

Submission to the Commission of Audit from the National Heart Foundation of Australia



Portfolio:	Health
Terms of reference addressed:	Efficiency and effectiveness of government expenditure
Key points:	<p>Cardiovascular disease is the most costly disease group in terms of direct healthcare expenditure, accounting for \$7.9bn or 11% of spending each year</p> <p>The Australian Government has opportunities to improve efficiency and effectiveness of expenditure and reduce avoidable hospital admissions by:</p> <ol style="list-style-type: none">1. Increasing early detection of people at high risk of chronic and acute disease2. Improving quality of healthcare services3. Increasing uptake of cost-effective cardiac rehabilitation and secondary prevention programs.4. Investing in cost-saving and cost-effective preventive health measures

The Heart Foundation appreciates the Australian Government's 2013 election commitment to "tackle chronic diseases" and "prepare the health system for the demographic changes ahead".¹

While there has been significant progress over the past five decades, cardiovascular disease (CVD) – heart, stroke and vascular disease – remains the leading cause of death in Australia, the most expensive disease group in terms of direct healthcare costs and a major cause of avoidable hospital admissions and disability.

We acknowledge the Government's determination to improve the efficiency and effectiveness of health expenditure, noting there are significant opportunities to achieve this by reducing avoidable hospital admissions, especially the large number caused by avoidable cardiovascular disease. This is particularly important following the introduction of activity based funding, with shared acute and sub-acute care costs between federal and state/territory governments.

¹ *The Coalition's Policy to Support Australia's Health System*, August 2013.

Measures that can help achieve this goal are set out below.

1. Improve early detection of people at high risk of heart attacks, strokes and other chronic conditions by improving the uptake of absolute risk assessment and on going-management in primary care, in line with initiatives in other countries, such as New Zealand and the UK.

Cardiovascular disease – principally heart attack and stroke – has a strong relationship with other significant chronic diseases, in particular type 2 diabetes and chronic kidney disease.

Because they share risk factors, underlying causes and disease mechanisms, these major chronic diseases often occur together. For example, it is estimated that more than 400,000 Australians have both CVD and diabetes. Importantly, effective prevention and management of one condition can lead to reduction in the risk of related diseases.²

Unfortunately, too many people are at high risk of developing these diseases, or who are currently living with them, go unrecognised in the community. This leads to avoidable hospital admissions and premature death at significant social and economic costs to the nation.

Early detection and ongoing management of these chronic diseases is the key to reducing the number of CVD events (such as heart attacks and stroke) occurring each year. It will also reduce the incidence of diabetes and chronic kidney disease.

The current suite of government-funded health checks do not effectively identify those at risk. Primarily this is 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.

In 2009, the Australian Institute of Health and Welfare published a framework for monitoring the prevention of vascular and related disease. The framework cited evidence that existing vascular and related disease assessment and management programs had limited uptake and were not well integrated or promoted as part of a national preventative health system.

It revealed that less than a quarter of those over 75 years and only 6% of those aged 45-49 were accessing regular health checks.³

Action is needed to improve uptake of the absolute risk assessment guidelines in primary care and to ensure ongoing management of patients at high risk. This could commence with the introduction of a simple indicator to measure and assess performance in general practice.

² Australian Institute of Health and Welfare (2009) *Prevention of cardiovascular disease, diabetes and chronic kidney disease: targeting risk factors*.

³ Australian Institute of Health and Welfare (2009) data summarised in National Vascular Disease Prevention Alliance Position Paper, May 2011, *Risk awareness raising, assessment and management for the prevention of vascular and related diseases*.

2. Increase the quality of care by addressing variations in care, developing action plans, and supporting new clinical standards currently under way.

Improving the quality of care will help reduce costs to the health system. The Australian Government should therefore continue to support measures that will directly improve the quality of frontline care delivered in both primary and acute care settings.

This can be achieved by supporting:

- the establishment of a national cardiac devices register, currently underway. This will help improve the quality of care for people receiving high risk cardiac devices.
- the development of CVD action plans as a measure to identify priorities and drive improvements in service delivery.
- the development of new clinical standards for heart attack and stroke currently being developed by the Australian Commission on Safety and Quality in Healthcare.

3. Increase the uptake of cardiac rehabilitation and secondary prevention for patients who have had a heart attack or have heart failure. This will greatly reduce the chance of having further cardiac events while improving their quality of life.

There are 684,000 Australians living with coronary heart disease (CHD), most of whom have had a heart attack or have angina.⁴

People who have had a heart attack or other cardiac events are at high risk of future heart attack. Fortunately, there is strong evidence to show that this risk can be markedly reduced through effective cardiac rehabilitation/secondary prevention.

Since the 1980s, meta-analyses of traditional cardiac rehabilitation have shown a reduction in mortality of about 25%.

Cardiac rehabilitation is designed to encourage lifestyle modification, address psychosocial risk factors including depression, and enhance the quality use of medicines which have been shown to improve health outcomes in this group (these include lipid lowering, antihypertensive, anti-platelet and other medications).

Although the World Health Organisation and the Heart Foundation recommend that all patients who have had a heart attack, heart surgery, or other heart or blood vessel disease are routinely referred to an appropriate cardiac rehabilitation and prevention program, only a minority access these services.

While there are no national figures available in Australia, a Queensland study showed that 70% of acute coronary syndromes (ACS) patients did not access cardiac rehabilitation programs.⁵

⁴ Australian Institute of Health and Welfare (2008) *Australia's Health 2008*.

Disturbingly, studies suggest the biggest contributor to non-completion of cardiac rehabilitation is lack of referral to a cardiac program.⁶

Reform of cardiac rehabilitation services, with a focus on driving up access and participation rates, is an ideal candidate for a national partnership agreement, possibly with individual states or territories, to drive innovation and reform that can become models for adoption elsewhere.

National Partnership Agreements - either bilateral or multilateral - could be used to address serious gaps in cardiovascular services, improve health outcomes and reduce avoidable hospital admissions. Areas in which partnership agreements could be used to improve quality and better manage costs include:

- Cardiac rehabilitation – improving low access and completion rates
- Multi-disciplinary heart failure programs – improving quality and access
- Reducing time to treatment for people suffering heart attack and stroke

4. Invest in cost-effective or cost-saving preventive health measures, including:

- a. improving nutrition through a strengthened food reformulation program, implementing an action plan to reduce salt intake, and supporting the introduction of the new star-based front-of-pack labelling system**
- b. reducing smoking rates through proven tobacco control strategies, including tobacco tax and education campaigns**
- c. helping more people become more active by supporting active travel (walking, cycling and access to public transport) and school-based programs.**

Food reformulation

The potential health gains from food reformulation are enormous. Reducing intake of sodium from processed food by 15-25% in Australia would avert 5,800-9,700 heart attacks and 4,900-8,200 strokes within ten years.⁷

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

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

⁵ Scott I, Lindsay K, Harden H (2003) *Utilisation of outpatient cardiac rehabilitation in Queensland*, Medical Journal of Australia.

⁶ Nagle A, et al (2002) *Prevalence of referral, attendance and completion of outpatient cardiac rehabilitation in the Hunter region of NSW*, American Heart Journal.

⁷ Goodal S, Gallego G. (2008) *Scenario modelling of potential health benefits subsequent to the introduction of the proposed standard for nutrition, health and related claims*, Sydney: Centre for Health Economics Research and Evaluation.

- Cutting saturated fat intake from 13.5% to 11% of daily energy intake could result in 3,500 fewer diet related deaths each year.⁸

A 2007 study published in the *British Medical Journal* suggests that a reduction in salt intake of 25% to 30% could lead to a dramatic reduction in heart attacks and strokes by 20% or more.⁹

Poor diet is known to influence the risk of cancer, heart disease and other conditions. Around 70,000 fewer people would die prematurely each year in the UK if diets matched the nutritional guidelines on fruit and vegetable consumption, and saturated fat, added sugar and salt intake. There are social inequalities within diet-related ill health that demand attention. And alongside the social impacts, the economic burdens of diet-related ill health are huge – perhaps £6 billion in additional NHS costs alone each year.

Food Matters: Towards a strategy for the 21st century: UK Cabinet Office, July 2008

A US study published in 2010 suggests that collaboration with industry that decreases mean population salt intake by 9.5% (as achieved in the UK) would avert, over the lifetime of adults aged 40 and over:

- 514,000 strokes
- 480,000 heart attacks
- \$32.1bn in medical costs.¹⁰

While regulation would be the most effective means of achieving food reformulation, the voluntary engagement of industry through firm government leadership has proven to be effective in the UK and elsewhere. The Australian initiative – a government-NGO-food industry partnership known as the Food and Health Dialogue – is off to a good, though slow start, and now needs to be strengthened and accelerated. It has its origins with the Howard Government under the leadership of former Assistant Health Minister, Christopher Pyne.

Tobacco control

Tobacco kills 15,500 Australians every year costing the health system and the economy \$31.5bn annually.¹¹ Tobacco is Australia's leading preventable cause of death and injury and is a major cause of cardiovascular disease, including heart attack, peripheral vascular disease and stroke.

Research conducted internationally and in Australia, shows that when a tax increase occurs, the number of people quitting and seeking help to quit increases.

Studies also show that people from lower socio-economic groups may be more likely to quit as a result of tax increases. Tobacco use is significantly higher among disadvantaged groups.

⁸ UK Cabinet Office (2008) *Food Matters: Towards a strategy for the 21st century*.

⁹ Cook N, et al (2007) *Long term effects of dietary sodium reduction on CVD outcomes*, British Medical Journal.

¹⁰ Smith-Spangler C, et al (2010) *Population strategies to decrease sodium intake and the burden of cardiovascular disease: A cost-effectiveness analysis*, Annals of Internal Medicine.

¹¹ Australian Institute of Health and Welfare (2012) *Australia's Health 2012*.

Increases in tobacco taxation are strongly supported by the Australian community. Opinion polls and surveys conducted over the past 20 years show majority support for tobacco tax increases, especially if the revenue is diverted into smoking cessation and health initiatives.

We note and applaud the Australian Government's commitment to introduce in full the tobacco tax increases announced by the former government earlier this year. The Australian Government should continue to invest in tobacco control – particularly taxation and education campaigns - as highly cost-effective public health interventions.

Physical activity

Physical inactivity is a major health problem in its own right. Disturbingly, about half of Australian adults (54%) are not sufficiently physically active to gain health benefits. Physical inactivity:

- costs the health budget an estimated \$1.5bn a year¹²
- causes 16,000 premature deaths a year¹³
- increases the risk of heart disease, stroke, diabetes, colon and breast cancer
- is a critical factor in Australia's obesity epidemic, with more than half of all Australian adults being overweight or obese.

The Australian Government should establish a partnership between key stakeholders to help drive greater participation rates in physical activity, including through active travel, school-based programs and workplace initiatives.

Further information

Our contact officer, [REDACTED], Director, Government Relations, can provide any further background information you may need. He can be contacted at anytime on either [REDACTED] or via email at [REDACTED]

ATTACHMENTS:

1. Fact sheet: Acton on heart disease will reduce avoidable hospital admissions

¹² Australian Institute of Health and Welfare (2007) *The Burden of Disease and Injury in Australia 2003*.

¹³ Medibank Private, Econtech and KPMG (2008) *Cost of Physical Inactivity, 2nd Report*.

Action on heart disease will reduce avoidable hospital admissions

- Cardiovascular disease (CVD)¹⁴ is the leading killer of Australians: 46,000 deaths (31.7% of all deaths) in 2010¹⁵
- CVD is the most costly disease group: \$7.9bn or 11% of direct healthcare expenditure a year¹⁶
- CVD accounts for a large number of potentially preventable hospitalisations
- The direct health costs of heart attacks is estimated at \$1.1bn a year
- There are an estimated 3.7m Australians with long-term CVD¹⁷
- 1.4m Australians have a disability associated with CVD¹⁸
- CVD death rate in rural/remote areas is 1.4 times higher than in major cities¹⁹
- Millions of Australians have risk factors for CVD and are unaware of it. For example, 6.5m Australians have high blood cholesterol, but 90% of them are unaware of it²⁰
- Addressing lifestyle factors can reduce mortality risk by 66%²¹

Heart, stroke and vascular disease – collectively known as cardiovascular disease (CVD) – remains the leading killer of Australians.

While mortality rates have been in decline for several decades, CVD still causes around one-third of all deaths (31.7%), is a leading cause of the total burden of disease in Australia (18%), and imposes massive social and economic costs, comprising 11% of total direct healthcare expenditure.^{22,23}

Key actions will reduce death and suffering from CVD and cut avoidable hospital admissions. These include:

- investing in prevention – tobacco control, physical activity and nutrition
- ensuring heart attack patients get access to cardiac rehabilitation, and
- early detection of people at high risk in primary care.

¹⁴ Heart disease, stroke and vascular disease are collectively known as cardiovascular disease (CVD).

¹⁵ Australian Bureau of Statistics (2012) *Causes of death 2010*.

¹⁶ Australian Institute of Health and Welfare (2012) *Australia's Health 2012*.

¹⁷ Australian Bureau of Statistics (2012) *National Health Survey 2011-12*.

¹⁸ Australian Institute of Health and Welfare (2009) *Impact of falling cardiovascular disease death rates: deaths delayed and years of life extended*. Bulletin 70.

¹⁹ Australian Institute of Health and Welfare (2011) *Cardiovascular Disease Australian Facts 2011*.

²⁰ Australian Bureau of Statistics (2013) *Australian Health Survey, Biomedical Results for Chronic Diseases*.

²¹ Loeffel M, Walach H. (2012) *The combined effects of healthy lifestyle behaviours on all cause mortality: A systematic review and meta-analysis*, Preventative Medicine.

²² Australian Bureau of Statistics (2012) *Causes of death 2010*.

²³ Vos, T & Begg, S. (2003) *The burden of cardiovascular disease in Australia for the year 2003*, Centre for Burden and Cost-effectiveness, University of Queensland School of Population Health.