



strokefoundation

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Submission to the Senate Select Committee on Health inquiry into health policy, administration and expenditure

The National Stroke Foundation is the voice of stroke in Australia. Our mission is to stop stroke, save lives and end suffering. We are a national not-for-profit organisation that works with stroke survivors, carers, health professionals, government and the public to reduce the impact of stroke on the Australian community.

Background to stroke in Australia

Stroke is a medical emergency which, with survival, requires ongoing support and management. In Australia there are over 50,000 strokes a year. There are now over 437,000 people living in Australia with stroke. Two-thirds of these people sustained a disability that impeded their ability to carry out activities of daily living unassisted. This population is projected to grow to over 700,000 people living with the effects of stroke by 2032.ⁱ Stroke is the leading cause of long-term disability in adults and represents 25 per cent of all chronic disability.ⁱⁱ Common outcomes include paralysis, speech and swallowing difficulties, problems with memory, hearing and eyesight. The spectrum of disabilities arising from stroke, and their duration, varies from person to person. In some cases the disability may be minor and short-lived, such as partial loss of mobility in the arms or legs. However, in other cases there may be severe paralysis in the limbs or cognitive impairment that can last for several years or be permanent. Severe strokes can place a great burden on carers and family as well as patients.

The Senate Select Committee on Health (the Committee) has provided its terms of reference on which it will base its inquiry. These are:

- a. the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting;
- b. the impact of additional costs on access to affordable healthcare and the sustainability of Medicare;
- c. the impact of reduced Commonwealth funding for health promotion, prevention and early intervention;

- d. the interaction between elements of the health system, including between aged care and health care;
- e. improvements in the provision of health services, including Indigenous health and rural health;
- f. the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;
- g. health workforce planning; and
- h. any related matters.

NSF has structured its response against each of these terms of reference.

- a. **the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting;**

The best chance of surviving and recovering from a stroke is to be placed in a specialised stroke unit with dedicated beds. Stroke units are the most effective therapy available for acute stroke. They can save lives and reduce the level of disability.ⁱⁱⁱ Acute stroke units are the driving forces of stroke care system reforms in many countries.^{iv}

The NSF with the potential impact of reduced funding on hospitals and their ability to effectively treat people undergoing a stroke in a specialised unit with a dedicated team, if possible. The 2013 National Stroke Audit showed that 35% of stroke patients nationally who arrived at a hospital with a stroke unit were denied access to a stroke unit bed. Analysis of stroke unit bed numbers demonstrates that the result is due to stroke unit beds being used to treat non-stroke patients (although there was also a shortfall in beds in some hospitals). On the day of the audit there were 615 stroke unit beds nationally and 654 stroke patients in stroke unit hospitals.^v

With such pressures on hospital beds already, the NSF is very concerned at the number of stroke patients that may not receive the evidence-based care necessary that a specialised stroke unit provides if hospital funding were to be reduced. Patients with stroke who are treated in specialised units have better survival and functional outcome than those treated in general medical wards.^{vi} The reduction of funding may force some hospitals to cease operating a specialised stroke unit and thereby impact on death and disability rates from stroke.

NSF is concerned with the possible reduction in funding affecting Activity Based Funding (ABF) currently operating in hospitals. The National Health Reform Agreement, signed by all Australian governments in August 2011, commits to funding public hospitals using ABF where practicable. However, the Federal Treasurer announced in this year's budget that from 2017-18 the Australian Government will introduce revised public hospital funding arrangements, to recognise States' and Territories' responsibility for managing an efficient public hospital sector.

The NSF is also interested in what the new revised funding arrangements will entail. If ABF were removed and funding rely on the Consumer Price Index, or some other mechanism, there is a chance that funding will decrease in real terms and could prove to be a disincentive to hospitals that have been working towards and ABF model in which they have established efficiencies. There have also been case in some parts of the country where hospitals have used ABF to improve access to evidence based care such as stroke units. If ABF no longer existed as a mechanism for change there is the possibility that care could deteriorate. NSF strongly advises the Committee to give attention to current ABF and possible impacts should it be withdrawn.

NSF is also concerned about the flow on implications for hospitals regarding the possible implementation of a co-payment. It is still uncertain as to how the co-payment may effect waiting times on hospital emergency departments and whether there will be an increased demand for diagnostic and pathology services within the hospital environment. There is also a possibility that States and Territories may introduce their own payments to offset these flow on effects from the increased demand.

c. the impact of reduced Commonwealth funding for health promotion, prevention and early intervention;

The reduction in funding for prevention and early intervention has many ramifications for chronic disease sufferers and people presenting with high risk factors for cardiovascular disease (CVD), in particular stroke. The NSF is concerned that reduced funding will lead to poorer health outcomes and therefore higher hospital admissions. NSF would like the Committee to be aware of the following information:

- For the financial year 2011–12, \$2.23 billion, or 1.7% of total health expenditure, went to public health activities, which include prevention, protection and promotion.^{viiiii} Discontinuing the National Partnership Agreement on Preventive Health has removed at least \$368 million dollars from the current financial year's budget for prevention, protection and promotion. This represents at least 15 per cent of the 2011-12 budget allocated for public health activities.
- The latest report on *Australia's Health 2014* advises that 14.6% of Australia's deaths are due to coronary heart disease and 7.7% due to cerebrovascular disease – together contributing to 22.3% of deaths in Australia.
- In total, CVD is Australia's biggest killer causing more than 46,000 deaths each year - just over a third of total mortality - and afflicting 3.5 million adults.^{ix} It accounts for 16% of the overall burden of death and disease in Australia and is the most expensive disease group in terms of direct healthcare costs, at \$7.74 billion a year or 10.4% of recurrent expenditure.^x
- Australia spends less on prevention and public health services than most other Organisation for Economic Co-operation and Development (OECD) countries, ranking in the lowest third in 2010–11. New Zealand spends the most, with 7% of total health expenditure, followed by Canada at 5.9%.^{xi}
- In 2008, The World Health Organisation estimated that up to 80% of heart disease, stroke and type 2 diabetes and more than one-third of cancers worldwide could be prevented by eliminating shared modifiable risk factors—mainly tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol.^{xii}

- Over 90% of Australian adults have at least one modifiable CVD risk factor, while 64% have three or more. Current NHMRC-endorsed guidelines support an absolute CVD risk management approach to reducing the burden of CVD in Australia. This is based on knowledge that individual CVD risk factors such as blood pressure have a continuous association with the risk of CVD events and that moderate reductions in several risk factors will be more effective in reducing overall CVD risk than a major reduction in one risk factor alone. Absolute CVD risk assessment and management is therefore likely to have the greatest effect on lowering an individual's risk of cardiovascular events.^{xiii}

Preventing cardiovascular disease

- Too many Australians are unaware of their personal risk factors for diseases such as stroke and heart disease (collectively known as cardiovascular disease or CVD), type 2 diabetes and chronic kidney disease and are not empowered to self-manage their risk.^{xiv}
- A coordinated approach is required to increase awareness of individual vascular and related disease risk, to provide high quality assessment of individual risk and to provide appropriate interventions to support risk management.
- CVD has a strong relationship with type 2 diabetes and chronic kidney disease. Because they share risk factors, underlying causes and disease mechanisms, stroke, heart and vascular diseases often occur together with diabetes and chronic kidney disease. For example, it is estimated over 400,000 Australians have both CVD and diabetes. Thus, effective prevention and management of one condition can lead to reduction in the risk of related diseases.
- Identification of risk and action to modify these risk factors has significant potential to reduce the number of CVD events occurring each year and reduce incidence of diabetes and chronic kidney disease and yet current Australian Government funded health checks are not identifying those at risk primarily because of low access rates, non-integrated approaches to CVD risk assessment and the absence of a national program to support better management of risks for CVD and related diseases like type 2 diabetes and kidney disease.^{xv}

Prevention and early intervention is effective

- Prevention leads to a better quality of life and increased life expectancy.
- In recent decades there have been major improvements in tobacco control, road trauma and drink-driving, skin cancers, immunisation and cardiovascular disease.^{xvi}
- Health promotion, regulation and increased taxation have each played a role in reducing smoking rates among both males and female. Death rates from smoking-related diseases have fallen, with a time lag, from the high levels of the 1970s and 1980s—lung cancer deaths have fallen by 40%, and chronic obstructive pulmonary disease deaths by 60%.^{xvii}

Funding in prevention needs to be increased, not reduced.

- NSF readily promotes the importance of enabling people to attend an integrated health check for the purposes of early intervention with chronic disease, however the impending introduction of a co-payment is proving to be an obstacle. It is recommended the Committee look at ways in which to provide incentives for people to obtain an integrated health check.
- NSF recommends that the Committee consider the impact of the removal of the National Partnership Agreement on Preventive Health and the abolition of the Australian National Preventive Health Agency (ANPHA).
- The NSF supports and endorses the National Prevention Taskforce Report. NSF believes the recommendations from this report provide a strong framework for preventing chronic disease in Australia. The NSF recommends that the recommendations of the report be taken forward by the Department of Health and through intergovernmental forums to build on the work ANPHA began.

d. the interaction between elements of the health system, including between aged care and health care;

The NSF supports an improvement in the interface between aged care and health care, in particular the NDIS which is yet to be rolled out across the country.

Stroke survivors face many issues in relation to the ageing and disability interface. Many stroke survivors are over 65 and will be required to access disability services for the first time in their lives, however the current environment holds many uncertainties. For example, the replacement of Medicare Locals with Primary Health Networks has not been communicated effectively.

Perhaps the biggest issue for stroke survivors is the fact that because of the nature of their required treatments (such as allied health therapies), they may be classified as 'Tier 2' rather than 'Tier 3' and not be entitled to funding for their treatment but instead be referred to the health sector for treatment. Tier 3 is the only category that will receive actual services, whereas Tier 2 will not.

Anecdotal evidence from the National Aged Care Alliance (NACA), of which NSF is a member, suggests that some allied health professionals, such as speech pathologists, have lost block funding from State and Federal Health departments, with the intention being that they will receive funding through the NDIS. However, if stroke survivors are categorised as 'Tier 2' they will miss out on these services unless they pay out of their own pockets. This represents an enormous issue for stroke survivors who are already limited by the number of visits to certain allied health services, which can also take some time to access. It also represents an issue for providers of allied health services because they will not make up the shortfall in earnings through the NDIS.

Of particular concern to the NSF is the transition of under 65 year-olds from a Home and Community Care (HACC) program to a Commonwealth Home Support Program (CHSP),

particularly where a person in their early 60s presents with an ageing related issue that does not qualify for a tier 3 service and is also too young for CHSP.

The NSF also remains concerned regarding the apparent discrimination between residential care and community care settings. For instance, the Department of Health's CHSP is looking at removing access to day therapy centres for residents of aged care facilities but not those accessing home support while living at home. There is also a concern that residents many miss out on other services such as allied health, social participation and transportation services.

Evidence from other jurisdictions has also found that co-payments reduce the use of prescription medicine, consultations with GPs and specialists, and ambulatory care. This has been found to be the case in countries such as Ireland, Canada, Italy, Belgium, Germany and Denmark. For instance, in Italy, the abolition of the co-payment on prescriptions coincided with a significant uptake in medicine use by hypertension patients, while in Denmark there was a significant decrease in preventative health care services (such as screening for ischaemic heart disease) when patients had to pay.^{xviii}

A co-payment will affect chronic disease sufferers who choose to delay or avoid necessary preventative assessments and treatments. This in turn will mean that they will not give themselves the best chance of reducing their high risk factors. In addition to this, some high-risk people will not have an integrated health check or see a GP to determine if they need to address any high risk factors for chronic disease until they experience more severe symptoms.

The NSF would also like to point out the inadequacy of the chronic disease allied health care provisions under the current MBS item of five sessions per year for all allied health services. This includes speech pathology, physiotherapy and occupational therapy. A typical chronic disease sufferer could exhaust their five sessions in a month and be forced into out of pocket expenses for further services.

The NSF supports the introduction of more programs to bridge the gap between health care and aged care. The Transition Care Program (TCP) is a good example of bridging this gap. This program provides short-term care to older Australians directly after discharge from hospital. The program aims to improve care recipients' level of independence and functioning and to delay entry to residential aged care. TCP can be delivered in the community (at home) or in a home-like live-in setting. Between 2005 and 30 June 2013, this program assisted 87,142 people, of which 54% returned to live in the community—18% without assistance from community-based aged care services, and 36% with assistance from community-based aged care services. About 1 in 5 (21%) entered residential aged care directly from transition care, and 2% of care recipients died while receiving care.^{xix}

The move to residential aged care can be a daunting move for stroke survivors. Anecdotal evidence from stroke survivors and workers in aged care raises the following difficulties faced by aged care residents:

- Financial challenges. Residents already spend 80% of their pension on residential care and many spend most of the remainder on prescription medicines and visits to GPs and allied health professionals. This can also involve transport costs, given that many GPs now do not visit residential facilities due to the inability of many residents to pay their bills. The possible introduction of a co-payment will exacerbate this problem even further.
- NSF runs a program called StrokeConnect, which provides support to stroke survivors during their hospital stay and release afterwards. NSF found that upon release from hospital 58% of stroke survivors reported feeling overwhelmed and having difficulty coping. Following the support provided by Stroke Connect, 84 per cent of stroke survivors surveyed thought that the referral to StrokeConnect helped them feel more confident about leaving hospital and adjusting to life after stroke. Providing this early support assists stroke survivors in making a full recovery and can save potential trips back to hospital. There is a real need for more programs like this to act as a conduit between hospital and aged care – whether it be in a residential facility or at home.

e. improvements in the provision of health services, including Indigenous health and rural health;

Improving health services

In late May, the Minister for Health announced that “from early 2016, five of the ten existing PIP incentives will be streamlined into a single incentive, focussing on continuous quality improvement in general practice and we will continue to work with the Australian Medical Association and others to finalise details of the new incentive and improvements to PIP”.

NSF supports the improvement in vascular and related disease detection and prevention. NSF encourages GPs to conduct integrated health checks for the early detection and risk management of people at increased risk of developing chronic kidney disease, type 2 diabetes, heart disease or stroke, as well as linking in with other systems such as chronic disease management plans.

A recent study showed that Australian GPs are not adhering to current NHMRC clinical practice guidelines when they manage cardiovascular disease risk. They base their prescribing decisions on the levels of individual risk factors such as blood pressure and cholesterol. This means they are likely to prescribe cholesterol lowering and blood pressure lowering medications to people at low absolute cardiovascular risk, if one of these risk factors is elevated, while not prescribing much needed medications to those at high risk if these factors are not elevated^{xx}.

The NSF believes that improvements can be made to health system payments and incentives to better support implementation of best practice as outlined in current guidelines.

Indigenous and rural health

It has been well documented that indigenous Australians maintain the poorest health on average, have lower life expectancies and have the lowest access rates to health services. Recent data also indicates that chronic diseases, such as cardiovascular disease, cancer, diabetes and kidney disease contribute to two-thirds of the health gap between Aboriginal

and Torres Strait Islander people and non-Indigenous Australians.^{xxi} Data from the Australian Bureau of Statistics also shows that about 80% of the mortality gap between Aboriginal and Torres Strait Islander people and non-Indigenous people can be attributed to chronic diseases.^{xxii}

In terms of stroke, the following facts are particularly of concern:

- The hospital admission rate for stroke among Indigenous Australians is about 1.5 times greater than in non-Indigenous Australians
- Deaths attributed to stroke among Indigenous Australians is about 1.9 times greater than for non-Indigenous Australians, with the largest disparity in mortality occurring in Indigenous people aged less than 65 years. For example, among Indigenous people aged 35–54 years, the mortality rate associated with cerebrovascular disease is about five times greater than in non-Indigenous people.^{xxiii}

f. the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;

NSF is concerned with the current cap on certain MBS items that are required by stroke survivors. Allied health services such as speech pathology and physiotherapy, can be capped at 5 visits (for all services combined). However, a stroke survivor may need to receive more than one service per week in the early stages of their rehabilitation and thereby exhaust their quota within two months after their stroke. Once this occurs a stroke survivor will be forced to pay for the services. This can lead to some stroke survivors not being able to receive the necessary treatment to facilitate their recovery. In some cases this could eventually lead to another hospitalisation. NSF recommends that the Committee look at the impact of caps on MBS items used by stroke survivors such as allied health services.

As part of the National Vascular Disease Prevention Alliance, the NSF is advocating for better integration of MBS items that currently encourage disease specific rather than chronic disease approaches. At present, assessment of risk in primary care is reimbursed through disease specific MBS items (such as diabetes risk assessments) but not for more general health checks. Uptake of non disease-specific health checks is low and needs to be increased. By adding integrated health checks to the MBS items list the uptake is hoped to increase.

h. any related matters.

NSF would like to draw the Committee's attention to the current situation of Primary Health Networks (PHNs) replacing Medicare Locals. NSF recommends that PHNs have the capability to coordinate multidisciplinary teams with a view to assisting people with chronic disease. PHNs will also be well placed to implement Preventative Health Taskforce recommendations such as supporting healthy decisions through primary care.

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