AUSTRALIAN CHRONIC DISEASE PREVENTION ALLIANCE

Response to National Preventive Health Strategy

Final response 19 April 2021

Questions 1 – 3: Personal and organisation details

Note – each question asks us to select from the following:

- *Strongly Agree*
- *Agree*
- *No opinion*
- *Disagree*
- *Strongly disagree*

VISION

4. Do you agree with the vision of the Strategy? Please explain your selection. (1000 word limit) p8

Strongly Agree | Agree | No opinion | Disagree | Strongly Disagree

We strongly support early intervention, targeting risk factors and better information at all stages of life. This should encompass risk assessment and early detection of disease, so people can understand and be supported to manage their risk at all stages of life to prevent disease and improve outcomes.

We strongly support addressing the broader causes of poor health and wellbeing, including social determinants that require action from sectors beyond health.

AIMS

5. Do you agree with the aims and their associated targets for the Strategy? Please explain your selection. (1000 word limit) (p8)

Strongly Agree | Agree | No opinion | Disagree | Strongly Disagree

We agree with the aims and strongly support the inclusion of targets for each aim in the strategy.

We recommend that the subsequent Blueprint for Action include more detail around achieving SMART targets – specific, measurable, achievable, relevant, time-bound.

Aim 1 – Australians have the best start in life

We support the explicit inclusion of 'improving the prevention of risk factors for chronic conditions … in childhood to create strong foundations.'

Aim 2 – Australians live as long as possible in good health

We recognise the value of prevention and health promotion to keep people well longer. Risk assessment and early detection is especially important as people age to halt or slow disease progression, prevent avoidable complications, and enable treatment at an earlier stage of disease for better outcomes.

A focus on health checks for Australians aged 45+ years (similar to the target for Indigenous-specific general practitioner health checks in Aim 3) could strengthen Aim 2.

Aim 3 – Health equity for target populations

We support the focus on health equity and specific targets to address priority populations. We would support a target for increased years of healthy life for Aboriginal and Torres Strait Islander populations, alongside the target relating to Indigenous-specific general practitioner health checks.

There is an unacceptable life expectancy gap between Aboriginal and Torres Strait Islander peoples and other Australians. We recognise that chronic conditions contribute to 80 percent of the mortality gap

between Indigenous and non-Indigenous Australians. The Indigenous-specific general practitioner health checks provide an opportunity to assess risk factors, support people to understand and manage their risk of disease and detect silent conditions early for better outcomes.

The impact of chronic conditions also needs to be better addressed in the strategy to address the existing health inequities related to heart disease, diabetes, stroke, kidney disease and cancer for Aboriginal and Torres Strait Islander peoples, people from rural and remote areas, and people from lower socioeconomic areas.

Aim 4 – Investment in prevention is increased

We strongly support increased investment in prevention and we strongly support the target to increase investment to 5 percent of national health expenditure by 2030. This aligns with the Western Australian Government commitment, and we would support commitments from other States and Territories to align with this target. Regular milestone reporting on the progress from the existing investment towards the 5 percent target will be essential, along with transparency on how this increased investment is being allocated to the focus areas. Investment in programs and initiatives aimed at addressing the risk factors for preventable chronic diseases will be critical.

Evidence shows spending on prevention would save lives, improve population health, and create economic and health returns on investment.[1] In Australia, there is a $14 return on investment for every dollar spent on public health interventions.[2]

We note there are opportunities to create investment in prevention through regulatory approaches including a sugary drinks levy (estimated $400m per year in revenue)[3] or a volumetric tax for all alcoholic drinks (estimated $2.7b per year in revenue).[4] For example, the UK Government has committed to a sugary drinks levy and allocated revenue to tackle childhood obesity. While these regulatory approaches are identified in the text, the prevention strategy would be strengthened through including taxation measures as policy achievements by 2030 with the dual purpose of raising revenue for prevention and improving health.

PRINCIPLES

6. Do you agree with the principles? Please explain your selection. (1000 word limit) (p8)

Strongly Agree | **Agree** | No opinion | Disagree | Strongly Disagree

We broadly support the principles with some specific comments below.

Principle 1 - Multi-sector collaboration

We welcome the emphasis on multi-sector engagement, which acknowledges responsibilities beyond the health sector. This is important to instil ownership, accountability, and action from other sectors. Health is a fundamental human right, and it should be integrated into all policies across sectors.

This principle should also reflect engagement across levels of government.

Australia's response to the COVID-19 pandemic has demonstrated the value of a collaborative approach and there is an opportunity to apply these lessons to preventive health more broadly.

Principle 2 – Enabling the workforce

The current health system is set up to prioritise treatment of existing conditions rather than promoting prevention, risk assessment and early detection. This principle should also recognise the levers required to enable the workforce, including funding, technology, and infrastructure to reorient the health system towards prevention.

Principle 3 – Community engagement

This principle could be strengthened by explicitly highlighting the importance of consumer engagement and the value of input informed by lived experience.

---

[1] World Health Organization 2018. Saving lives, spending less: a strategic response to noncommunicable diseases.
[2] Masters R et al. Return on investment of public health interventions: a systematic review. Journal of Epidemiology and Community Health. 2017; 71:827-834.
[3] Veerman JL et al. The Impact of a Tax on Sugar-Sweetened Beverages on Health and Health Care Costs: A Modelling Study. PLoS ONE. 2016; 11:e0151460
[4] Robinson E et al. Increasing the Price of Alcohol as an Obesity Prevention Measure: The Potential Cost-Effectiveness of Introducing a Uniform Volumetric Tax and a Minimum Floor Price on Alcohol in Australia. Nutrients. 2020; 12:603.

Principle 4 - Empowering and supporting Australians

Recommendation – Change to "Healthier environments that empower and support Australians"

We note that environmental factors have been diluted from the previous version, which included the environment as a key principle. The strategy should prioritise environments that support health and empower individuals, shifting the focus away from individual responsibility for health behaviours to a broader context that recognises the influence of environmental factors.

These environmental factors include an increased availability, affordability, and marketing of energy-dense foods, as well as a built environment that is designed to encourage more sedentary behaviour.

Principle 6 – The equity lens

We support the addition of the equity lens to ensure progress benefits those with the greatest need and does not exacerbate existing inequalities. The equity lens should be extended beyond access to healthcare to also focus on equitable access to environments that promote and support health, and equitable access to information, health promotion and prevention.

ENABLERS

7. Do you agree with the enablers? Please explain your selection. (1000 word limit) (pp32-42)

Strongly Agree | **Agree** | No opinion | Disagree | Strongly Disagree

We broadly support the enablers with some specific comments below.

The role of regulation in prevention is not adequately addressed in the draft strategy, despite being recommended as an important enabler by the World Health Organization Best Buys[5] and Australian modelling.[6] The importance of regulation to counter industry influence is demonstrated in Australia's success in tobacco control and we would support the inclusion of regulatory approaches to address commercial determinants of health and create healthier environments.

Enabler 1 – Leadership, governance and funding

We support this enabler and its positioning as a priority enabler. We strongly support the policy achievements, including sustainable funding through an ongoing, long-term prevention fund; a national, independent governance mechanism to guide preventive health priorities and funding; and a health lens applied to policy decisions with partnerships across sectors and levels of government.

These elements are key to enabling system-wide change and require resourcing, sustained funding, and evidence-based guidance to prioritise prevention.

Enabler 2 – Prevention in the health system

We strongly support this enabler and its positioning as a priority enabler.

We strongly support the explicit recognition of risk assessment and early detection as a core part of embedding prevention in the health system – including system enablers. These enablers are important for primary prevention, as well as assisting people with a chronic disease to manage their condition in the community, prevent complications and reduce avoidable hospitalisations.

Health professionals should be supported to assess and clearly communicate patients' risk of disease. This includes development and promotion of risk assessment tools and strategies, adequate training for health professionals, and ensuring strong referral pathways to support behavioural risk management programs including weight management, nutrition, and physical activity services.

Voluntary patient enrolment and social prescribing could strengthen relationships between patients, health providers and community services to support behavioural changes and improve health outcomes.

Enabler 3 – Partnerships and community engagement

We support the strategy's recognition of community and consumer engagement to ensure meaningful opportunities for people with lived experience to contribute to policy making and programs.

---

[5] World Health Organization 2018. Saving lives, spending less: a strategic response to noncommunicable diseases.
[6] Assessing Cost-effectiveness in prevention. ACE-Prevention. 2010.
Assessing Cost-Effectiveness of Obesity Prevention Policies in Australia. ACE-Obesity Policy. 2018.

We also support the explicit recognition of vested interests by the food and alcohol industry in health policy and we recommend the Government develop guidelines to set clear expectations and boundaries around engagement with unhealthy industries. Commercial determinants of health are a contributing factor to chronic disease and the food and alcohol industries have a clear conflict of interest when participating in health policy development. We strongly support protecting public health policymaking from conflicts of interest, including through transparent engagement processes, conflict of interest registers and limiting unhealthy industry engagement in policymaking to implementation.

8. Do you agree with the policy achievements for the enablers? (1000 word limit) (pp32-42)

Strongly Agree | **Agree** | No opinion | Disagree | Strongly Disagree

We broadly support the policy achievements for the enablers and have included comments in question 7.

FOCUS AREAS

9. Do you agree with the seven focus areas? Please explain your selection. (1000 word limit) (pp43-65)

Strongly Agree | Agree | No opinion | **Disagree** | Strongly Disagree

We broadly support the existing focus areas, including priority actions to address leading causes of chronic disease – tobacco, unhealthy diet, physical inactivity, alcohol, and mental ill health. We strongly support the focus area on cancer screening and prevention, which recognises the benefits of early detection to improve treatment options and outcomes and seeks to enhance the efficacy and evidence base for screening programs.

However, this section of the strategy needs to address the enormous burden of chronic disease beyond cancer. This includes major causes of death and disability, such as heart disease, diabetes, stroke, kidney disease, dementia, and lung conditions.

The strategy highlights secondary prevention as a form of prevention and demonstrates the benefits of secondary prevention in cancer screening, yet there is a gap for other chronic diseases and biomedical risk factors that can be effectively assessed, detected, and managed in primary care.

The Minister for Health made a public commitment to include cancer and chronic disease screening as a key element of the strategy. While the draft strategy includes cancer screening and prevention as a focus area, it omits risk assessment and early detection of other chronic conditions.

Recommendation - Include "Increasing chronic disease risk assessment and early detection" as a focus area to complement the existing section on cancer screening and prevention. This should highlight actions to assess and manage risk of heart disease, stroke, type 2 diabetes, and chronic kidney disease, including mass media awareness campaigns, enabling the health workforce to provide risk assessments and support people to manage risk, and building the evidence base through research, data, and evaluation.

Recommendation – Include high blood pressure, high cholesterol, and high blood glucose as modifiable and treatable risk factors. These risk factors are not addressed in the strategy, despite contributing to greater disease burden than other risk factors and having effective management options.

Chronic diseases are the leading cause of death and disability in Australia, yet much disease burden could be prevented.

Around 2.5 million Australians are living with high risk of cardiovascular disease and around 2 million Australians are living with pre-diabetes. There are also 1.5 million Australians who are unaware they are living with signs of kidney disease[7] and around 500,000 people with silent undiagnosed type 2 diabetes.

Chronic kidney disease, diabetes and cardiovascular disease affect 29 percent of Australian adults and frequently occur together.[8] One in three hospitalisations involve diabetes, cardiovascular disease and/or chronic kidney disease. People with diabetes are two to four times more likely to develop heart disease[9]

[7] ABS. Australian Health Survey 2012
[8] White SL. Chronic Kidney Disease, Diabetes & Cardiovascular Disease: Evidence Report 2021. Kidney Health Australia, Melbourne, Australia, March 2021.
[9] Haffner, S., Lehto, S., et al (1998). Mortality from Coronary Heart Disease in Subjects with Type 2 Diabetes and in Nondiabetic Subjects with and without Prior Myocardial Infarction. *New England Journal of Medicine*, 339(4), pp.229-234.

and heart disease is responsible for nearly one-third of all deaths in people with diabetes.[10] Meanwhile, cardiovascular mortality is around 60 percent higher in people with chronic kidney disease compared to those without chronic kidney disease.[11]

There is huge potential to reduce cardiovascular disease (CVD), diabetes, and kidney disease across the population, minimising suffering, and healthcare costs. An estimated 80 percent of CVD events are preventable by intervening to reduce risk.[12,13] Yet, only 24 percent of Australians at high risk of a first-time CVD event are receiving basic best-practice preventive therapies.[14]

There is good evidence to support risk assessment, management of risk and early detection for CVD, kidney disease and type 2 diabetes – especially for people at high risk.

Absolute CVD risk assessment estimates the cumulative risk of multiple, and sometimes synergistic risk factors, to predict a heart attack or stroke event in the next 5 years. There are validated algorithms for identifying people at risk. The Framingham risk equation (currently recommended in Australia) uses information from multiple risk factors including age, sex, smoking, cholesterol, blood pressure and diabetes to provide an estimate of the likelihood of developing CVD over the next 5-years.[15] The Framingham risk equation has been validated in multiple different populations, including Australia using the AusDiab study.[16] Risk equations can be easily statistically updated over time to account for changes in CVD event rates and risk factor distributions.

Despite several policy advances in primary care, the clinical assessment and management of CVD remains sub-optimal. One in three Australians eligible for CVD risk assessment do not have up-to-date blood pressure and cholesterol measurements recorded.[17]

Preventive treatments are cost-effective and safe. Lipid- and blood pressure-lowering therapies were listed as one of five cost-effective interventions for preventing chronic disease in the population in both the Australian Assessing Cost-Effectiveness in Prevention (ACE-Prevention) study[18] and the World Health Organisation "Best Buy" interventions.[19] Lipid- and blood pressure-lowering therapies are recommended for people at high risk of a CVD event. Evidence from large-scale randomised trials show that lipid- and blood pressure-lowering therapies lower the risk of CVD events and all-cause mortality.[20,21]

Modelling shows that we could prevent 1,217 strokes in a year if the rate of uncontrolled hypertension in Australia was reduced from the current rate of 23 percent to the target rate of 17 percent.[22] In addition, over five years there would be around 386 fewer deaths attributable to stroke and potential savings of around $1.3 billion over five years.

---

[10] Harding, J., Shaw, J., et al. (2016). Age-Specific Trends From 2000–2011 in All-Cause and Cause-Specific Mortality in Type 1 and Type 2 Diabetes: A Cohort Study of More Than One Million People. Diabetes Care, 39(6), pp.1018-1026.
[11] Di Angelantonio, E., et al., Renal function and risk of coronary heart disease in general populations: new prospective study and systematic review. PLoS Med, 2007. 4(9): p. e270.
Perkovic, V., et al., The relationship between proteinuria and coronary risk: a systematic review and meta-analysis. PLoS Med, 2008. 5(10): p. e207
[12] Chiuve SE, Fung TT, et al. Adherence to a low-risk, healthy lifestyle and risk of sudden cardiac death among women. JAMA. 2011;306(1):62-9. PubMed PMID: PMC3210472.
[13] Chiuve SE, McCullough ML, et al. Healthy lifestyle factors in the primary prevention of coronary heart disease among men: benefits among users and nonusers of lipid-lowering and antihypertensive medications. Circ. 2006 Jul 11;114(2):160-7. PubMed PMID: 16818808. Epub 2006/07/05.
[14] Banks E, Crouch SR, et al. Absolute risk of cardiovascular disease events, and blood pressure- and lipid-lowering therapy in Australia. MJA. 2016 May 02;204(8):320. PubMed PMID: 27125809. Epub 2016/04/30.
[15] D'Agostino RB, Sr., Vasan RS, et al. General cardiovascular risk profile for use in primary care: the Framingham Heart Study. Circulation. 2008 Feb 12;117(6):743-53. PubMed PMID: 18212285. Epub 2008/01/24.

[17] Knight, J & Raffoul, N. 'Cardiovascular disease risk assessment in the Australian primary care setting'. GP20 conference presentation, Nov 2020
[18] Vos T, Carter R, et al. Assessing cost-effectiveness in prevention: ACE–prevention September 2010 final report: University of Queensland; 2010.
[19] World Health Organisation. From Burden to "Best Buys": Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries 2011.
[20] Ettehad D, Emdin CA, Kiran A, Anderson SG, Callender T, Emberson J, et al. Blood pressure lowering for prevention of cardiovascular disease and death: a systematic review and meta-analysis. The Lancet. 2016;387(10022):957-67.
[21] Collins R, Reith C, Emberson J, Armitage J, Baigent C, Blackwell L, et al. Interpretation of the evidence for the efficacy and safety of statin therapy. The Lancet. 2016;388(10059):2532-61.
[22] Deloitte Access Economics. 2020. The economic impact of stroke in Australia, 2020.

Treating CVD can also help tackle other chronic diseases such as chronic kidney disease, diabetes, and dementia, which share many of the same risk factors.

Systems to support follow-up and recall of patients can be implemented within existing primary care frameworks. There is evidence that multifaceted prevention programs that pair absolute CVD risk assessment with patient education and appropriate follow-up are effective in reducing CVD events. For example, a Canadian program that involved absolute CVD risk assessment and patient education within pharmacies followed by recall by GPs resulted in a 9 percent reduction in hospital admissions for acute myocardial infarction, stroke and congestive heart failure over a one year period.[23]

Modelling from the UK suggests that even a small one percent reduction in CVD events or a 5 percent decrease in blood pressure and cholesterol across the population due to population-wide CVD prevention measures could save around £30 million per year (AUD $54 million/year) and improve overall health.[24] Modelling to identify the best approaches to optimise CVD prevention specific for Australia are needed and could be identified as research priorities in the strategy. In the meantime, encouraging systematic CVD risk assessment, management and follow-up is possible within the current primary care environment.

Early detection of kidney disease and pre-diabetes is important to halt or slow progression and prevent avoidable complications. There are 4,400 diabetes-related amputations each year,[25] 300,000 Australians living with some degree of diabetic retinopathy[26] and around 360,000 people with diabetes who are also living with kidney disease.[27] Early detection is crucial to enable earlier treatment and better outcomes. The number of Australians living with type 2 diabetes has climbed from just over 430,000 in 2001[28] to nearly 1.2 million in 2020.[29]

10. Do you agree with the targets for the focus areas? (1000 word limit) (pp43-65)

Strongly Agree | Agree | No opinion | **Disagree** | Strongly Disagree

While we broadly support the targets for the existing focus areas, the strategy would be strengthened through including targets on risk assessment and early detection for chronic conditions, including heart disease, type 2 diabetes, chronic kidney disease, and stroke.

Recommendation - Include specific targets to increase risk assessment and early detection of chronic diseases. Targets could identify the proportion of the eligible Australian population meeting the RACGP Red Book Guidelines for risk assessment and early detection of chronic conditions, through absolute CVD risk assessment, screening for pre-diabetes and kidney disease, and regular blood pressure and cholesterol checks. For example, all people at high risk of kidney disease should have a kidney health check every 1-2 years, comprising eGFR, urine albumin creatinine ratio, and blood pressure check.[30]

The Mitchell Institute report on absolute CVD risk assessment recommended that the Australian Government establish a target of 90 percent of people aged 45-74-years (from 35 years for Aboriginal and Torres Strait Islander people) receiving an absolute CVD risk assessment within five years, in line with guidelines.[31] This target was determined to be feasible, based on the New Zealand 'More Heart and Diabetes Checks' program, which delivered heart and diabetes checks for 90 percent of the target population in New Zealand.[32]

---

[23] Kaczorowski J, Chambers LW, et al. Improving cardiovascular health at population level: 39 community cluster randomised trial of Cardiovascular Health Awareness Program (CHAP). BMJ. 2011;342:d442.
[24] Barton P, Andronis L et al. Effectiveness and cost effectiveness of cardiovascular disease prevention in whole populations: modelling study. BMJ. 2011;343:d4044.
[25] Australian Commission on Safety and Quality in Health Care, (2016). Australian Atlas of Healthcare Variation. [online] Australian Government. Available at: http://www.safetyandquality.gov.au/atlas/ [Accessed 29 Jun. 2016].
[26] Dirani M. Out of sight (2013): A report into diabetic eye disease in Australia. Melbourne: Baker IDI Heart and Diabetes Institute and Centre for Eye Research Australia.
[27] Calculations based on: Australian Institute of Health and Welfare 2014. Cardiovascular disease, diabetes and chronic kidney disease— Australian facts: Prevalence and incidence. Cardiovascular, diabetes and chronic kidney disease series no. 2. Cat. no. CDK 2. Canberra: AIHW
[28] ABS. Australian Social Trends, December 2007. Cat. no. 4102.0. Canberra, 2007. http://www.ausstats.abs.gov.au/.
[29] https://www.ndss.com.au/wp-content/uploads/snapshots/2020/ndss-data-snapshot-202006-type2-diabetes.pdf
[30] Chronic Kidney Disease Management in Primary Care (4th edition). Kidney Health Australia, Melbourne, 2020
[31] Dunbar JA et al. Heart Health: the first step to getting Australia's health on track. Australian Health Policy Collaboration: Melbourne, Victoria University, October 2017.
[32] Allen & Clarke. More Heart and Diabetes Checks Evaluation. Final report. 2016.

There is currently no national, linked dataset available to track CVD risk screening in Australia. This makes it difficult to establish a baseline and set clinical practice targets. Lessons learnt from successful international primary CVD risk screening campaigns show that setting national (and localised) screening targets helps drive uptake of CVD assessments. This was one of the many enablers that supported uptake of CVD and diabetes risk screening in the New Zealand 'More Heart and Diabetes Checks' program.

11. Do you agree with the policy achievements for the focus areas? (1000 word limit) (pp43-65)

Strongly Agree | Agree | No opinion | **Disagree** | Strongly Disagree

While we broadly support the policy achievements for the existing focus areas, the strategy needs to include policy achievements to address the enormous burden of chronic disease.

The policy achievements identified in the cancer focus area are relevant and applicable to chronic disease – including mass media awareness campaigns, enabling the health workforce, and building the evidence base. All these areas are crucial and require government funding to build a systems approach to support chronic disease risk assessment, management of risk and early detection, and reduce the impact of preventable chronic diseases.

Recommendation - Include specific policy achievements to increase risk assessment, management of risk and early detection of chronic diseases by 2030, including:

- Mass media campaigns are used to increase community awareness, uptake of risk assessment and ongoing management of risk.
- Health care providers are supported and engaged to encourage and support people to assess and manage chronic disease risk.
- An increased focus on Aboriginal and Torres Strait Islander people, low socioeconomic, CALD, and rural and remote populations through targeted, localised and culturally appropriate engagement.
- Interventions focused on increasing chronic disease risk assessment and early detection are developed based on evidence built through research, data, and evaluation.
- Engagement strategies are informed by existing and new data to drive behavioural change and support chronic disease risk assessment and ongoing management of risk.
- The quality and analysis of national data is improved, leading to improved services and higher rates of risk assessment.
- The evidence base supporting new risk assessment (screening) programs is developed further, enabling safe and cost-effective approaches to be considered by the Government.
- Education and health promotion initiatives are delivered to raise awareness of the modifiable risk factors that lead to preventable chronic diseases.

There are existing risk assessment programs that could be scaled-up for greater impact. For example, the 'My Health for Life program' in Queensland is a Government-funded behaviour modification program for people at high-risk of developing a chronic disease.[33] To date, 16,658 people have enrolled in the program, 10,620 participants have completed the program, and over 210,000 chronic disease risk assessments have been undertaken. At the completion of the program, 70 percent of participants had reduced their waist circumference, and 49 percent met Australian physical activity guidelines. Six months after completion of the program, 48 percent of participants had further decreased their waist circumference, and 83 percent of participants met Australian physical activity guidelines. The ability of the strategy to learn from, and build on, initiatives such as this, will be critical to its success.

Comments on other focus areas:

Focus area – Improving access to and the consumption of a healthy diet

We support the strategy's dual focus on reducing the consumption of unhealthy foods and improving the consumption of healthy diets. We recognise the impact of unhealthy foods and drinks on increased risk of overweight and obesity, and chronic conditions.

[33] https://www.myhealthforlife.com.au/

This section could be strengthened by including additional policy achievements and regulatory approaches to improve the food environment and address commercial determinants of health. We recommend:

- The Health Star Rating system has been mandated to facilitate healthier food choices.
- Children's exposure to unhealthy food and drink marketing is restricted through government regulation. Regulations should apply to all media and forms of marketing to which children are exposed.
- A 20 percent health levy on sugary drinks has been introduced. Sugary drinks increase risk of overweight and obesity and have also been linked to elevated risk of chronic kidney disease.[34]

Focus area – Increasing physical activity
We support the strategy's dual focus on reducing sedentary behaviour and increasing physical activity. We welcome the focus on creating environments that encourage movement and enable people to be physically active. We recommend strengthening the policy achievement around mass media campaigns to include investment in evidence-based physical activity campaigns to support behaviour changes, with targeted approaches for high-risk populations.

Focus area – Reducing alcohol and other drug harm
We support this focus area and suggest this section could be strengthened by including regulatory approaches to pricing to reflect the societal cost of alcohol. Taxation reforms and regulation have been identified in the National Alcohol Strategy and should be included in the policy. We recommend including: Increasing the price of alcohol through volumetric taxation on all alcoholic products and introducing a minimum floor price for alcohol. A volumetric tax could raise an estimated $2.7 billion per year and establish an economic incentive to reduce alcohol consumption.[35]

Focus area – Protecting mental health
We support this focus area and suggest this section could be strengthened by including policy achievements that support an integrated approach to physical and mental health, based on the interaction between chronic conditions and mental ill health. Eighty percent of people with mental illness also have a serious physical health condition, which is often not diagnosed or treated.[36] Over 10,000 people with mental illness die prematurely from chronic diseases each year,[37] and chronic diseases cause 10 times more premature deaths than suicide for people with mental illness.[38]
The link between physical and mental ill health goes both ways. Chronic disease can also increase risk of mental illness, such as anxiety or depression, and these conditions can have a significant social impact.

CONTINUING STRONG FOUNDATIONS

12. Do you agree with this section of the Strategy? Please explain your selection. (1000 word limit) (pp66-67)

Strongly Agree | **Agree** | No opinion | Disagree | Strongly Disagree

We support and highlight the crucial importance of the next steps to enable the strategy to achieve its desired outcome. The Blueprint for Action must be resourced and include the underlying detail to achieve targets and policy achievements in the strategy.

We note this is a 10-year strategy and should be visionary to achieve better health for Australians beyond the initial budget cycles. It is important for the strategy to be supported across political parties with sustained commitment to long-term funding to achieve its purpose.

It should also be clearer how the strategy will intersect with the primary care strategy, as there appears to be a disconnect between the development of these two strategies. A core enabler of the prevention strategy is embedding prevention in the health system – and this will need to connect with the primary

[34] Clin J Am Soc Nephrol 14: 49–56, 2019
[35] Robinson E et al. Increasing the Price of Alcohol as an Obesity Prevention Measure: The Potential Cost-Effectiveness of Introducing a Uniform Volumetric Tax and a Minimum Floor Price on Alcohol in Australia. Nutrients. 2020; 12:603.
[36] ABS. National Health Survey: Mental health and co-existing physical health conditions, Australia, 2014-15. Canberra: ABS; 2016
[37] Roberts R, Lockett H, Bagnall C, Maylea C, Hopwood M. Improving the physical health of people living with mental illness in Australia and New Zealand. Australian Journal of Rural Health. 2018;26(5):354-62.
[38] ABS. Mortality of people using mental health services and prescription medications. Analysis of 2011 data. Canberra: ABS; 2017.

care strategy. Both the prevention and primary care strategies would be strengthened by demonstrating how the strategies will work together.

OTHER

13. Please provide any additional comments you have on the draft Strategy. (No word limit)

In summary, we strongly support the strategy and commend the government for its work in developing this strategy, in particular the target to invest 5 percent of the health budget in prevention and the associated funding and governance mechanisms. We are strongly supportive of sustained, increased investment in prevention for long-term health and wellbeing. We strongly encourage bipartisan support for this target, and similar commitments from state and territory governments.

We note that the strategy needs to be funded and the subsequent Blueprint for Action needs to be well-resourced and developed swiftly with more detail, supported by monitoring and evaluation to track progress towards targets and policy achievements over the next 10 years. We would welcome ongoing engagement as the Blueprint is developed.

As noted earlier, it should also be clear how the concurrent Primary Health Care 10 Year Plan will intersect with the prevention strategy to enable prevention to be embedded in the health system.

We broadly support the focus areas, including key risk factors and a commitment to increase cancer screening and prevention. We are, however, concerned that major actions to prevent chronic disease are overlooked in the strategy, particularly in the absence of detail, targets, and policy achievements for chronic disease beyond cancer in the focus areas.

Specific actions to prevent chronic disease and support timely diagnoses are particularly important following COVID-19, due to the expected ongoing effects for vascular diseases and the need for risk assessment and early detection to assess and manage long-term health after COVID-19. As a result of the pandemic, many Australians appear to have delayed vital cancer screenings, routine health checks and diagnostic tests. Importantly, this delay in preventive care could have a significant and lasting impact on our health system and community well beyond the end of COVID-19, hence the urgent need for investment and priority actions in prevention, risk assessment and management, and early detection of chronic disease.

This is particularly important as chronic diseases are largely preventable. The below statistics highlight the enormous impact on Australians:

- Chronic diseases affect millions of Australians.
- One in two Australians have a chronic disease. These conditions cause nearly 90 percent of death and disability in Australia and are responsible for 50 percent of all hospitalisations.[39]
- Chronic diseases are costly to treat and account for around one-third of national health expenditure.[40]
- Cardiovascular disease affects 4 million Australians, and a further 2.5 million Australians are at high risk of cardiovascular disease. One Australian dies from cardiovascular disease every 12 minutes, yet it is largely preventable.
- Eight out of 10 strokes could be prevented. One Australian has a stroke every 19 minutes. Regional Australians are 17 percent more likely to suffer a stroke than Australians living in cities.
- 1.5 million Australians are unaware they are living with signs of kidney disease.[41] Up to 90 percent of kidney function can be lost before symptoms are apparent, meaning early detection is essential to prevent progression to kidney failure, which requires treatment with costly dialysis. Together, diabetes and high blood pressure cause more than half of all kidney failure cases.[42]
- Over 2 million Australians have prediabetes, and an estimated 500,000 Australians have undiagnosed type 2 diabetes. Preventable complications include blindness and amputations.

[39] AIHW. https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/chronic-disease/overview
[40] AIHW 2014. Australia's Health 2014.
[41] Australian health survey: biomedical results for Chronic Diseases 2011-12, ABS, Canberra 2013.
[42] ANZDATA Registry. 43rd Report, Chapter 1: Incidence of Renal Replacement Therapy for End Stage Kidney Disease. Australia and New Zealand Dialysis and Transplant Registry, Adelaide, Australia. 2020. Available at: http://www.anzdata.org.au

- Diabetes cost the Australian economy around $14.6 billion per annum according to 2010 estimates[43] and this is forecast to increase to $30 billion by 2025.[44]
- One in three cancers could be prevented by addressing modifiable risk factors. An estimated 145,000 new cancer cases are diagnosed each year.
- Cardiovascular disease, kidney disease, type 2 diabetes and cancer share common risk factors and interact to increase overall risk.
- More than one-third of chronic disease burden could be prevented by addressing modifiable risk factors, including tobacco, overweight and obesity, unhealthy diets, physical inactivity, alcohol consumption, high blood pressure, high cholesterol, and high blood glucose.[45]

About ACDPA

The Australian Chronic Disease Prevention Alliance (ACDPA) is an alliance of Cancer Council Australia; Diabetes Australia; National Heart Foundation of Australia; Kidney Health Australia; and Stroke Foundation. Members work together to collectively advocate for prevention, integrated risk assessment, effective management of chronic disease risk, and early detection. www.acdpa.org.au

[43] Lee, C., Colagiuri, R., Magliano, D., Cameron, A., Shaw, J., Zimmet, P. and Colagiuri, S. (2013). The cost of diabetes in adults in Australia. Diabetes Research and Clinical Practice, 99(3), pp.385-390

[44] Department of Health. Australian National Diabetes Strategy 2016e2020. Canberra: Commonwealth of Australia, 2015. http://www.health.gov.au/ internet/main/publishing.nsf/Content/nds-2016-2020.

[45] AIHW 2019. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015.