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Productivity Commission
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Dear Sir/Madam

Stroke Foundation's response to the Productivity Commission's interim report on 'Delivering quality care more efficiently'

I am writing on behalf of Stroke Foundation in response to the Productivity Commission's interim report on 'Delivering quality care more efficiently'. Stroke Foundation welcomes the Commission's key findings and recommendations in relation to how we can ensure services are delivered across a range of sectors, including the health sector, in a more sustainable and productive way, with better outcomes for all Australians.

Stroke Foundation is a national charity that partners with the community to prevent stroke, save lives and enhance recovery. As the voice of stroke in Australia, we stand alongside survivors of stroke and their families, healthcare professionals and researchers, and build community awareness, foster new thinking, and support survivors on their journey to live the best possible life after stroke.

There are an estimated 45,785 stroke events in Australia annually.[1] More than 440,000 survivors of stroke are living in Australia.[1] The lifetime costs associated with strokes that occurred in Australia in 2023 exceed $15 billion ($350,000 per person), including healthcare, lost productivity and unpaid carer costs.[1] Research shows that without a concerted effort to improve stroke prevention and awareness, the number of annual stroke events in Australia is expected to reach 72,000 by 2050.[1]

Stroke is one of the leading causes of disability in Australia, and a third of stroke events result in a disability which impedes the survivor of stroke's ability to carry out activities of daily living unassisted.[2] Additionally, many survivors of stroke speak of falling into a 'black hole' once they are discharged from hospital, and there is a clear need for greater integration of care across the health system, in order to facilitate improved quality and continuity of services for survivors of stroke. Therefore, Stroke Foundation supports the Commission's recommendations that (a) the Australian Government should pursue greater alignment in quality and safety regulation of the care economy, including the NDIS (Recommendation 1.1), and (b) governments should embed collaborative commissioning to increase the integration of care services (Recommendation 2.1).

More than 80 percent of strokes can be prevented through addressing key modifiable biomedical and behavioural risk factors, including smoking, uncontrolled high blood pressure, obesity, excess alcohol consumption, and high cholesterol.[3] Stroke Foundation is committed to reducing the number of preventable strokes in Australia, and as such, we strongly support the Commission's draft recommendation that a National Prevention Investment Framework be established by the Australian Government in collaboration with state and territory governments, to support investment in prevention programs that improve outcomes and reduce demand for future acute care services.

Outlined below is a summary of the prevention programs that Stroke Foundation is currently delivering at a national and state and territory level, and how the proposed National Prevention Investment Framework may support primary and secondary stroke prevention. We have also included key points for consideration when developing a new, more robust assessment and evaluation process for prevention programs.

Stroke Foundation's primary and secondary prevention programs

Primary prevention

Chronic conditions such as stroke are complex, multifactorial problems that require a sustained, long-term, and multifaceted strategy; however, without serious action on primary prevention, which on average is 3 to 4 times more cost-effective than treatment,[4] it will not be possible to stem the tide of chronic conditions in Australia. The lifetime costs associated with strokes that occurred in Australia in 2023 are more than $15 billion, including $5.6 billion in healthcare costs to government, $6.3 billion in lost productivity costs ($2.9 billion in employment impacts and $3.4 billion in household impacts) and $3.9 billion in unpaid carer costs.[1] Therefore, the economic and broader societal benefits of government investment in stroke prevention are clear.

When individuals are identified as high risk for chronic conditions such as stroke, it is critical GPs have proven, effective risk factor modification programs that they can refer their patients to. These programs must be underpinned by validated behaviour change models and not be condition-specific, addressing the shared modifiable risk factors for many chronic conditions. One such example is the Queensland Government-funded *My health for life* program, a free evidence-based behaviour modification program for people at high-risk of developing a chronic condition. *My health for life* has been developed using the validated Health Action Process Approach model for behaviour change. Stroke Foundation is proud to be partnering with the Healthier Queensland Alliance and Queensland Government to deliver this program, which enables chronic conditions to be detected early, helping participants to reduce their risk of developing stroke, heart disease and type 2 diabetes, and avoid unnecessary hospital admissions.

Since its inception in 2016, the program has initiated health coaching for more than 33,000 high-risk participants. The program has also delivered long-lasting positive effects for Queenslanders. Of those who have completed the program, 68 percent have reduced their waist circumference, 88 percent feel the initiative has had a positive impact on their health and wellbeing, 55 percent are meeting alcohol consumption guidelines and 45 percent are meeting physical activity guidelines.

In addition to the *My health for life* program in Queensland, primary prevention programs focused on chronic condition risk factor modification, employing a variety of models, are currently being delivered in a number of jurisdictions across Australia.

Recommendation: *Australian and state and territory governments to establish a co-funding arrangement, and collaborate on program design, for primary prevention programs, to ensure all Australians, regardless of where they live, have access to high-quality, best-practice chronic disease risk factor management.*

Secondary prevention

People are at higher risk of stroke after their first stroke. Four in 10 survivors of stroke will go on to have another stroke,[5] and recurrent stroke is more likely to be fatal or cause major disability.[6] The lifetime costs associated with recurrent strokes that occurred in Australia in 2023 are more than $3 billion, including healthcare, lost productivity and unpaid carer costs, highlighting the significant benefits of government investment in effective secondary stroke prevention.

More than 80 percent of strokes can be prevented,[3] and this provides an opportunity to support health behaviour change and prevent secondary stroke from occurring; however, once in the community, many survivors of stroke find appropriate, evidence-informed health behaviour change interventions unavailable or difficult to access. There is a clear need for services that address behaviour modification for the reduction of stroke risk factors, to reduce further stroke. As such, Stroke Foundation is proud to be partnering with the Australian and Tasmanian Governments to deliver the *Living Well After Stroke (LWAS)* program.

LWAS is a person-centred, 8-week program that provides survivors of stroke who have an identified need to change health behaviours to reduce their risk of future stroke, with a clear pathway for effective, evidence-based education and intervention to support this health behaviour change. This is done through a Health Action Process Approach, that has been shown to be an effective model for people with chronic illness and disability.[7] *LWAS* ensures survivors of stroke are supported to build motivation, set goals, plan, and implement and track health behaviour change for a variety of health behaviours related to reducing risk of stroke recurrence, including physical activity, healthy eating, smoking cessation, and consuming

alcohol within safe limits. Ongoing investment in the *LWAS* program is needed to ensure more survivors of stroke are equipped with a toolkit of transferrable skills and strategies to support long-term self-management.

Improving the quality of stroke treatment provided in Australian hospitals is critical to reducing the impact of stroke. For example, access to stroke unit care, characterised by provision of care in one location by a multidisciplinary team including medical, nursing and allied health professionals with expertise in stroke, is proven to make the biggest difference to patient outcomes following stroke, both in hospital and after.[8, 9] In line with the *Living Clinical Guidelines for Stroke Management*,[10] patients who receive care in a stroke unit are assessed and informed of their risk factors for recurrent stroke, educated about strategies to reduce their risk, and where appropriate, prescribed blood pressure-lowering, lipid-lowering and antithrombotic or anticoagulation medications. They also receive effective discharge care planning, which in addition to educating them about behaviour modification and medications that can help reduce their stroke risk, provides them, their family members and carers with information on, and referrals to, relevant supports and services in the community.

Importantly, results from Stroke Foundation's National Acute Services Audit have shown that not all self-designated stroke units meet the core requirements for stroke unit care, and having a robust way of evaluating which hospitals have the essential elements of stroke unit care is an important step to ensuring quality care and good patient outcomes. Therefore, the Australian Stroke Coalition (ASC), co-chaired by Stroke Foundation and the Australian and New Zealand Stroke Organisation (ANZSO), has developed a voluntary system for certification of stroke units in Australian hospitals, which has been piloted and evaluated. The *ASC Stroke Unit Certification* program has the goal of certifying all centres providing stroke care in Australia by 2030, and is currently funded by participating hospitals through a cost-recovery model. It is critical that stroke unit certification is endorsed by the Australian Government, and embedded as a mandated, business as usual process within Australian hospitals, with ongoing funding, similar to the hospital accreditation process that is coordinated through the Australian Health Service Safety and Quality Accreditation Scheme.

Recommendation: *Australian and state and territory governments to establish a co-funding arrangement for both of the LWAS and Stroke Unit Certification programs, to ensure all Australian survivors of stroke, regardless of where they live, have access to best-practice secondary stroke prevention, which will reduce the number hospital readmissions for stroke and the pressure on already overstretched primary care and community services.*

Adoption of a robust assessment and evaluation process for prevention programs

1. *When prioritising different proposals, how should factors such as overall net benefits, net fiscal effects, cost-effectiveness, equity, ease of implementation, timescale and the value of future benefits and costs be weighted? Are there existing frameworks that do this well?*

A structured and consistent approach to assessing proposals is essential for fair and transparent comparisons. Factors such as ease of implementation, acceptability, size of the population likely to benefit, availability of alternative options, trust in the data and return on investment, are all relevant to priority setting when different proposals are being considered.

Typically, costs and benefits should be the primary consideration when prioritising the allocation of limited resources to different proposals. When the costs and benefits for a particular proposal are based on primary data collection, the estimates are more reliable than estimates of costs and benefits derived from an economic simulation model; however, the limited scope of the primary data collection may make it difficult to compare proposals. In economic models, there are usually standardised time horizons for the costs and benefits presented. When the estimates of costs and benefits are based on an economic model, the reliability of the data for making longer-term estimates, and the assumptions underpinning the model, need to be scrutinised further. It is important to review sensitivity and multivariable probabilistic uncertainty ranges.

Consistency is important with regard to sources of data and time horizons, as well as which costs are included over a fixed timeframe. All proposals should be assessed with a minimum 5- or 10-year time horizon, so that those whose benefits are achieved over a longer duration are fairly compared with

proposals that have an immediate benefit. Discounted costs and benefits that occur beyond the first year are also needed.

The inclusion of costs from a broad perspective is also important, for example direct and indirect costs to society. When considering indirect costs, both labour force impacts and household productivity are important, so as not to disadvantage different age group and gendered contributions to society.

While there are various examples in the published literature of mixed methods, structured approaches to priority setting, we do not believe we should be suggesting any one approach, but rather it should be left to those with technical expertise in priority setting to describe their preferred framework.

2. *Should there be minimum cost-effectiveness and/or cost-benefit ratios and how should they be set?*

We do not believe there should be minimum cost-effectiveness and/or cost-benefit ratios; however, proposals that are potentially cost-saving, or those that are more cost-effective (e.g. have a lower cost per positive outcome achieved), should be prioritised. Where the costs and benefits of two different proposals are similar, factors such as the level of trust in the data, fiscal effects, equity, and ease of implementation should be carefully examined and considered when making a decision about the allocation of resources.

3. *How should decision makers balance the need to assess early effectiveness of programs with the need to maintain consistent long-term funding for programs with long-term benefits?*

The early effectiveness of programs may not necessarily reflect their long-term benefits. Ideally however, there are concrete short-term benefits that lead to longer-term benefits for patients. For example, the provision of reperfusion therapies for acute stroke will reduce the amount of damage to the brain, and improve patient independence and survival. This in turn will increase their workforce productivity, and reduce the likelihood of institutionalisation. When proposals rely on data collected in the short-term, these outcomes should continue to be monitored for their ongoing effectiveness. Conversely, preventing stroke is a long-term investment, with benefits realised many years later. To fairly compare options over the longer term, time horizons are needed that also account for the costs of delivering each option successfully.

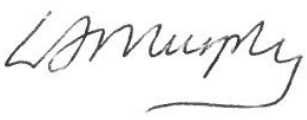
4. *How could a diversification strategy be designed to ensure that prevention programs from different sectors and with benefits across different timeframes are funded?*

There should be clear communication regarding time horizons for the estimates of costs and benefits, and whether these are based on primary data collection or economic modelling. A recommendation could be to have standardised time horizons for proposals. Please see our response to Question 1.

In summary, stroke prevention remains one of the most cost-effective ways of reducing the impact of stroke, including the demand on acute care services, and boosting national productivity, in Australia. Stroke Foundation strongly supports the establishment of a National Prevention Investment Framework to facilitate investment in prevention programs that improve outcomes for all Australians. By embedding rigorous, long-term evaluation and clear co-funding arrangements between the Australian and state and territory governments, this Framework will drive sustainable, high-value investment in primary and secondary stroke prevention. This will save lives, reduce avoidable hospitalisations, and deliver significant economic and societal benefits for decades to come.

Thank you for the opportunity to provide feedback on the interim report.

Yours sincerely



Dr Lisa Murphy
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