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To whom it may concern

Re: Submission to the Joint Select Committee inquiring and reporting on Preventative Health Care in Tasmania

I am pleased to provide this response to the above Inquiry on behalf of the National Stroke Foundation (NSF) and the Collaboration for an Integrated Primary Care Pathway, namely; NSF, Tasmania Medicare Local, Heart Foundation Tasmania and Diabetes Tasmania. For any queries on this submission please contact Connie Digolis on cdigolis@strokefoundation.com.au.

As a member of the Tasmanian Chronic Disease Prevention Alliance and through this, the Health in All Policies Collaboration, the NSF has followed with interest the policy discussion regarding social determinants of health and the need for coordinated and integrated action in preventative health.

We support the submission to this Inquiry from the Health in All Policies (HiAP) Collaboration and in particular its focus on the need for an intersectoral approach to health. We support the principle that health must be mainstreamed through all policies to deliver improved health outcomes and to curb Tasmania's growing health spend.

As highlighted in the Fair and Healthy Tasmania Report 2011 health inequity is a particular concern for Tasmania given that its citizens fall behind other Australians on key health and lifestyle measures. Tasmanians are at a greater risk of chronic disease for a range of reasons and have identified low health literacy.

There is a real need to identify preventative health solutions that can address this inequity over the longer term. These solutions need to ensure broad access to programs and systems of support that assist Tasmanians to identify and manage their chronic disease risk.

We don't seek to repeat the information and statistics provided by the HiAP Collaboration in their submission, rather we provide this contribution to highlight key health sector preventative health considerations from a chronic disease prevention and management perspective.

Our main focus is in Terms of Reference 2; ***The challenges to, and benefits of, the provision of an integrated and collaborative preventive health care model which focuses on the prevention and early detection of, and intervention for, chronic disease.***

Background to chronic disease

Heart, stroke, kidney disease and diabetes contribute significantly to burden of disease of Tasmanians and the economic implications of this are escalating¹. Tasmania has the highest prevalence of heart and vascular disease in Australia and these conditions continue to kill more Tasmanians per year than any other disease group. In 2011/12, there were 114,000 Tasmanians living with heart and vascular diseases² and over 22,775 Tasmanians living with type 2 diabetes³. In addition to this, 1 in 6 Tasmanians have diagnosed kidney disease⁴.

In addition to those Tasmanians with established disease, there are a large proportion of Tasmanians who are at high risk of developing a heart attack, stroke, kidney disease and diabetes. The Australian Health Survey of 2011-12, showed that, 30.4% of Tasmanians have recorded high blood pressure, 39.4% of Tasmanians have recorded high cholesterol, 21.7% of Tasmanians are smoking, 69.4% of Tasmanians are sedentary or only exercise at low levels and 64.7% of Tasmanians are overweight or obese⁵. There are also estimated to be 10,000 Tasmanians living with diabetes but as yet undiagnosed and 45,000 with pre-diabetes⁶.

Significantly the majority of Australian adults over 25 years of age have at least one modifiable risk factor with, 64% having three or more modifiable risk factors⁷. Over 20% of adult workers are classified as being at high risk of type 2 diabetes using the Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK).

Many high risk individuals are unaware of their risk status and are therefore unlikely to undergo comprehensive, absolute risk assessment in an unprompted manner in primary care. The shared risk factors that contribute to these diseases; high blood pressure, obesity, smoking, high cholesterol, poor diet and exercise are all modifiable and the earlier they are assessed and subsequently managed, the greater the chance of avoiding or minimising an event occurring.

In light of the evidence, the NSF, Heart Foundation (Tasmania), Diabetes Tasmania and Tasmania Medicare Local (TML) advocate for further action to implement a pathway that supports a nationally consistent approach to identify vascular disease risk and supports early referral of those believed to be at higher risk to receive a full integrated health check (IHC) assessment with their doctor before the culmination of risk factors results in debilitating disease or organ damage.

The NSF recommends the Tasmanian Government pursue an integrated and collaborative preventative health care model which focuses on the prevention, early detection and early intervention for chronic disease. This section outlines how a preventative health model within the health care system would support people with vascular and related diseases.

To achieve the goal of making Tasmania the healthiest state by 2025, drastic measures are required, not to mention the ability to benchmark and track progress towards this goal.

In order to achieve this goal, the NSF, Heart Foundation (Tasmania), Diabetes Tasmania and TML propose that the Tasmanian Government establish health targets. Health targets were originally introduced in New Zealand in 2007 as a way to highlight priority areas in which the government wanted to see measurable progress in the health system.

In 2009, in recognition that cardiovascular disease (CVD) and diabetes are the leading cause of morbidity, the New Zealand government included 'Better Diabetes and Cardiovascular Services' into their suite of health targets.

¹ Taylor, R. (2013). *State of Public Health*. Hobart: Department of Health and Human Services

² ABS. (2013).

http://www.abs.gov.au/AUSSTATS/subscriber.nsf/log?openagent&43640do001_20112012_tasmania.xls&4364.0.55.001&Data+Cubes&E1236E2882E56A1CA257B820017A805&0&2011-12&07.06.2013&Latest

³ NDSS. (2013). <http://www.ndss.com.au/>. Retrieved from National Diabetes Services Scheme.

⁴ Kidney Health. (2013). <http://www.kidney.org.au/>

⁵ Australian Health Survey. (2013). <http://www.abs.gov.au/australianhealthsurvey>

⁶ Diabetes Australia, 2013

⁷ AIHW 2011. Health determinants, the key to preventing chronic disease. Cat No. PHE 157. Canberra:AIHW

The establishment of health targets has been a success, with one of their targets (90% of the eligible population to have their cardiovascular risk assessed in the last five years) to be met by 30 June 2015, as part of its Integrated Performance and Incentive Framework agreement with district health boards.⁸ A recent report shows the success in establishing consumer access points and consistent messaging along with initiatives that target specific population groups – in this case, Maori and Pacific males over the age of 35.

Establishing health targets would be an effective way for the Government to demonstrate its progress towards becoming the healthiest state by 2025. It will enable a state wide, coordinated approach and set clear goals for improving access to preventative measures for all Tasmanians, most especially those at an increased risk.

The means to improving health outcomes for Tasmanians need not start from scratch and the Tasmanian Government could utilise the research and program development already undertaken and partner with Tasmanian public health organisations to deliver Australia's first system-wide prevention pathway and empower Tasmanians to take control of their personal health outcomes.

A Preventative Health Care Model

This pathway will enable Tasmanians to better understand and manage personal risk factors and ensure access to a high quality integrated health check from their GP. These checks are recognised as the most effective and efficient form of health assessment and are built around guidelines approved by the National Health and Medical Research Council. They are a key tool in preventing chronic disease via medication and/or referral to high quality lifestyle modification advice.

Australian studies have found that there is a need for improving the uptake of absolute risk guidelines and GP understanding of the rationale for using absolute risk and conducting integrated health checks, rather than treating risk factors individually⁹. Another study in the UK found that a one-stop cardiovascular risk assessment service by community pharmacies was feasible in the setting of a large city in the UK and identified around two-thirds of those screened—for whom intervention for cardiovascular risk or an additional risk factor was indicated. The majority of clients were men for whom attendance at general practice was known to be low and some success was had in targeting people from more deprived areas and with a minority ethnic background.

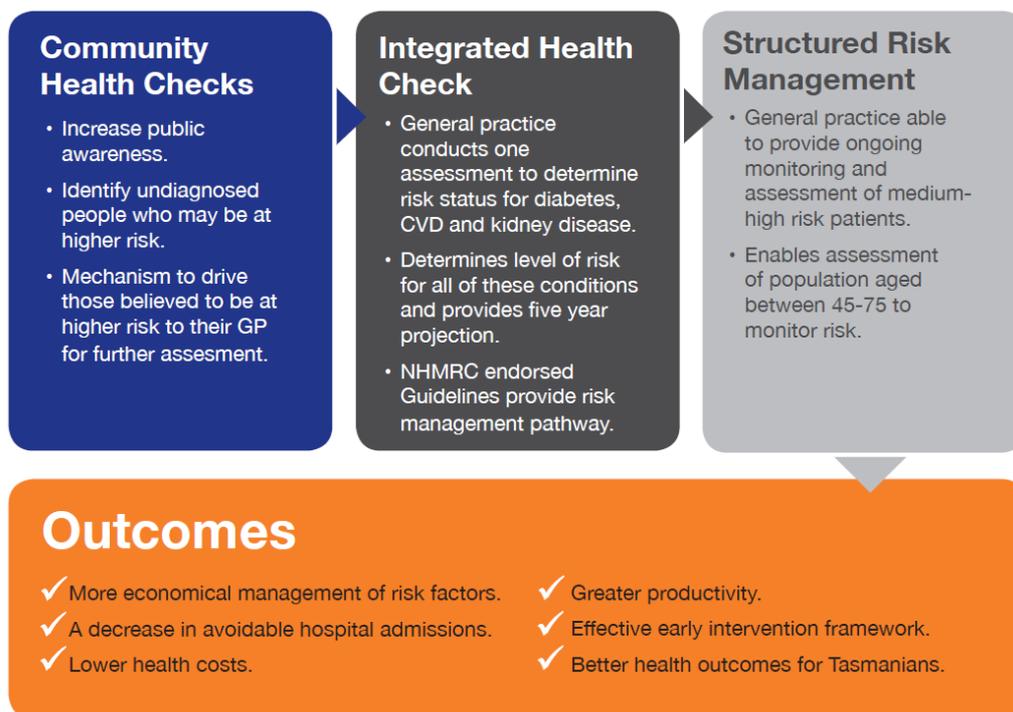
This model – whereby opportunistic health checks are delivered within community precincts - is important for areas of socioeconomic disadvantage, as it provides the most cost-efficient way of increasing health literacy and preventing chronic disease from developing. Research shows that poor health outcomes are higher in low socioeconomic areas and providing a targeted health check program in these communities will ensure individuals at an increased risk are guided to understand what they can do in order to manage their level of risk. Making lifestyle changes at the earliest stage is far cheaper than the cost of hospitalization if people's risk factors aren't addressed.

The prevention pathway proposal for Tasmania is scalable, starting out in targeted areas of Tasmania (such as areas of low socioeconomic advantage) and designed to grow over a three-year period. The key aim is to increase access to high quality integrated health checks performed by a GP.

The pathway consists of:

⁸ Ministry of Health "PHO Performance Programme and transition to the Integrated Performance and Incentive Framework" (9 July 2014) <<http://www.health.govt.nz>>.

⁹ Jansen J, Bonner C, McKinn S, et al. General practitioners' use of absolute risk versus individual risk factors in cardiovascular disease prevention: an experimental study. *BMJ Open* 2014;4:e004812. doi:10.1136/bmjopen-2014-004812



This model will achieve three key aims. Firstly it will increase community knowledge about risk factors for chronic disease that can be managed to prevent onset of disease and guide those who may be at risk towards a more comprehensive diagnosis. Secondly it will increase the number of general practices supported to provide efficient and effective integrated health checks. Thirdly it will lay the groundwork for better management of risk factors, via medication and/or referral of patients to programs that assist with lifestyle modification, ultimately preventing the onset of disease.

The importance of each of these three pathway steps cannot be underestimated. By providing greater awareness of chronic disease risk, more people will visit their GP to discuss their health risk further. The growth in people requesting integrated health checks will be matched by the rise in GPs who provide integrated health checks and therefore able to detect those with chronic disease, or those at risk of chronic disease, at the earliest opportunity. By managing chronic disease risk, some hospital admissions can be avoided and alleviate the current burden on acute care.

This model will also enable us to target areas of socioeconomic disadvantage and improve the health status in these areas, along with establishing a primary care approach that will enable more Tasmanians to have their risk factors assessed, recorded and maintained. It's reasonable to say, that by taking this initiative, the Tasmanian Government will be supporting a system that ensures all Tasmanians over the age of 45 are receiving an integrated health check every two years and that the necessary interventions are being made to minimise a chronic event or development of a chronic disease.

Cost and benefit

Australia's first prevention pathway model can be implemented in Tasmania for around \$400,000 per year over three years. This includes costs to conduct community health check stations, funding for a project officer to work with GP practices as they embed integrated health checks in their practice and funding for program evaluation. A detailed budget and implementation plan can be provided on request.

Introduction of a prevention pathway in Tasmania will result in fewer cases of diabetes, kidney disease, stroke and heart disease and the Tasmanian Government will directly benefit from the reduced hospital costs that result.

The estimated \$1.2m program cost (\$400,000 per year over three years) will be offset if we are simply able to prevent:

- 39 admissions for heart attack per year, OR
- 57 admissions for angina per year, OR
- 21 admissions for stroke per year.

Given that 80% of strokes alone can be prevented, it is realistic to say these savings could be realised within a short period of time.

In addition to this, according to the Public Health Report 2013, for period 2010/11 there were 1,357 preventable hospital admissions for diabetes. Based on hospital costs of \$2,248pp, keeping these people out of hospital will save over \$3M.

Evaluation of previous community and pharmacy-based health check programs with a referral mechanism to GPs suggests that this is achievable.

Anecdotal evidence from counterparts in New South Wales shows that GPs have found that patients who have come after receiving a community health check are far more engaged and prepared to make the necessary lifestyle and medication changes than those that have not.

Conclusion

The chronic disease burden in Tasmania is growing. Research shows that early intervention to stop chronic conditions from developing, in particular those that are preventable, is the most effective way to lower the incidence of cardiovascular, diabetes and kidney disease; the most costly chronic diseases in Tasmania.

The proposals outlined in this submission aim to address the key risk elements for reaching those in the community who are potentially at increased risk of developing CVD and related disease. A significant opportunity has been identified for linking individuals into a pathway that supports a best practice approach and facilitates engagement with a range of key stakeholders in preventative health. This evidence-based approach offers the Tasmanian Government the opportunity to take the initiative and improve the level of chronic disease incidence.

This proposal has been a collaborative effort between the NSF, the National Heart Foundation Tasmania, Diabetes Tasmania and Tasmania Medicare Local. All four members support the Select Committee's initiative in investigating ways to improve preventative health in Tasmania.