National Stroke Foundation

Submission to the Tasmanian Parliament's Joint Select Committee on Preventative Health Care Inquiry

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INTRODUCTION

The National Stroke Foundation welcomes the opportunity to provide a response to the Tasmanian Parliament's Joint Select Committee on Preventative Health Care Inquiry.

As a member of the Tasmanian Chronic Disease Prevention Alliance and through this, the Health in All Policies Collaboration, the National Stroke Foundation 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 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 stroke or cardiovascular disease perspective. Our main focus is on Terms of Reference 2: *The need for an integrated and collaborative preventative health care model which focuses on the prevention, early detection and early intervention for chronic disease*.

TASMANIA'S HEALTH CHALLENGE

There are clear health issues facing Tasmanians and various reports identify health indicators showing Tasmanians have higher prevalence of risk factors for chronic disease than other Australians.

The National Health Survey 2007/08 reported that 79% of Tasmanian residents reported having one or more chronic health conditions. Alarmingly 44.9% reported three or more conditions – the highest Australian rate listed in the Survey (NT was not listed).[1]

The prevalence of heart, stroke and vascular disease (cardiovascular disease or CVD) is higher in Tasmania with 7.6% prevalence compared with 5.1% nationally.[2]

A major risk factor for CVD and stroke in particular is hypertension or high blood pressure and Tasmanian prevalence is 13.2% compared with 9.4% nationally.[3] This prevalence rises to 19.7% in 45-64 year olds and 46.5% in over 65s[4].

Obesity is another major CVD risk factor and the *2009 Tasmanian Population Health Survey* reports that over half of all Tasmanians reported being overweight or obese (51.9%). Almost 1 in 5 Tasmanians are obese (18.7%), with over 60% of those aged 45 years and over[5].

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[1] National Health Survey 2007/08
[2] Australian Institute of Health and Welfare. Heart, stroke and vascular diseases — Australian facts 2004. AIHW, 2004, Cat. No. CVD 27
[3] Australian Institute of Health and Welfare. Heart, stroke and vascular diseases—Australian facts 2004. AIHW, 2004, Cat. No. CVD 27
[4] National Health Survey 2007/08
[5] Tasmania Department of Health and Human Services, Epidemiology Unit, Population Health, 2009 Tasmanian Population Health Survey: Highlights

Alarmingly, 14.3% of obese Tasmanians have diabetes compared to only 6.6% of all Tasmania[6]. Type 2 diabetes is another major risk factor for stroke.

Avoidable mortality, which refers to deaths that could have been avoided if effective interventions had been in place, is an issue for Tasmania which experiences higher avoidable mortality rates than all other jurisdictions, except the Northern Territory[7].

While avoidable mortality is improving it is worth noting that the Tasmanian population is ageing at a faster rate than anywhere else in Australia[8].

"In 2006 the populations of Tasmania and South Australia shared the highest median age of approximately 39 years. By 2051, Tasmania's median age is projected to be 49.8 years compared to Australia's median age of 45.2 years"[9].

Age is another major factor in CVD meaning potential further pressure on avoidable mortality if effective prevention measures are not implemented.

Finally, the *Fair and Healthy Tasmania Strategic Review* and subsequent *a Healthy Tasmania* policy document identifies health literacy as a significant concern for Tasmania.

"The Australian Bureau of Statistics tells us that more than 60 per cent of people in Tasmania do not have adequate health literacy, including 30 per cent of people educated to a Bachelor degree[10].

Low health literacy is a significant and mainstream issue that contributes both to poor health outcomes and the cost burden for Tasmania's health and human services system.

Low health literacy limits people's capacity and motivation to self-manage their health, causes avoidable hospital admissions and emergency service usage, medication and treatment errors, and makes it hard for people to access our services.[11]"

Health literacy has a significant impact on stroke given the time critical nature of stroke treatment. Life saving thrombolysis can only be administered within 4.5 hours of a stroke and early access to specialist stroke units is proven to result in better health outcomes for stroke patients.

Tasmanian hospitals have stroke units but access to thrombolysis is poor. Our 2011 Clinical Audit identified that no patients received thrombolysis treatment during the reporting period. The same report showed that 7% of stroke patients nationally received the treatment[12].

This troubling statistic is in large part due to the fact that only 23% of Tasmanian stroke patients get to hospital in time to receive the treatment. Nationally this figure is 36%[13].

While geographic distance and transport issues are often a barrier, we know that failure to act when stroke symptoms arise is the main factor behind stroke treatment delay, accounting for around 68% of the total delay in time to admission for ischaemic stroke[14].

Many people are unable to act because they cannot recognize the symptoms of stroke when it occurs. Currently one in five people cannot recognize any signs of stroke and only a third of

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[6] Tasmania Department of Health and Human Services, Epidemiology Unit, Population Health, 2009 Tasmanian Population Health Survey: Highlights
[7] Tasmania Department of Health and Human Services, Epidemiology Unit, Population Health, Health Indicators Tasmania 2008
[8] Tasmania Department of Health and Human Services, Epidemiology Unit, Population Health, Health Indicators Tasmania 2008
[9] Tasmania Department of Health and Human Services, Epidemiology Unit, Population Health, Health Indicators Tasmania 2008 p11
[10] Australian Social Trends, Australian Bureau of Statistics, 4102.0, June 2009
[11] Tasmania Department of Health and Human Services, Population Health, a Healthy Tasmania, Setting new directions for health and wellbeing p. 17
[12] National Stroke Foundation (2011) National Stroke Audit Acute Services Organisational Survey Report 2011
[13] National Stroke Foundation (2011) National Stroke Audit Acute Services Clinical Audit State Report 2011 Tasmania
[14] Webster P, Radberg J, Lundgren B, Peltonen M. (1999) Factors associated with delayed admissions to hospital and in-hospital delays in acute stroke and TIA. Stroke; 30: 40-48.

people can recognize three or more signs.[15]

In this light we would support efforts to raise health literacy levels and stroke literacy specifically as part of a prevention approach.

In terms of impact, cardiovascular disease is Australia's leading cause of death and a leading cause of disability. Between 2001 and 2005 CVD killed over 1000 people per year in Tasmania, accounting for more than a quarter of all deaths[16].

Stroke is also expensive. It is noted in the Health Indicators Tasmania Report that Stroke is an important contributor to hospital costs with average length of hospital stay twice that of other cardiovascular disease[17]. This is largely due to the disability that results from stroke and the rehabilitation needs that follow[18].

A PREVENTATIVE HEALTH CARE MODEL

The National Stroke Foundation 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.

It is our view that there are many elements of the Tasmanian Government's *Connecting Care, Chronic Disease Action Framework for Tasmania 2009-2013* policy document that should be retained as part of a preventive health care model. Indeed, these policy principles need to be supported with sufficient targeted investment in order to realise significant health gains in Tasmania.

The National Stroke Foundation advocates for a system that empowers people to identify and manage their personal health risk. Our position is in-line with *Connecting Care* Action Items including:

- Early detection and early intervention programs, including lifestyle and risk factor modification
- Appropriate management and clinical care for people with chronic disease
- People with or at risk of chronic disease supported to actively self-manage their health
- Integration and coordination of prevention and care

We know that too many people are not aware of their personal risk factors for diseases such as stroke and heart disease, type 2 diabetes and chronic kidney disease and are not empowered to self manage that risk.

We also know that there is currently no integrated system for detecting, assessing or managing risk of vascular and related diseases within the health system and that existing primary care health checks are underutilized. An Australian Institute of Health and Welfare report from 2009 reported that only 6.7% of eligible people accessed the 45-year-old health check and that only 23% of eligible people accessed the older persons health assessment[19].

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.

In line with recommendations from the National Vascular Disease Prevention Alliance we believe

[15] National Stroke Foundation. National Stroke Awareness Survey. Unpublished data. 2011
[16] ABS, Mortality Database
[17] AIHW, Australia's Health 2004, Canberra, 2004, p.61
[18] Tasmania Department of Health and Human Services, Epidemiology Unit, Population Health, Health Indicators Tasmania 2008
[19] Risk assessment opportunities provided by Medicare – description and demand (Australian Institute of Health and Welfare, 2009)

there are three key stages required to empower Tasmanians to better understand, manage and improve their disease risk.

Firstly there must be government investment in quality controlled and evaluated activities to increase identification of potentially at-risk individuals and refer these people to general practice for more comprehensive assessment and follow up.

A system of proactive checks in primary care and other community settings such as community health centres, pharmacies and workplaces is required to maximize population reach and, importantly, to reduce inequalities in access.

Appropriate activities range from awareness raising of risk factors through to undertaking preliminary risk awareness and early identification activities such as blood pressure measurements or using the AusDrisk assessment tool.

Unlike screening programs, such as those for breast and colorectal cancers, a program of this type would not provide a screening test. Rather it would aim to increase an individual's awareness of risk through consideration of individual risk factor status and prompt more thorough ongoing risk assessment and risk management.

Individuals would be provided with tailored advice about what they can do to reduce their personal risk of vascular and related disease. Subsequent action would entail a combination of lifestyle advice and access to related programs and, when necessary, further assessment.

The second step is provision of high quality assessment of individual vascular and related disease risk by collecting data on major risk factors through simple questions, tests and measurements considered in the context of risk for CVD, diabetes and kidney disease.

The primary care setting, including that of general practice and Aboriginal Medical Services, is the appropriate one for undertaking comprehensive vascular and related disease risk assessments and delivering ongoing preventative care for those people identified to be at higher risk. Assessment may be undertaken by a General Practitioner (GP) or by a practice nurse working with a GP and with protocols.

Assessment in the general practice setting should be undertaken amongst those referred through the community based settings but could also be initiated by the GP or practice nurse on visits for other matters. Ongoing preventative care may be provided by the relevant team of medical, nursing and allied health professionals in the primary care and other community settings.

The assessment should include recognised measures to assess risk including:

- A CVD risk assessment (an absolute risk assessment where appropriate and consideration as high risk if clinically indicated).
- AUSDRISK (+/- blood glucose tests).
- Serum creatinine and urinary albumin.

Assessment and classification of moderate and high-risk individuals should result in provision of medical interventions to reduce individual risk and referral to quality-assured lifestyle modification programs. GP's would prescribe necessary medication and refer people at risk to lifestyle interventions which could be delivered through a range of community settings.

Medical interventions could include drug treatments for high blood pressure and high blood cholesterol.

Principal evidence-based lifestyle interventions could include: smoking cessation services; weight management or exercise and behaviour change programs. Lifestyle modification programs such as Get Healthy that incorporate weight reduction, healthy eating and physical activity support are

currently available and efforts should be made to ensure easy access for all people who may be at increased risk of vascular diseases. Establishment of a systematic process for identification of risk of CVD, diabetes and kidney disease will increase referrals to such programs increasing their efficiency.

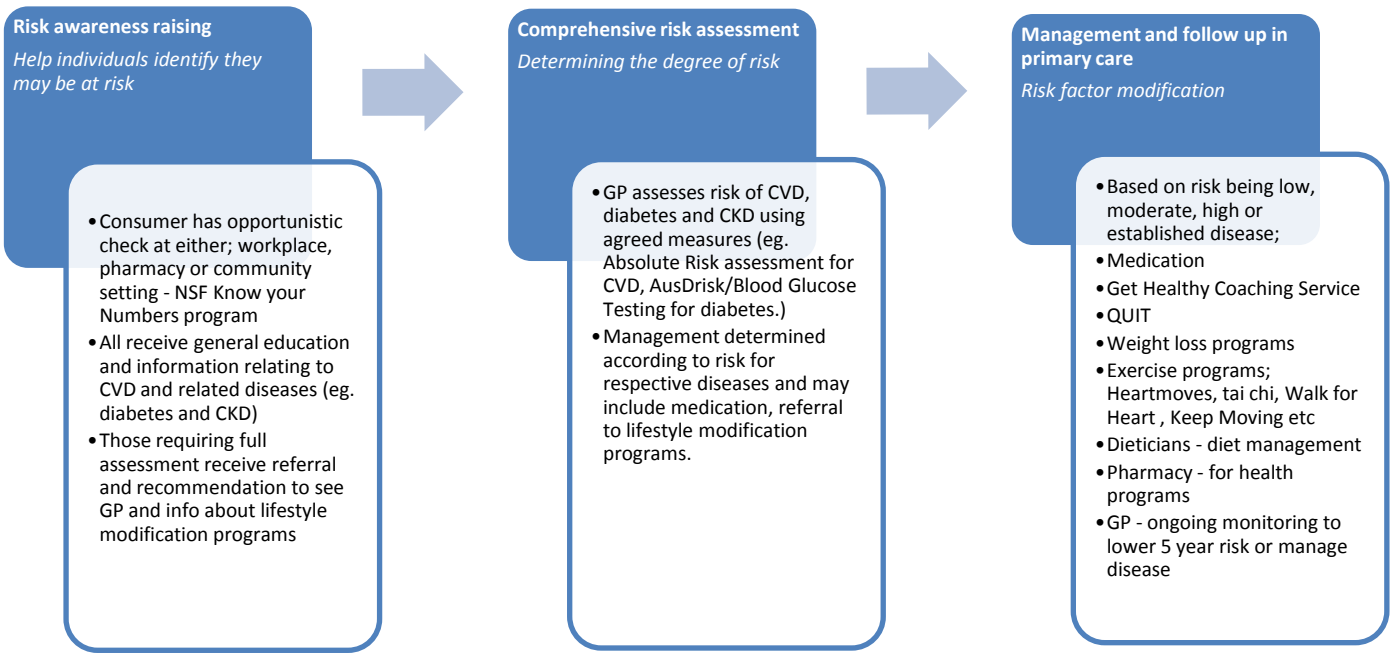
There is also scope to develop and introduce new tools designed to assist consumers to better understand their risk and involve them in the process of decision making about treatment and care.

Decision aids are an example of a tool used by health practitioners to involve patients in the decision making process about things such as potential medical treatment and lifestyle modification. Ranging from story board style tools to increasingly sophisticated Smartphone and tablet technology, decision aids are demonstrating potential to be a useful and effective communication tool.

The use of decision aids with patients has been shown to significantly increase knowledge as well as accuracy of risk perception[20]. Patients are reported to have greater satisfaction with the decision making process, have more realistic expectations and are more likely to be decisive with fewer patients left undecided about their treatment[21].

As a specific example, for patients with atrial fibrillation who had participated in a major clinical trial, the use of an audiobooklet improved their understanding of the benefits and risks associated with different treatment options and helped them make definitive choices about therapies[22].

To quote from a literature review on shared decision making and decision aids: “better aids are those in which the information is personalised to the individual patient. Therefore, web based or computer programs can have an advantage. They can be programmed to enhance interactivity and contain the potential for personalising information such as individual risk factors based on each patient’s risk profile”[2324].



[20] Stacey D, Bennett CL, Barry MJ, Col NF, Eden KB, Holmes-Rovner M, Llewellyn-Thomas H, Lyddiatt A, Légaré F, Thomson R. Decision aids for people facing health treatment or screening decisions. Cochrane Database of Systematic Reviews 2011, Issue 10. Art. No.: CD001431. DOI: 10.1002/14651858.CD001431.pub3.
[21] Thistlethwaite, Jill, Evans, Rebecca, Nan Tie, Rodney, and Heal, Clare (2006) Shared decision making and decision aids. Australian Family Physician, 35 (7). pp. 537-540.
[22] Man-Son-Hing M, Laupacis A, O’Connor AM, et al. A patient decision aid regarding antithrombotic therapy for stroke prevention in atrial fibrillation: a randomised controlled trial. JAMA 1999;282:737–43.
[23] Shared decision making and decision aids, A literature review, Jill Thistlethwaite BSc, MBBS, MMEd, FRCGP, FRACGP, DRCOG.
[24] Edwards A, Elwyn G. The potential benefits of decision aids in clinical medicine. JAMA 1999;282:779–80.