key element of the global chronic disease challenge.

Australia has joined all other members of the World Health Organisation to endorse a robust set of nine goals and 25 indicators to achieve a 25% reduction in mortality rates from the four main chronic disease groups - cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 2025.\textsuperscript{7}

This follows agreement at the United Nation’s High Level Meeting on Non-Communicable Diseases [chronic disease] in September 2011, only the second time that the UN has convened a summit on a major health issue (the other was HIV/AIDs in 2001).

Proposals in this submission will help Australia achieve key NCD targets, including:

- 10% relative reduction in prevalence of insufficient physical activity
- 30% relative reduction in mean population intake of salt
- 30% reduction in prevalence of current tobacco smoking
- Halt the rise in obesity.

As the WHO states, NCDs are the leading cause of death in the world. The four main non-communicable diseases - cardiovascular disease, cancer, chronic lung diseases and diabetes - kill three in five people worldwide. A revision of the existing National Chronic Disease Strategy should result in a meaningful, action-oriented document to better reflect the global chronic disease strategy, its focus on CVD as well as the key goals adopted by the World Health Assembly in 2013.

There is substantial evidence on the impacts of chronic diseases on individuals, families, communities and the economy. They are the major cause of death and disability in Australia and a significant driver of health system utilisation and costs, generating billions of dollars in avoidable health expenditure each year.

But while Australia has achieved significant success in addressing major challenges to population health, such as tobacco control and road trauma, we still do not have a comprehensive commitment to averting preventable chronic diseases. We are not adequately addressing known risk factors and determinants of chronic diseases, such as obesity, high blood pressure, high cholesterol and risky use of alcohol, nor implementing cost-effective interventions to prevent and effectively manage chronic diseases.

**Chronic Diseases: The case for changing course**

Mitchell Institute: Summary Report, December 2014
2. Prevent: Stop disease before it starts

Key points

2.1 Increase investment in prevention
2.2 Renew and strengthen the national food reformulation program
2.3 Develop and fund a national physical activity strategy
2.4 Develop and fund a national obesity prevention strategy
2.5 Invest in tobacco control, especially education campaigns and fully fund the Tackling Indigenous Smoking initiative
2.6 Continue to invest in the StrokeSafe Ambassador program

Preventing chronic disease

While medical technology, procedures and pharmaceuticals continue to improve, a growing number of Australians are developing diseases and suffering premature death because of avoidable lifestyle risk factors.

Healthy choices have the potential not only to improve our health now and into the future, but the health of our children.

Hon Tony Abbott MP
Minister for Health and Ageing
Media Release, May 8, 2007

An ounce of prevention is worth a pound of cure

The Heart Foundation and the National Stroke Foundation warmly welcomed the Coalition’s commitment to tackle chronic diseases and prepare the health system for the demographic changes ahead. In particular, the Liberal Party wrote to the Heart Foundation in September 2013, stating, among other things, that the Coalition:

- understands the importance of having effective prevention strategies to combat the rates of cardiovascular and other lifestyle related disease.
- will continue to work with health professionals to develop effective strategies to combat the rise of lifestyle-related disease
- is committed to reducing smoking rates in Australia.
Prevention is a critically important part of this challenge as investment in well-targeted, evidence-based prevention measures will reduce death and disease while easing pressure on health budgets. A range of cost-effective initiatives that should be embraced or strengthened are set out below.

### 2.1 Increase investment in disease prevention

**Recommended action:** Funding for prevention should be increased to 5% of health care expenditure, with phased increases funded by small allocations from increased taxes on tobacco and alcohol.

Government funding for public health in Australia is woefully low when compared with other OECD countries, ranking in the lowest third.

In 2011-12, just 1.7% of total government health expenditure went to public health activities, including prevention, protection and promotion. This was well behind New Zealand (7%), Canada (6.5%) and Slovakia (5%).

Funding for public health should be increased over time to 5% of total health expenditure. Such a move is in line with public expectations. A survey commissioned by VicHealth and the Public Health Association of Australia in 2010 found that a majority of respondents supported additional funds being allocated to federal and state government health budgets to prevent people from getting sick and to help people have better health (79.1% support or strongly support).

Nearly three-quarters of respondents (73.3%) supported increasing funds spent on prevention from 2% to 5% of the health budget.9

### 2.2 Renew, strengthen the national food reformulation program

**Recommended action:** Renew and strengthen the national food reformulation program (the Food and Health Dialogue). Investment: $800,000 a year.

Food reformulation – government working with public health groups and industry to reduce salt, saturated fat and sugar in processed food while boosting good nutrients, such as fibre – is one of the most cost-effective public health measures available to government.

It is being increasingly used worldwide to prevent premature death from diseases such as heart disease, stroke, diabetes and some cancers.

This approach was pioneered in Australia by the Howard Government when then Assistant Health Minister, Christopher Pyne, convened a quick service restaurant
industry roundtable on trans fats. This was later expanded to also look at saturated fat in food products.

Since then, the roundtables have grown into the Food and Health Dialogue, in which government is working with industry and public health groups (the Heart Foundation, Public Health Association of Australia and the Dietitians Association of Australia) to work towards agreed food reformulation targets.

This voluntary partnership has achieved measureable improvements in the food supply, with 2,200 tonnes of salt being removed per year from the first four food categories alone.

An independent evaluation, published in the journal *Nutrients* in September 2014, looked at the impact of Australia’s fledgling food reformulation program – the Food and Health Dialogue.

It found substantial decreases in salt in reformulated bread and cereal categories and declines in salt in processed meats and concluded: “These data show that the Australian food industry can reduce salt levels of processed foods and provide a strong case for broadening and strengthening of the Food and Health Dialogue process”.

The potential health gains from food reformulation are enormous. Reducing intake of sodium from processed food by 15-25% in Australia would avert 5,800-9,700 heart attacks and 4,900-8,200 strokes within ten years.

The UK government believes that major health gains can be made through food reformulation, including:

- Reducing daily UK salt intake to 6g a day could result in 20,000 fewer premature deaths each year; and

- Cutting saturated fat intake from 13.5% to 11% of daily energy intake could result in 3,500 fewer diet related deaths each year.

While regulation would be the most effective means of achieving food reformulation, the voluntary engagement of industry through firm government leadership has proven to be effective in the UK and elsewhere. The Australian initiative is off to a good, though slow start, and now needs to be strengthened and accelerated.

While the Food and Health Dialogue has not met for more than a year, its work is critically important. It needs to be renewed and strengthened, particularly as the approach taken by the Dialogue has had an important and measured impact on the health of our food supply. The work should also be expanded to address - as originally envisaged - portion sizes.
2.3 Develop and fund a national physical activity strategy

**Recommended action:** The Australian Government should work with state, territory and local government, public health groups and others with expertise in physical activity to develop a comprehensive, funded national physical activity strategy for Australia. Investment: $800,000.

Australia needs a national physical activity strategy to help people move more and sit less. The evidence is compelling.

Physical inactivity is a major health problem in its own right. Disturbingly, two in three (66.9%) Australians aged 15 and over are sedentary or have low levels of exercise.\(^{13,14}\)

Physical inactivity:

- Costs the health budget an estimated $1.5bn a year\(^ {15}\)
- Causes an estimated 16,000 premature deaths a year\(^ {16}\)
- Contributes to almost one-quarter of the cardiovascular burden of disease in Australia (24%)\(^ {17}\)
- Increases the risk of heart disease, stroke, diabetes, colon and breast cancer
- Is a critical factor in Australia’s obesity epidemic, with more than half of all Australian adults being overweight or obese\(^ {18}\)

If physical activity is thought of as a medication with an adult dose of 30 to 60 minutes a day, there is scarcely anything that could be taken daily that would provide such comprehensive health benefits.

And yet, despite strong evidence of the benefits of physical activity, far too many Australians lead sedentary lives. Eight in 10 children do not meet physical activity guidelines of 60 minutes a day\(^ {19}\).

Older Australians fare little better, however, most Australians (68%) are either sedentary or undertake low levels of physical activity.\(^ {20}\) Since 2001, the number doing very little or no exercise has continued to increase. These low levels of physical activity will drive up chronic disease including heart disease and stroke, type 2 diabetes and some cancers.

Any comprehensive approach to countering the impact of chronic disease must include a funded strategy to promote physical activity across the Australian population.
Helping people (adults and children) to be more physically active is important for population health. Not only does it help people stay healthy, but physical activity aids recovery from heart attack or stroke, and helps to prevent a second event from occurring.

The Heart Foundation welcomes support by government for programs that encourage people to move more and sit less.

The Heart Foundation Walking program is a free national walking group, underpinned by a model that facilitates the development of walking groups in communities by partnering with local providers such as health services, workplaces and local government.

In addition, the Heart Foundation has set out a comprehensive suite of actions needed to address low levels of participation in physical activity in the Blueprint for an Active Australia. This should form the basis of a national physical activity strategy.

The Blueprint makes it clear that there are benefits to the economy, society and to government that go well beyond the very substantial benefits to the health of Australians. For example:

- Fit workers have lower absenteeism and higher productivity
- Well-designed communities that support walking and cycling can reduce traffic congestion
- Community physical activity can increase social wellbeing and increase social cohesion.

A cross-sector approach is vital to ensure these benefits are realised and that environments and facilities in schools, workplaces, communities and cities make it easier for people to walk, cycle and be active.

But, as the Blueprint clearly states, “government leadership and investment is vital”.

Improving links to lifestyle modification programs

Evidence-based, physical activity programs play a critical role in countering chronic disease and keeping people well and out of hospital. Currently, effective, evidence-based programs are not well integrated into primary health care, with poor linkages and referral pathways resulting in ineffective use of available resources.

The Heart and Stroke Foundations are working with an alliance of 11 partners - the National Physical Activity Alliance - to promote the need for better linkages for people living with, or are at risk of, chronic disease and who need to access an evidence-based lifestyle modification program.
With a range of existing evidence-based lifestyle modification programs that have proven effective in the prevention and management of chronic health conditions already developed, the Alliance is seeking support to develop a process which will allow increased accessibility for the Australian population into these programs.

The Alliance is seeking support to improve the accessibility and sustainability of existing evidence-based programs through clearly defined referral pathways and economic subsidies.

This includes access to prevent chronic disease and manage existing disease effectively across all care settings (including rehabilitation and community based exercise settings). The facilitation of financial incentives for providers to deliver these programs will have clear benefit in attracting and retaining users within the target demographic.

The Australian Government should:

- Work with state, territory and local government, public health groups and others with expertise in physical activity to develop a comprehensive, funded national physical activity strategy for Australia
- Support walking and cycling safely to school programs that help schools to create safe walking and cycling routes in partnership with local government as well as offer safe riding programs for children. This could be conducted along similar lines to the Black Spot road safety program
- Create a walking and cycling infrastructure program to support local government with its active travel infrastructure task, similar to the Roads to Recovery program
- Improve accessibility and sustainability of evidence-based lifestyle-modification programs for people with, or at risk of chronic disease through clearly defined referral pathways and economic subsidies
- Provide assistance to sport and recreation clubs to engage more people in physical activity, making better use of existing infrastructure and programs
- Provide financial or tax incentives to encourage employees to walk, cycle or take public transport to work
- Assist local government to create and expand regional rail trails, cycle routes and walking/hiking tracks to promote tourism and recreation
2.4 Develop and fund a comprehensive obesity prevention strategy

**Recommended action:** Develop and fund a national obesity prevention strategy. Investment: $800,000 to develop the strategy.

Being overweight or obese are risk factors for many chronic diseases, including heart disease, stroke, type-2 diabetes, kidney disease and some cancers.

Alarmingly, more than three-in-five Australian adults are overweight or obese and for children aged 5-17, 25% are overweight or obese. Also, in the past 20 years, the average Australian has put on 6kg, and if this rate continues, by 2030, the average Australian will be obese.

The National Preventative Health Taskforce released a major report on preventive health with a major focus on obesity, alcohol and tobacco) in 2009. It concluded that there was an urgent need for action, stating:

One of the greatest public health challenges confronting Australia and many other industrialised countries is the obesity epidemic. Australia is one of the most overweight developed nations, with over 60% of adults and one in four children overweight or obese. The prevalence of overweight and obesity has been steadily increasing over the last 30 years.

Obesity is particularly prevalent among men and women in the most disadvantaged socio-economic groups, people without post-school qualifications, Indigenous Australians and among many people born overseas. It will be important to work together as a nation to solve this serious problem. There is no simple solution or singular approach.

These factors speak to a ‘learning by doing’ approach - that is, the staged trialling of a package of interventions accompanied by good monitoring and evaluation. Behaviour change is an essential component of any response to obesity; however, this is a complex process for individuals that extends beyond education and the provision of information.

The comprehensive, staged recommendations of the Taskforce continue to be relevant and widely supported. It is disturbing that few have been embraced.

The Australian Government should:

- Develop a comprehensive, funded national obesity prevention strategy, drawing on recommendations of the Preventive Health Taskforce.
- Provide robust support for implementation of the Health Star Rating front-of-pack labelling system, with increased support for education campaigns.
Renew and strengthen the national food reformulation program.

Fund robust obesity prevention public education campaigns.

Prohibit the exposure of children to the marketing and promotion of junk food to children during TV programs popular with children.

Explore options for a tax on sugar-sweetened beverages, with funds raised earmarked for health promotion.

2.5 Invest in tobacco control, especially education campaigns

Recommended action: The Australian Government should provide robust support for plain packaging of tobacco products, provide strong support for smoking education campaigns and at least maintain current funding levels, provide continued implementation of the 12.5% annual tobacco tax increase, and renew and strengthen funding for the Tackling Indigenous Smoking initiative.

The Heart Foundation and the Stroke Foundation commends the Australian Government for its commitment to tobacco control. It is a commitment that is saving lives, including many from heart attack, peripheral vascular disease and stroke.

Australia has been a global leader in tobacco control for the past three decades. This took a major step forward in recent years with the introduction of the world-first plain packaging of cigarette packets, increases in tobacco taxes, and the decision by the Future Fund and a number of superannuation funds to end their investment in tobacco companies. On top of this Australia has continued its investment in tobacco control public education campaigns. The Australian Government’s on-going commitment to fund tobacco control public education campaigns is deeply appreciated.

The combined approach of legislation, education campaigns and taxation works exceptionally well. In 1980, some 35% of Australians were daily smokers.24 Today 12.8% of Australians are daily smokers.25 This is a highly significant public health achievement.

Yet more needs to be done if Australia is to reach its target of 10% of the population as daily smokers by 2018.26

Smoking remains a leading cause of ill-health, death and disability in Australia. It accounts for some 15,000 deaths a year 27 and is estimated to account for 10% of the total burden of cardiovascular disease.28

The risk of heart disease and stroke is two-to-four times higher among smokers than non-smokers and this risk increases with the heaviness of smoking.29 Smokers have
more heart attacks at a much younger age than non-smokers\textsuperscript{30} and have have up to four times the risk of suffering sudden cardiac death than people who don’t smoke.\textsuperscript{31}

\begin{center}
\begin{quote}
We can take pride in the bipartisan approach that has seen support for tobacco control from successive Australian governments. But much remains to be done.

Mike Daube, ‘Fifty Years On’
Medical Journal of Australia, 20 January 2014
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For many years, we knew that cigarettes kill half of all lifetime smokers. But recent Australian research reveals this to be an under-estimate and that smoking will kill two-in-three long-term smokers.\textsuperscript{32}

The research, from the Sax Institute’s 45 and Up Study, supported by the Heart Foundation and NSW Cancer Council, found that two-thirds of deaths in current smokers can be directly attributed to smoking – much higher than international estimates of 50%.

The four-year analysis looked at health records from more than 200,000 people in NSW and found current smokers were cutting at least 10 years off their lifespan.

\textbf{Tackling Indigenous Smoking}

Smoking is one of the major drivers of the health expectancy gap between Aboriginal and Torres Strait Islanders and the non-Indigenous population. In recognition of this, the Tackling Indigenous Smoking initiative was commenced to help drive down premature death and suffering caused by tobacco consumption. The Australian Government commissioned the University of Canberra to conduct a review of the program in 2014 while imposing a $130m cut to the program over the forward estimates.

As the Australian Bureau of Statistics makes clear, smoking is the most preventable cause of ill health and early death among Aboriginal and Torres Strait Islander people, increasing the risk of coronary heart disease, stroke, numerous cancers, and many other conditions.

Daily adult smoking rates for Indigenous Australians, though in decline, are still at 41%, or 2.6 times the rate of non-Indigenous Australians.\textsuperscript{33}

The need for a robust and well-funded, coordinated program drive down the disturbingly high smoking rates among Indigenous Australians is self-evident.

Evidence points to a pleasing reduction in the prevalence of smoking among Indigenous Australians since the Tackling Indigenous Smoking initiative commenced.
The Government is - at the time of writing - considering the recommendations of the University of Canberra review.

We urge the Government to:

- respond positively to the review
- ensure that Indigenous tobacco control is a high priority
- provide funding commensurate with the level of need that matches, or exceeds, original funding levels for the Tackling Indigenous Smoking Initiative.

### 2.6 Continue to invest in the StrokeSafe Ambassador Program

**Recommended action:** The Australian Government should continue to fund the StrokeSafe Ambassador Program to increase awareness of stroke risk factors and signs of stroke in the community. Investment: $325,000 a year.

Stroke places a significant avoidable burden on the Australian community as not enough people know how to prevent stroke or know how to recognise and act promptly if they have one.

Many Australian adults are at risk of stroke - 9 out of 10 have one risk factor for stroke, and 75% have three stroke risk factors - yet too few are prepared to act if one was to occur. Nearly two thirds of Australian adults have not heard of FAST (the simple acronym to help recognise stroke) and many could not name a single sign of stroke.

StrokeSafe Ambassadors are trained volunteers who deliver education sessions across Australia to groups of people with a target age of 55 years and over. Ambassadors have been successful at increasing knowledge and improving behaviour in relation to stroke risk factors as well as improving knowledge of the signs of stroke.

Since August 2012, the program has been funded by the Australian Government to deliver 2,000 presentations to 40,000 Australians by 30 June 2015. We are set to deliver well over this target.

Additional funding will ensure our current Ambassadors can keep delivering talks and that we can continue to improve the effectiveness and efficiencies of the program. In early 2014 an evaluation of the program by Monash University found that participants increased their knowledge of stroke risk factors and their knowledge of FAST signs.

At three months not only had participants retained this knowledge, the session had had an impact on their health behaviours. 83% had increased their fruit and
vegetable intake, 76% had increased their physical activity and 19% had quit or reduced smoking. 80% of participants had intended after the session to speak to their doctor about a risk assessment and at three months the same proportion of participants had done so.

Funding the program from July 2015 onwards will ensure that these results can continue to be built upon.
3. Check: Early detection saves lives, money

Key points

3.1 Drive early detection of key chronic diseases
3.2 Review the national cardiovascular disease risk guidelines
3.3 Fund the FAST mass media campaign
3.4 Fund the ‘Will you recognise your heart attack?’ campaign

The Coalition’s Policy to Support Australia’s Health System

Australia’s health system is under increasing pressure from rising levels of chronic disease. We need a strong primary care workforce in order to provide better care and earlier interventions for people with complex and chronic health conditions. This is essential to improving the quality of life for patients, but will also alleviate demand on hospital services. Australia’s health system faces challenges due to demographic changes, increasing prevalence of chronic disease and the tyranny of distance faced by many rural and remote communities.

August 2013

Early detection is in everyone’s interest. And early treatment reduces pain, cuts costs and lowers the risk of disability or death.

Ban Ki-moon
United Nations Secretary-General
19 September 2011
Remarks to General Assembly meeting on the Prevention and Control of Non-Communicable Diseases
3.1 Drive early detection of key chronic diseases

**Recommended action:** Include the integrated health check and on-going management of patients at risk as part of the development of a new, quality-focussed Practice Incentive Program. Investment: Low cost or cost-neutral.

Well-established, NHMRC approved-guidelines call for general practitioners to conduct assessments for eligible patients to detect those at risk of having a heart attack, stroke or developing type 2 diabetes or chronic kidney disease. Because these diseases often co-exist and share many risk factors, the NVDPA recommends that these assessments be done concurrently as part of an integrated health check.

However, relatively few GPs routinely conduct these checks for eligible patients, therefore missing the opportunity to ensure people at high risk are managed to ensure they stay alive and well and out of hospital.

Combining a risk assessment for heart disease and stroke, a type 2 diabetes check and a kidney disease test into an ‘integrated health check’ is considered best practice as it consolidates the necessary checks a patient can request from their doctor.

During 2014, the then Health Minister, Peter Dutton, announced that the government would develop a new quality-focussed Practice Incentive Payment, by consolidating five existing PIP schemes into a single program.

Undertaking integrated health checks and ensuring on-going management of patients at risk should be incorporated into the proposed quality-PIP.

A new quality-focussed Practice Incentive Payment (PIP) which includes detection and prevention of vascular and related diseases should require general practices to:

- Check eligible patients for vascular and related conditions through an ‘integrated health check’ which includes an absolute cardiovascular risk assessment, diabetes check and kidney disease check;
- Manage the overall risk profile of patients, stratify risk (high, moderate, low) and address their combined risk factors through advice about healthy eating, healthy physical activity and healthy weight, medical management and/or facilitating and coordinating access to evidence-based prevention programs;
- Maintain a patient register, with recall and reminder system for patients eligible for assessment and those who require management of risk;
- Record and report proportion of eligible patients who are checked, who have their risk managed according to the relevant practice guidelines, who have a GP management plan, and who access evidence-based prevention programs.
The quality PIP should be linked to Primary Health Networks, with the Networks charged with promoting uptake of the integrated health check through education, systems support, creating linkages with relevant prevention services in the Network, measurement, and reporting and evaluation via quality improvement audits.

A new quality-focused PIP would complement existing PIPs and encourage general practice to implement an integrated health check for the early detection and risk management of people at increased risk of developing chronic kidney disease, type 2 diabetes, heart disease or stroke. The integrated health check would link into existing systems, for example, forming an integral part of chronic disease management as an entrance point into the current Chronic Disease Management Plan mechanism.

This integrated approach to detection and prevention of vascular and related disease incorporates the recommendations of existing guidelines and policies of the National Health and Medical Research Council (NHMRC), Royal Australian College of General Practitioners (RACGP), Australian Primary Care Collaboratives program (APCC), the National Prescribing Service (NPS) and other government agencies and primary care organisations.

This is a unique and important opportunity to ensure significantly greater adherence to existing evidence-based guidelines for the detection and prevention of the major vascular and related diseases and prevention of heart attack and stroke in people at high risk.

The potential benefits include:

- Improved detection of people at increased risk of vascular and related disease;
- Improved management of risk for people who have not developed disease;
- Reduced prescribing and reduced use of publicly funded health coaching and health promotion services for those at low risk, with more targeted, evidence-based prescribing for medications, including statins and anti-hypertensives and behaviour change/lifestyle interventions;
- Fewer avoidable hospitalisations;
- Reduced red tape, due to integration with existing primary care initiatives and a system which complements other mechanisms;
- Improved quality systems in general practice through targets and audits to measure adherence to guidelines.

The inclusion of the integrated health check in a quality-focused PIP is supported by the National Vascular Disease Prevention Alliance, which comprises the Heart Foundation, National Stroke Foundation, Diabetes Australia and Kidney Health Australia.
3.2 Review the national cardiovascular disease risk guidelines

**Recommended action:** The Heart and Stroke Foundations, together with the National Vascular Disease Prevention Alliance, recommend an investment of $800,000 to review the current guidelines for the management of absolute CVD risk, developed according to NHMRC requirements. Investment: $800,000.

The NHMRC approved guidelines for the management of absolute cardiovascular disease risk (2012) support clinicians to assess risk of heart attack or stroke among the general population (45 years and over).

Absolute cardiovascular disease (CVD) risk assessment is the probability, expressed as percentage, that a person may experience a cardiovascular event within a specified period. This guideline, developed with the assistance of Australian Government funding, is a lynchpin to preventive initiatives to reduce the incidence of heart attack and stroke across Australia.

The National Vascular Disease Prevention Alliance recognise the need to update evidence-based clinical recommendations to guide best practice.

Each year, around 55,000 Australians suffer a heart attack (which equates to one heart attack every 10 minutes) and around 430,000 Australians are living with stroke. The extent of this pressing problem is illustrated by the following Australian statistics:

- Around 3.7m Australians had a long-term cardiovascular disease (2011-12)
- There were 44,000 deaths attributed to CVD in Australia in 2012
- CVD was responsible for more deaths than any other disease group (30% of the total)
- CVD was the main cause for more than 520,000 hospitalisations in 2011-12
- CVD has the highest level of health-care expenditure of any disease group
- Days of reduced activity for people with CVD were 1.4 times the average Australian
- Lower rates of employment and absenteeism due to CVD in 2004 were estimated to cost the economy around $2.2bn.

Clinical recommendations that improve detection and underpin evidence-based medicine to reduce CVD events are a priority in Australia. Emerging evidence from comparative assessment programs in New Zealand and overseas will inform new clinical guideline recommendations.
New Zealand Primary Healthcare Organisations have achieved 86% assessment rates of the eligible population, drawing on clinical guidelines as the basis for detection and management of risk, compared to 25% in Australia. Without updated evidence-based guidelines, patient care could be compromised, leading to increased hospitalisations, and a reduced workforce.

The Heart and Stroke Foundations, together with the National Vascular Disease Prevention Alliance, recommend an investment of $800,000 to review the current guidelines for the management of absolute CVD disease risk, developed according to NHMRC requirements.

There is an opportunity for significant positive change with limited investment. New evidence-based recommendations with the updated guideline will:

- guide clinicians in evidence-based practice to prevent the onset of CVD
- equip clinicians with advanced risk assessment and management algorithms, supporting earlier detection and management of CVD risk
- reduce the cardiovascular disease burden on the Australian healthcare system.

An investment of $800,000 to fully update the clinical recommendations over two years will help to establish and maintain the new online resource ensuring that health professionals are able to maintain a commitment to continuous professional quality improvement. Uptake of the new guideline will be strengthened by the support of the Improvement Foundation (Australian Primary Care Collaboratives) and colleges of general practice to ensure wide communication and to encourage broad clinical involvement. A better quality workforce delivers better outcomes for patients, more efficient care and dramatically lower health costs.

### 3.3 Fund the FAST mass media campaign

| **Recommended action:** | Continue spreading the FAST stroke signs message to all Australians. Investment: $2m a year. |

Failure to act when stroke symptoms arise is the main factor behind stroke treatment delay, accounting for around 68% of the total delay in time to admission for ischaemic stroke. Many people in Australia are unable to act because they cannot recognise the symptoms. Additionally many people with transient signs of stroke (transient ischaemic attack or TIA) do not act as symptoms seemingly resolve themselves. And yet up to 20% of patients having a TIA go on to have a subsequent stroke within 90 days if early preventative treatment is not instituted.
Half of those who experience stroke symptoms delay calling an ambulance; many individuals hope symptoms will alleviate; or will elect to speak to friends, family or their GP.\textsuperscript{36}

As a result less than half of patients present to hospital in time for potentially life-saving care. Importantly only 7% of those with ischaemic stroke receive clot-busting treatment.\textsuperscript{37}

Since 2007, the National Stroke Foundation has been successful in raising awareness of the signs of stroke by promoting the FAST test through social marketing campaign activity. $2m in Australian Government funding supported national rollout of the FAST message in 2014.

The central feature of the campaign is mass media advertising using a pre-existing ‘Fire in the Brain’ television commercial and associated print, radio and online promotion.

The FAST test is an easy way to remember and recognise the signs of stroke. FAST stands for Face, Arms, Speech and Time to act. Using the FAST test involves asking these simple questions:

- **Face** – Check their face. Has their mouth drooped?
- **Arms** – Can they lift both arms?
- **Speech** – Is their speech slurred? Do they understand you?
- **Time** – Is critical.

If you see any of these signs call Triple Zero (000) straight away. Evaluation of the program demonstrates that FAST increases community awareness of stroke signs in all areas where it is delivered.

Robust evaluation of the federal government funded campaign in 2014 found that the FAST campaign resulted in:

- An increase in the number of respondents who can recall one or more signs of stroke unprompted to 87% nationally (from 84% in 2011)
- An increase in calls to ambulance for stroke by 6.7% across Australia (after adjusting for underlying trends)\textsuperscript{38}
- 76% said that they would call an ambulance if stroke was suspected.\textsuperscript{39}

Analysis also showed that campaign effect on calls to ambulance lasted for approximately three months beyond the campaign period.
There is a social and economic benefit to be derived from increased awareness of stroke signs. Better awareness means more people getting to hospital in time for life saving treatment and ultimately less death and disability from stroke.

An updated systematic review and meta-analysis published in The Lancet has found for every 1000 patients who receive thrombolysis treatment within three hours of stroke, about 100 more will survive, alive and independent, than for 1,000 patients not thrombolysed.\textsuperscript{40}

Even when the effects of tPA are excluded admission to a stroke unit within three hours after symptom onset resulted in better outcomes three months later than those admitted after the first six hours. For every 1,000 people being admitted early 60 people avoid death and dependency.\textsuperscript{41}

There are also cost savings that result from quicker access to stroke treatment.

Previous analysis nationwide has estimated increasing access to tPA from 3\% to 20\% within 4.5 hours among patients that have had an ischaemic stroke would mean 300 additional patients each year would leave hospital alive and independent.\textsuperscript{42}

It is important to note that Australian Government funding for FAST will deliver better health outcomes for stroke patients and ultimately a reduction in the economic cost of stroke, however it is unlikely to be sustained if funding is limited to one year. Ongoing funding is crucial to ensure that the benefit of this campaign activity is capitalised on. The investment will build on the successful 2014 national campaign and ensure that we maximise the likelihood of people getting to hospital early enough for time-critical treatment.

\section*{3.4 Fund ‘Will you recognise your heart attack?’ campaign}

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\textbf{Recommended action:} The Heart Foundation recommends that $3m a year be provided to support the \textit{Will you recognise your heart attack?} campaign. Investment: $3m a year over four years. \\
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The Heart Foundation’s ‘\textit{Will you recognise your heart attack?}’ campaign aims to reduce heart disease mortality and morbidity by reducing patient delay in responding to the warning signs of heart attack and calling Triple Zero (000).

The campaign, which includes TV, radio and digital advertising, educates Australians about the warning signs and gives them the facts and confidence to call Triple Zero (000) if they think they are having a heart attack.

This is needed because too many heart attack patients delay calling an ambulance. This happens because not enough Australians are armed with the facts about heart
attack - they do not understand the warning signs or know what to do if they have a heart attack.43

Patient delay is the major contributor to pre-hospital delay and access to definitive treatment.44 People wait an average of four hours before they act on their warning signs.45 More than half of all deaths from heart attack occur before patients reach hospital 46 and about 25% of those who have a heart attack die within one hour of their first ever symptom.47

Despite the many advances in clinical treatment of heart attack, good outcomes rely on a person receiving prompt medical treatment, preferably within 60 minutes of their first symptom.48 The longer a patient experiencing a heart attack waits before seeking help, the greater the risk of permanent damage to the heart, ongoing disability and even death. Often this results in longer hospitalisation, ongoing disability, re-hospitalisation, and eventual heart failure.

The Heart Foundation’s Will you recognise your heart attack? campaign reached more than 6.5 million Australians between 2009 and 2013. Through the Heart Foundation’s investment it has led to significant increases in public awareness of the warning signs of heart attack and people’s confidence and intention to call Triple Zero (000). Further, it is estimated that one-in-ten, or 500,000 people, who saw the campaign made a lifestyle or behaviour change like losing weight, increasing exercise or giving up smoking. Key findings from the campaign include:

- TV advertisements provided two in three people with new information on heart attacks
- 50% increase in awareness of atypical symptoms
- People who had seen the adds were substantially more confident in knowing what actions to take and to call 000 quickly

Also, from our Heart Attack Survivors Survey:

People who have had a heart attack and who had seen the advertisements had better knowledge of signs and symptoms, as well as what actions to take. They were also more likely to have stated they knew they were having a heart attack when experiencing signs or symptoms. Importantly, they were significantly more likely to act within 30 minutes of experiencing their first symptoms, while those who hadn’t come across the advertisements were significantly more likely to wait at least three hours.

But these and further gains will be at risk without government support.
4. Treat: Improving care and outcomes

Key points

4.1 Reporting of treatment times for heart attack and stroke
4.2 Fund 4,000 public access defibrillators in sport clubs, venues
4.3 National audit for cardiac rehabilitation services
4.4 New national support system for heart attack survivors
4.5 Fund a review of vital heart failure guidelines
4.6 New clinical guidelines for stroke management
4.7 National online resource to support health professional adherence to stroke guideline
4.8 Fund national rollout of StrokeConnect

4.1 Reporting of treatment times for heart attack and stroke

Recommended action: The Heart and Stroke Foundations call for cardiovascular data gaps to be identified and addressed, especially for treatment times (eg, time to treatment, referral and completion rates for cardiac rehabilitation/secondary prevention, access and enrolment to appropriate multidisciplinary heart failure programs). Gaps in current quality/performance indicators at the national, state and local level need to be identified and addressed. Investment: Low cost.

Fast treatment, either through thrombolysis (administration of clot-busting drugs) or angioplasty (the use of balloons and stents to open blocked arteries) is critical to achieving good outcomes for people suffering from heart attack. It can make the difference between life and death. Fast treatment can also reduce the amount of damage done to heart muscle, reducing the chances of a further heart attack.

Data collected in the UK on the time it takes to treat heart attack sufferers has helped drive significant cuts in treatment times, saving lives and improving life expectancy.

Despite the fact that cardiovascular disease is the nation’s leading killer, a major cause of disability and the most expensive disease group in terms of direct healthcare costs, there are major gaps in heart attack data collection in Australia, including:
• no national quality/performance indicator sets for heart attack and stroke, and
• no frameworks to improved treatment time.

There is much room for improvement. A study published in the Medical Journal of Australia in 2010 highlighted disturbing evidence that many people having heart attacks didn’t get the treatment they should have, or didn’t get access to treatment within the recommended time.

The study found that just over one in five patients were likely to have been eligible for heart attack treatment (reperfusion therapy) but failed to receive it.

Evidence suggests:
• only 23% of heart attack patients are getting timely access to treatment, despite time factors being essential in determining survival rates
• there is significant variation in the implementation guidelines for the management of patients with heart attack and angina
• recent NSW health data indicates that revascularisation rates can vary by up to 30% between area health care services with comparable numbers of catheterisation facilities
• there is well-documented under-use of key CVD medicines at discharge and at 12 months after discharge
• the Heart Foundation recommends that eligible heart attack patients are given thrombolysis within 30 minutes, if primary angioplasty is not available. However, in the first half of 2000, fewer than 80% of eligible patients were treated within one hour
• relatively few (estimated to be around 30% or less) of eligible Australian patients access cardiac rehabilitation programs.

The cost of treating and managing patients with heart attack and angina is enormous. The total cost to the economy has been estimated to be $17.9bn a year, with direct health care costs accounting for almost $2bn a year.

The Heart Foundation acknowledges and applauds the development of the recent Clinical Standard for Acute Coronary Syndromes under the auspices of the Australian Commission for Safety and Quality in Health Care.

This represents a major step forward in addressing variations in care. But investment is needed to support this. In particular, national CVD data sets are needed to highlight variations in care and drive improvement in quality care.

A comprehensive effort is needed to ensure critical CVD data is collected, analysed and published. The Australian Institute of Health and Welfare should be
commissioned to identify and prioritise missing CVD data gaps, in consultation with key stakeholders. These should include:

- Time from 'call' to 'treatment' through (i) thrombolysis and (ii) angioplasty/stent implantation
- Proportion of patients admitted to hospital with coronary heart disease who on discharge receive (i) appropriate medications and (ii) are referred to a cardiac rehabilitation/secondary prevention program
- The proportion of eligible patients who access and complete a cardiac rehabilitation program or who enrol in a secondary prevention program.

### 4.2 National defibrillator program for sports venues and clubs

**Recommended action:** The Australian Government should support a public access defibrillator program with funding provided on an application basis for purchase, installation, maintenance and training for 4,000 defibrillators in sports clubs and sporting venues over four years. Investment: $6.5m a year.

The Heart Foundation calls on the Australian Government to fund a national program to get 4,000 defibrillators into public places, particularly sporting venues and sports clubs, and support associated training programs, including school-based first aid courses.

In Australia, less than one-in-ten people who have a sudden cardiac arrest outside of a hospital survive. A cardiac arrest occurs when the normal rhythm of the heart is suddenly disrupted, drastically diminishing the heart's capability to pump blood around the body.

The good news is that early defibrillation (an electric shock to the heart) together with cardiopulmonary resuscitation (CPR) can be life-saving in the event of a sudden cardiac arrest. To have the absolute best chance of success, defibrillation must be carried out in the first few vital minutes after sudden cardiac arrest. Therefore, to ensure Australia achieves and maintains world’s best practice in this area, a program to have public access Automated External Defibrillators (AEDs) located in strategic positions across Australia along with trained people to use them is essential.

In 2005, the Howard Government funded a demonstration project - *HeartStart Australia* - to test the viability of a program to install defibrillators in public areas. St John Ambulance was engaged to design and implement the project between 2005 and 2007 at a cost of $870,000. The project was evaluated with a report completed in 2008. The report concluded that the demonstration project could be judged as:
• *Effective* in providing a capable response to sudden cardiac arrest in public areas and demonstrating that Australian organisations can accept AEDs as part of their Occupational Health and Safety responsibilities;

• *Appropriate* as a method for establishing PAD in Australia and demonstrating the value of AEDs, but was not necessarily seen as the most appropriate model of defibrillation in the long term; and

• *Efficient*, with the proportion of program administration costs at 10-15% well within acceptable benchmarks.

By 2008, *Project HeartStart* had already saved 14 lives with more anticipated lives to be saved over the life expectancy of the units. Some $1.2m had been invested into the project with 302 AEDs rolled out across the nation. More than 3,000 people were trained in basic life support and defibrillation, with the bonus of additional life-saving skills being made available throughout the community.

Venues for their placement included airports, railway stations, fitness centres, entertainment centres, council facilities, various recreational clubs, schools, pools, police departments, commonwealth departments, and shopping centres, snow resorts, sporting bodies, tourist attractions, casinos and rural and remote communities where medical response times may be delayed.

Ongoing support by the Australian Government was sought in 2008 and 2010 to continue the roll out of Public Access Defibrillation across Australia. But without support, the project momentum was lost and the project closed.

The provision of defibrillators in public places - a concept internationally known as ‘public access defibrillation’ - is now widespread in many places throughout the world including the United Kingdom, Europe, USA and in every state and territory in Australia. These devices are easy to use and are now regarded as part of basic CPR training. Evidence from a number of studies has clearly shown a greater chance of survival from cardiac arrest in places where defibrillators are publicly available.

**The late Professor Ian Jacobs, Australian Resuscitation Council Chairman, Media Statement, September 12, 2008**

In 2012, the Heart Foundation, in collaboration with the Australian Resuscitation Council and St John Ambulance Australia, updated the joint position statement: Early Access to Defibrillation.

The statement highlights the importance of making automated external defibrillator (AED) units widely available within the community for the prompt treatment of sudden cardiac arrest. It calls on governments to:
- Increase the number of automated external defibrillators (AEDs) that are accessible in places where large amounts of people frequent.

- Build community confidence in the use of AED through the implementation of community awareness campaigns.

- Mandate the registration of all private and publically accessible AEDs, at the time of purchase, with local emergency service providers such as the ambulance service and Triple Zero (000) call centres.

- Develop a minimum standard to regulate the deployment of AEDs within large workplaces (over 200 employees) and to train employees in both AED use and CPR.

A study published in the journal *Circulation* in 1998, found that public access defibrillators (PAD) may be economically attractive in the United States, where 360,000 Americans experienced sudden cardiac arrest each year. According to the authors; “Our analysis shows that implementation of PAD in an urban centre in the United States is potentially economically attractive. Furthermore, defibrillation of out of - hospital sudden cardiac arrest patients by lay or police responders may save the lives of thousands of Americans each year. These represent important potential public health benefits.”

In 2012, St John in Victoria provided 100 free defibrillators to sporting clubs throughout the state, based on need. This program was launched following a number of deaths of promising young sportsmen on Victorian sporting fields in the previous years. Over 900 clubs expressed interest in receiving the free defibrillators along with an online training package to train users in each club. Some of the clubs took advantage of a special pricing for defibrillators to ensure that their club was prepared if they needed it.

**4.3 National audit of cardiac rehabilitation services**

**Recommended action:** The Australian Government should fund an audit of cardiac rehabilitation referral and completion rates that will help to identify gaps and opportunities for improvement in existing services. Investment: $1m for audit.

People who have had a heart attack or who have heart failure should be referred to and complete a cardiac rehabilitation or heart failure program.

Unfortunately, this does not happen often enough, despite strong evidence showing these programs work.
Cardiac rehabilitation and heart failure programs are an essential but underutilised part of recovery from heart attack and/or management of heart disease. It is estimated that attendance rates for cardiac rehabilitation are as low as 11-31%.

Patients with heart disease benefit enormously from participation in these programs and without them they face a substantially higher risk of another heart attack and readmission to hospital.

Cardiac rehabilitation programs guide and support patients to help them recover from heart attack. They encourage lifestyle modification such as quitting smoking, address psychosocial risk factors including depression, and improve medication management and compliance.

Cardiac rehabilitation programs are traditionally centre-based and patients attend them six weeks after they are discharged from hospital. Programs run once a week for six weeks and are typically delivered in outpatient settings in hospitals or community health centres.

Lack of referral to cardiac rehabilitation programs means not enough people receive the support and care they need to return to full health. This means they are at a much greater risk of being readmitted to hospital for further medical treatment.

Data from the Australian Institute of Health and Welfare shows 55,000 Australians were admitted to hospital in 2009-10 because they had a heart attack. Hospital admissions for heart attack have grown by 64% since 1998-99.

Each hospital admission for heart attack costs around $25,000 per patient, including more than $18,000 in direct hospital costs. The total cost to the hospital system in Australia is $1.4bn a year.

A significant part of this cost could be avoided through better access to, and completion of, cardiac rehabilitation. This is because more than one-third (34%) of hospital admissions for heart attack are repeat events. Many patients are
readmitted to hospital who have not attended or completed cardiac rehabilitation. It means they miss out on the care they need after their heart attack to maximise their chance of avoiding a future cardiac event.

Disturbingly, studies show the biggest barrier to patients not attending or completing cardiac rehabilitation is lack of referral to a cardiac program. 61

Cardiac rehabilitation is cost-effective

Cardiac rehabilitation is highly cost-effective and this can be measured in terms of better health and cost savings to the health system.

One Victorian study showed a 35% increase in five-year survival rates among patients who attended cardiac rehabilitation.62 Other studies have shown better outcomes for physical activity, blood lipid levels, medication adherence, health care utilisation, social adjustment, smoking reduction and reduced risk of a cardiac event reoccurring.63

A 2013 report by the UK’s National Health Service Improvement agency found that reaching a 65% uptake target of cardiac rehabilitation by eligible patients would result in a 30% reduction in unplanned cardiac readmissions equating to savings of £30.6m a year (A$5m).64

Whether the measure is health or economics, evidence clearly shows cardiac rehabilitation is essential for better outcomes for patients and taxpayers.

4.4 New national support system for heart attack survivors

| Recommended action: Invest in the Heart Foundation’s HEART FOR LIFE national support system for heart attack survivors. Investment: $500,000. |

More people are surviving heart attacks, but the impact is life changing. Heart Foundation assessment has identified that survivors are not receiving adequate support to make sense of their diagnosis and understand how to actively manage their condition long-term to minimise future impact.

Only 27% of survivors receive optimal post-heart attack care (lifestyle advice, cardiac rehabilitation referral and evidence-based medications).

Survivors are four times more likely to report poor health and most will have poorer quality of life and risk further heart attacks or hospital admissions without ongoing support.

Our heart attack survivor research shows:

- less than 1-in-3 understand their condition
many receive insufficient advice about key treatment and recovery matters eg, medication (40%), lifestyle changes (51%), future heart attack risk (62%)

- 2-in-3 not advised to attend cardiac rehabilitation
- 1-in-4 suffer depression
- 1-in-3 stop taking medications
- 1-in-4 unable to return to work
- 1-in-4 unable to resume simple daily activities (driving; housework; shopping) at their pre-heart attack level.

The Heart Foundation wants to fill this gap by providing a tailored ‘one-stop-shop’ of evidence-based information and tools during their recovery and life-after-heart-attack journey that complements health professional advice. A HEART FOR LIFE will provide an integrated support system with several access mechanisms - online platform, call centre, online chat with experts, hard copy resources, and peer support. This will empower survivors, provide reassurance and connect them to services and people going through similar experiences.

4.5 Fund a review of vital heart failure guidelines

**Recommended action:** Fully update the clinical recommendations in the prevention, detection and management of chronic heart failure, submit for inclusion on the NHMRC work plan and work through the processes for NHMRC approval.

Investment: $600,000.

Joint National Heart Foundation/Cardiac Society of Australia and New Zealand clinical guidelines for Chronic Heart Failure (2011) support clinicians to deliver best-practice care for Australians living with chronic heart failure. The guidelines require an update in response to emerging evidence on new therapies.

Widely considered the ‘epidemic of cardiology’, chronic heart failure remains a major public health issue with discordant management, recurrent hospital admission and disconnected care. Prevalence of this debilitating condition is high (rates of over 23% in those aged over 65 years) and among the most common reasons for GP consultation.

Heart failure is a pressing problem:

- chronic heart failure affects 2–3% of the population, with rates steeply increasing.66
• 30,000 Australians being diagnosed with heart failure each year (AIHW Cat no. AUS-34)

• 300,000 Australians are living with heart failure and oedema (AIHW Cat no. AUS 34).

• Heart failure is 1.7 times more common among Aboriginal and Torres Strait Islander people than other Australians, and occurs at a younger age.\textsuperscript{66}

• More than 45,000 Australians were hospitalised due to chronic heart failure in 2009–2010, equating to over 360,000 bed days.\textsuperscript{67}

• Readmission rates range between 13 to 33 per cent in all cause 30 day readmission rates for primary index admission of heart failure.\textsuperscript{4}

• Heart failure consumes $1000 million of the national healthcare budget, with two thirds of this amount on hospital services (AIHW Cat no. HWE 11).

Updated Heart Foundation guidelines will synthesise emerging evidence into clinical recommendations to guide clinicians in earlier case detection and improved management of heart failure patients, helping them to remain out of hospital for longer.

The Heart Foundation offers a suite of supporting resources designed to guide systems of care to underpin adherence to the new guideline. A national policy framework identifies principles and actions underpinning a systematic approach to heart failure care operating across state and territory jurisdictions that will lead to improved health outcomes; specifically event-free survival (a composite of the number of emergency presentations, hospitalisations and premature deaths).

There is an opportunity for significant positive change with limited investment. New evidence-based recommendations with the updated guideline will:

• guide clinicians in evidence-based medicine prevent the onset of heart failure

• equip clinicians with advanced diagnostic treatment algorithms, supporting earlier detection and management of patients diagnosed with heart failure

• prevent simple hospital admissions for chronic heart failure (diagnostic-related group 62B) costing approximately $3,440 each, and more complex admissions (diagnostic-related group 62A) costing $7,260. Based on these figures, a reduction in the estimated 2,000 readmissions could result in savings off the annual cost of hospital stays that currently ranges between $6.8m to $14.5m

• contribute to improved clinical data that will assist in local interrogation to understand the causes of variation in performance or determine acceptable levels for best practice.\textsuperscript{68}
An investment of $600,000 to fully update the clinical recommendations over two years will help to establish and maintain the new online resource ensuring that health professionals are able to maintain a commitment to continuous professional quality improvement. Uptake of the new guideline will be strengthened by the support of existing state-based cardiac clinical networks to ensure wide communication and to encourage broad clinical involvement. A better quality workforce delivers better outcomes for patients, more efficient care and dramatically lower health costs.

4.6 New clinical guidelines for stroke management

**Recommended action:** Review current stroke clinical guideline recommendations, submit for inclusion on the NHMRC work plan and work through the processes for NHMRC approval. Investment: $600,000.

The NHMRC approved Clinical Guidelines for Stroke Management, released in 2010, support Australian stroke clinicians to deliver best-practice stroke care. However they are urgently due to be updated to reflect emerging evidence in a number of areas including:

- the use of thrombolysis,
- management of transient ischaemic attacks,
- blood pressure management in acute stroke, and
- surgery for acute stroke.

This is leading to considerable debate about appropriate care, and in some instances, patients are missing out on new cost-effective care they should be receiving.

Development of new stroke clinical guidelines is required to provide certainty and support for stroke clinicians to deliver current evidence-based stroke care for Australian patients.

Without an update patient care in Australian hospitals will be compromised, more cost effective interventions may be overlooked and there is a very real increased risk of adverse stroke outcomes.
4.7 National online resource to support health professional adherence to stroke guidelines

**Recommended action** Establish and maintain an online professional development resource to improve health professional adherence to stroke guidelines and standards. Investment of $3.2m over four years.

National stroke audit data shows that care being provided to Australian patients does not meet Australian government approved guidelines.

For example:

- 42% of patients are being treated outside a stroke unit leading to 700 cases of unnecessary death and disability each year - this is despite 90% attending a hospital with a stroke unit
- 31% of stroke unit beds are occupied by non-stroke patients, denying care to stroke patients and leading to inefficiencies in hospital resource use
- Only 7% of patients receive potentially life-saving thrombolysis treatment
- 1/3 of hospitals are not providing routine assessments for the need for further rehabilitation
- 40% of hospitals are not routinely providing discharge care plans
- 70% of hospitals don't have protocols to review stroke patients after discharge. 69 70

A new online resource is being developed to support stroke health professionals to increase adherence to current stroke guidelines and improve patient outcomes. The interactive website will include access to the latest stroke guidelines and evidence, training modules to support upskilling as well as personalised data relevant to the health professional’s workplace.

An investment of $3.2m over four years will help to establish and maintain the new online resource ensuring that health professionals are able to maintain a commitment to continuous professional quality improvement. The resources will make use of existing state-based infrastructure including state stroke clinical networks to ensure wide communication and to encourage broad clinical involvement. A better quality workforce delivers better outcomes for patients, more efficient care and dramatically lower health costs.
4.8 Fund national rollout of StrokeConnect

**Recommended action:** Support the StrokeConnect program to guarantee a phone call to every Australian stroke survivor discharged home from hospital (estimated at 25,000 per year) to link them up with appropriate services. Investment of $3.5m per year.

Stroke survivors often speak of falling into a ‘black hole’ once they are discharged from hospital without the support of follow-up in the community.

The often profound and prolonged brain injury that results from stroke can severely impact a survivor’s ability to navigate an often complex health and welfare system in order to access the support and services they need to aid their recovery.

This is made worse by inconsistent delivery of support from the hospital system prior to discharge and in discharge planning.

There is no comprehensive program in Australia to ensure that survivors of stroke are followed up by liaison workers or community nurses as is the case with other disease groups. This means that those who live in need and are unable to actively seek support are often left to suffer in silence. They are not supported to recover quickly from their stroke and instead live with disability and other needs that impact on their ability to actively participate in society.

Fully funded the StrokeConnect program would provide a phone call to every stroke survivor in the period following discharge from hospital to home linking survivors with available services in the community appropriate to their needs.

The National Stroke Foundation has been piloting and developing the StrokeConnect model of care in response to survivor needs since 2008. It has been operating in Queensland with state government support since 2011. StrokeConnect is well placed to operate with the new Primary Healthcare Networks currently in development.

Evaluation of the pilot program and the Queensland model has demonstrated improved coordination of care, increased participation in relevant programs and improved health related quality of life, mood and participation in community activities.

Investment of $3.5m per year in the StrokeConnect program will guarantee a phone call to every Australian stroke survivor discharged home from hospital (estimated at 25,000 per year) to link them up with appropriate services. Deloitte Access Economics estimates for this investment StrokeConnect would result in nearly 1,300 survivors regaining their functional independence contributing to a cost savings of over $30m per year and lessening the demand for aged care and other related services.  

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