Australian Government

# Australian Government response to Review of cardiovascular disease programs

This response highlights commitment to reducing the burden of cardiovascular disease through targeted investment and through broader health reforms.

April 2011

## Introduction

Cardiovascular disease (CVD) is Australia's biggest killer and a leading cause of disability. In 2008, there were 48,456 deaths from CVD in Australia (34% of all deaths nationally).[1] There have been significant gains in recent decades, with a 76% reduction in the death rate for CVD since the late 1960s, and more than 78% of CVD deaths now restricted to people aged 75 years and over.[2] Nevertheless, there is always potential for further improvement in prevention, detection and treatment of CVD.

The Australian Government commissioned Ernst & Young to undertake the Review of Cardiovascular Disease Programs (the review) to identify the effectiveness of current programs to support prevention, early detection and better management of CVD. The CVD review was also to provide advice on staged options to improve CVD control nationally.

The government's response to the recommendations of the review outlines the Australian Government's commitment to reducing the impact of cardiovascular disease. The key focus of that commitment is health reform to improve and modernise Australia's health system to prepare for the challenges of the future - including the large and increasing burden of chronic conditions such as cardiovascular disease.

This response also reflects a firm commitment to core elements of our health system that are vital to CVD prevention, detection and management. National programs, including Medicare and the Pharmaceutical Benefits Scheme, continue to ensure access to care and medicines, promote best practice care and treatment and support the continuous improvement of our evidence-base. Through these programs there is a significant investment in CVD at the national level.

The government has framed its response to the review's recommendations in the context of existing programs as well as the national reforms to the health and hospitals systems. The response also reflects the government's strong commitment to its fiscal strategy and strict spending limits to return the budget to surplus.

## The national health reform agenda — implications for CVD

The Australian Government is investing an additional $7.8 billion over the period 2010-2014 for fundamental reform of the health system. These far-reaching national health reforms will ensure that we can provide affordable and accessible health care for all Australians, and cope with the demands of the future.

The reforms are designed to significantly improve and modernise Australia's health system through reform to governance and financing arrangements. Performance and accountability measures will be implemented to ensure continuous improvement, and an increased focus on primary health care and immediate investments in infrastructure aim to alleviate pressure on the public hospital system.

Structural reform will change the way health services are delivered through better access to high quality, integrated care designed around the needs of the patient and a greater focus on prevention, early intervention and the provision of care outside of hospital, where and when people need it.

Additionally, there will be a focus on delivery of services to meet local needs. Responsibility for hospital management will be devolved to Local Hospital Networks, giving communities and clinicians a greater say in how hospitals are run. Local Hospital Networks will work closely with Medicare Locals and new aged care information and assessment services to deliver better integration and smoother transitions for patients across the entire health system.

To ensure local clinicians have a say in how hospitals are run the government is establishing Lead Clinicians Groups. The Lead Clinicians Groups measure recognises the role of clinical leadership and expertise in delivering safer and higher quality health care, to the benefit of patients and their families. The establishment of Lead Clinicians Groups will, where feasible, build upon and complement current state and territory initiatives in the area of clinical engagement. Clinical leadership and engagement is an essential part of a well integrated and functioning health system and these groups will work closely with Medicare Locals and Local Hospital Networks.

The government will pay 50 per cent of the efficient costs of growth for hospital services provided to public patients. This will be done in two stages, increasing to 45 per cent in 2014-15 and to 50 per cent in 2017-18. This funding will be provided on an activity basis, funding hospitals for the services they actually provide.

Through Activity Based Funding the government will reward public hospitals for treating more patients more efficiently, ensuring quicker access to elective surgery and emergency department care. This is a major transformation in national funding for public hospitals that will yield improvements in access to care.

To drive improvement in the quality of care and transparency around the performance of health services through the new Performance and Accountability Framework, the National Performance Authority (NPA) will develop and produce Hospitals Performance Reports and Healthy Communities Reports (on primary health care performance). These reports will help Australians make more informed choices about their health services, and help ensure the standard of care patients receive continues to improve. This framework will be used over time to improve performance across hospital, GP and primary health care services.

The government is also making immediate investments in improved access to care, increasing availability of care that is currently in short supply. The government is funding 1,300 extra sub-acute beds to improve access to palliative care, rehabilitation and mental health services.

The government is also continuing to deliver major initiatives to improve elective surgery and emergency departments, by building new operating theatres and emergency department beds. New services are also being established to reduce the pressure on emergency departments, by providing people with prompter access to care in the community. One such initiative is an after-hours GP telephone advice service, which will make it easier to talk to a doctor after hours. From 1 July 2011, this service will provide medical advice over the phone after-hours from a registered nurse, and if necessary, a GP. The service will make it easier for people to get advice on urgent medical conditions and be given advice on the best course of action.

These major reforms will deliver better health and hospital services. The changes to the funding arrangements will provide a secure funding base for health and hospital services into the future. The new governance arrangements will improve the responsiveness of the system to local needs, enhance the quality of services and allow greater transparency. The reforms will drive improved health outcomes for all Australians, including improvements to the prevention and management of specific conditions that affect many Australians such as CVD.

## Australian Government response to the CVD review

The review report specified seventeen recommendations, including seven higher priority recommendations grouped as foundation recommendations, and ten additional recommendations.

### Foundation recommendations

F1. Use the National Health and Medical Research Council (National Institute of Clinical Studies) to manage the development and review of new and existing national clinical practice guidelines for CVD.

F2. Work strategically with the National Institute of Clinical Studies (NICS) within the NHMRC to improve uptake of nationally standardised clinical guidelines across general practice, acute and community care.

#### Government response

The government recognises the importance of clinical guidelines in translating evidence into practice, to improve the safety and quality of health care. This has been demonstrated through the leading role of the National Health and Medical Research Council (NHMRC), direct support for the development and uptake of guidelines related to CVD, and the emphasis on national standards and performance in national health reforms.

The NHMRC sets standards for the development and review of guidelines, to ensure that they are based on the best available scientific evidence and make clear recommendations for health professionals practising in an Australian health care setting. The NHMRC approves externally developed guidelines that meet the relevant requirements. The NHMRC recommends that all guidelines be reviewed every five years. The Office of NHMRC develops

some clinical practice guidelines on behalf of the Department of Health and Ageing on request.

The National Institute of Clinical Studies, as part of NHMRC, works to improve health care by getting the best available evidence from health and medical research into everyday practice.

The NHMRC established a National Clinical Practice Guidelines Portal to improve access to high quality, evidence-based clinical practice guidelines via a single entry point. This was launched in February 2010 and currently includes nine CVD related guidelines. The relevant website is www.clinicalguidelines.gov.au. This website also includes the NHMRC's Australian Guidelines in Development Register, which aims to improve guideline quality and reduce duplication of guidelines.

The Heart Foundation and NHMRC have partnered to create the Acute Coronary Syndromes Resource Exchange. This web page www.emergencycare.nhmrc.gov.au/gateway enables health professionals across Australia to share tools and resources aimed at improving the uptake of Acute Coronary Syndromes guideline recommendations.

In December 2009, the NHMRC released a stroke care information package designed to improve care for people presenting to the emergency department with acute stroke and transient ischaemic attack. The stroke care package is based on the National Stroke Foundation (NSF) Clinical Guidelines for Acute Stroke Management and aims to support greater guideline uptake in emergency departments.

The NHMRC also contributes to the evidence base for CVD clinical practice guidelines, through its funding of research. In 2009, the NHMRC invested more than $106 million into research on cardiovascular disease, up from $92 million in 2008. With a $74 million increase in funding since 2000, NHMRC funding to cardiovascular disease has increased at an annualised rate of 23% over the decade.

Since 2007, the Department of Health and Ageing has directly funded work on guidelines related to CVD, including the CVD complications of diabetes. This has included:

- Clinical Guidelines for Stroke Management 2010 (National Stroke Foundation)
- CVD absolute risk management guidelines (under development by the National Stroke Foundation, on behalf of the National Vascular Disease Prevention Alliance)
- three specific guidelines on the cardiovascular complications of diabetes and diabetic foot guidelines (under development by the Baker IDI Heart and Diabetes Institute)
- a discussion paper outlining an improved collaborative model for the development of CVD clinical guidelines (National Heart Foundation, 2010) and
- a review of the 2003 Clinical Practice Guidelines for the Management of Overweight and Obesity (risk factors that can influence the burden of CVD) to be undertaken by the NHMRC.

The government is currently considering a proposal from National Heart Foundation seeking $2 million over five years to trial and evaluate the collaborative model for the development of CVD clinical guidelines. The government expects to consult with key stakeholders including the NHMRC, the Australian Commission for Safety and Quality in Health Care (ACSQHC) and the National Stroke Foundation in appraising this proposal.

The Australian Government has provided a range of funding support to improve the uptake of clinical guidelines associated with CVD, including the CVD complications of diabetes, through the Royal Australian College of General Practitioners, the Rural Health Education Foundation, and the Australian Primary Care Collaboratives Program, which supports general practices in improving patient care, including a major focus on coronary heart disease.

The government also acknowledges the importance of easy-to-access information sources for clinical guidelines and pathways that clinicians can use in their everyday work. The government funds the Practice Incentives Program (PIP) to improve the quality and safety of healthcare delivered by GPs, and has included a requirement for electronic decision support for GPs.

Through national health reform the government will also make a landmark $466.7 million investment over two years in the key components of an electronic health record system. This investment will allow all Australians to have access to a personally controlled electronic health record. The initial rollout of the personally controlled electronic health record focuses on providing the patient's health information at the point of care, when authorised by the patient. The clinician's existing electronic decision support tools could then provide appropriate guidance based on the patient's health information.

Improved clinical governance is also a key feature of the government's reforms, including the development and use of clinical guidelines and reconnecting clinicians as partners in planning and delivering healthcare. The reforms reflect a strong and increasing focus on quality and safety in health care and include:

- a National Performance Authority
- lead clinician groups to advise on clinical care and standards, and to develop and encourage the use of evidence-based clinical guidelines and national standards and
- a permanent and expanded role for the Australian Commission for Safety and Quality in Health Care (ACSQHC).

These reforms, coupled with new funding arrangements will provide a supportive framework for implementation of evidence based guidelines and national clinical standards at the local level.

The government's health reform agenda is giving consideration to a strategic and systematic national approach to the development and updating of clinical guidelines and their uptake in practice, including the future role of the Australian Commission for Safety and Quality in Health Care (ACSQHC).

For example, under its expanded role, the ACSQHC will develop and disseminate clinical safety and quality standards and guidelines in the areas of hospitals, mental health and primary care. This will include identifying priority areas and commissioning and managing the development and quality assurance of clinical safety and quality standards and guidelines. The clinical guidelines will be developed by clinical experts and endorsed by the National Health and Medical Research Council (NHMRC). The government will consult with the ACSQHC on the opportunity to address CVD standards and indicators as part of the government's consideration of the National Heart Foundation's guidelines proposal. However, work on the expanded role of the ACSQHC may not begin until the 2012-13 financial year.

F3. Support the work of the Australian Commission on Safety and Quality in Health Care (ACSQHC) to validate its draft operating principles and technical standards for Australian Clinical Quality registries.

**Government response**

The government's health reforms on national standards, performance and clinical governance reflect a strong and increasing focus on quality and safety in health care.

On 20 April 2010, the Council of Australian Governments (COAG) National Health and Hospitals Agreement agreed to continue the Australian Commission for Safety and Quality in Health Care (ACSQHC) as a permanent body with an expanded role in order to develop national clinical safety and quality standards.

The National Health and Hospitals Network Bill 2010 (the bill) provides the framework for the establishment of the ACSQHC as a permanent authority with expanded functions. The bill was passed by the Australian Parliament on 21 March 2011.

The ACSQHC has tested and validated the draft Operating Principles and Technical Standards for Australian Clinical Quality Registries. The Australian Cardiac Procedures Registry and the Australian Stroke Clinical Registry were two of the six Clinical Quality Registries engaged to test and validate the Operating Principles and Technical Standards, with pilot funding of approximately $1 million and $0.5 million respectively. The pilots are now complete.

The ACSQHC has revised the draft Operating Principles and Technical Standards, based on the final reports of the pilot sites and an independent external evaluation. The revised principles and standards can be used by stakeholders to assess the feasibility and value of specific registries established to improve the quality and safety of cardiac procedures.

It is anticipated that in 2011 ACSQHC will develop a costed technical infrastructure plan for Australian Clinical Quality Registries.

F4. Develop an implementation plan for general practice to support the implementation of Absolute Risk Assessments (ARA) to identify people at risk of heart disease, stroke, diabetes, and kidney disease and then address their risk factors through a program involving on-going management.

**Government response**

The Australian Government acknowledges the importance of primary care in preventive health.

The government is funding the National Stroke Foundation, on behalf of the National Vascular Disease Prevention Alliance (NVDPA) to develop CVD absolute risk management guidelines, to complement the NVDPA's existing NHMRC-endorsed CVD absolute risk assessment guideline. This project is due to be completed in February 2012. These clinical guidelines will support general practitioners to help prevent "first ever" cardiovascular disease events, using an absolute risk approach. The Department of Health and Ageing is currently considering a draft version of the guidelines, which are undergoing public consultation.

Under the Slashing Medicare Red Tape initiative, the government rationalised ten existing health assessments items into four new time based items commencing May 2010. The new

Medicare items include provision of appropriate preventive health care including the 45 year old health assessment and the older person's health check. The simplified health assessment items help people including those at risk of CVD to gain access to vital prevention advice and ease red tape burden on GPs allowing them to spend more time with their patients.

The government has announced that it will provide $30 million to pilot coordinated diabetes care from 1 July 2011 over the next three to four years. The Coordinated Care for Patients with Diabetes program is targeted at patients with diagnosed diabetes and is focused on managing care, thus helping to reduce the risk of patients progressing to CVD and other complications of diabetes.

Reforms are also focussing on early intervention and prevention to take pressure off other parts of the health system. The Commonwealth will tackle the lifestyle related risks that cause chronic disease — targeting smoking and binge drinking, in particular. The government has made a commitment of $872 million over six years under the COAG National Partnership Agreement on Preventive Health — the largest single commitment to health promotion by an Australian government.

The establishment of the Australian National Preventive Health Agency (ANPHA) on 1 January 2011 was a key milestone in this stream of health reform. The agency will lead the fight against preventable diseases through preventive health initiatives targeting obesity, along with alcohol, tobacco and other substance abuse, and will be the government's leading adviser on preventive health issues.

F5. Hospitals to be required to undertake and report the results of biennial audits of CVD services (heart attack and stroke) in acute and post-acute care.

**Government response**

The government's hospital reforms call for strong national standards and transparent reporting in the health system and improved clinical governance.

Although hospital performance information is already published by states and territories, it is only relevant to the jurisdiction to which the data relates. There are also differences between states and territories in the scope and data definitions, and in the presentation and accessibility of the information.

Transparency is a key feature of the government's reform of the health system. This will be driven through the publication of nationally consistent performance information about individual hospitals to be delivered by the planned National Performance Authority.

As an interim arrangement, the Australian Institute of Health and Welfare (AIHW) is publishing hospital-level performance information on the MyHospitals website, which was launched in December 2010.

Performance reporting in the MyHospitals website ensures a nationally consistent approach to providing information directly to consumers on the services provided by their local hospital as well as information on how the hospital performs.

The publication of higher level, consistent performance information about hospitals will support the ability of states and territories to publish selected performance information at the jurisdictional level. It is expected that as national hospital reporting evolves, first on the MyHospitals website and then in further work of the National Performance Authority,

jurisdictional reporting will also evolve to present additional complementary local context and reporting.

Consumers, including those with CVD, will benefit in practical ways through hospital level reporting, as well as from the improvements in system performance that will be driven by hospital level reporting.

F6. Investigate the benefits of including CVD risk factors in a national health survey and investigate the benefits and costs of including biomedical risk assessments such as blood and urine collection and analysis.

**Government response**

The Australian Government has committed $51.92 million over four years for the delivery of the first Australian Health Survey in partnership with the Australian Bureau of Statistics and the National Heart Foundation. The Australian Health Survey will collect information on a number of health indicators including diet, physical activity and prevalence of chronic disease risk factors. The survey will include a biomedical component where blood and urine samples will be collected from consenting survey participants and analysed for markers of chronic disease and nutrition status. The survey will commence in 2011.

The Australian Health Survey combines the existing ABS National Health Survey and National Aboriginal and Torres Strait Islander Health Survey undertaken every three and six years respectively, with two new surveys: the National Nutrition and Physical Activity Survey and the National Health Measures Survey (NHMS).

The main chronic disease biomarkers to be measured in the NHMS relate to cardiovascular disease, type-2 diabetes and chronic kidney disease, as these conditions together contribute significantly to disease burden and mortality in Australia and share many lifestyle-related risk factors. The ability to link the data on chronic diseases collected in the NHMS to the data collected at the AHS household interview (such as dietary intake, physical activity habits, use of medications and health services) will provide valuable information to better understand chronic disease risk factors and determinants of health.

Given the useful information expected from the survey the government will contribute up to an additional $1 million to support the measurement of biomarkers for CVD and other chronic diseases. It is expected that this contribution to the survey will result in the production of invaluable data and evidence that will also inform CVD related policy considerations and implementation strategies.

F7. Include specific CVD indicators, including Absolute Risk Assessment, in datasets for national and jurisdictional performance accountability frameworks.

**Government response**

The Australian Government notes that the Australian Commission for Safety and Quality in Health Care (ACSQHC) National Indicators Project, undertaken by the AIHW, has identified 55 indicators to improve safety and quality, including six CVD indicators (AIHW 2009, Towards national indicators of safety and quality in health care).

The Australian Health Survey, to commence in 2011, will collect data on risk factors, including CVD related risk factors.

Such indicators will be available to be utilised by the National Performance Authority (NPA), and in the overarching Performance and Accountability Framework (PAF). Under agreed arrangements the NPA is expressly required to report on selected clinical quality and safety indicators drawn from those developed by the ACSQHC.

## Additional recommendations

G1.1 Develop a government/ industry/ NGO partnership to achieve population wide reductions in saturated fat and dietary salt intake in the Australian context.

### Government response

As part of the COAG National Partnership Agreement on Preventive Health, the government has committed $1 million over four years for an industry partnership, with an initial focus on the food and beverage industry. This partnership has developed principles for industry engagement, initiated a scoping study to develop a nutrient profiling database, and developed an options paper to inform the development of a strategy to promote consistent industry and government consumer messaging on healthy eating practices and physical activity to be discussed with industry partners.

In March 2009, the government established a Food and health dialogue, which provides a non-regulatory platform for government to work collaboratively with industry to improve dietary intakes through reformulation, portion standardisation and consumer messaging. The dialogue's voluntary food reformulation program aims to reduce levels of salt, saturated fat and sugar, and increase beneficial nutrient such as fibre, across a range of commonly consumed products.

In addition, as part of its investment of $872 million under the COAG National Partnership Agreement on Preventive Health, the Australian Government is providing $72 million over the next four years for the Healthy Communities Initiative to support up to 90 local government areas in delivering effective community-based physical activity and healthy eating programs, as well as developing a range of policy environments to support healthy lifestyle behaviours.

The Australian Government will support the implementation of the Healthy Communities Initiative through investment in National Program Grants that enable the roll-out, targeting Local Government Areas Grant recipients, of proven healthy life style programs and development of a quality framework and program and provider registration system and information portal.

The Healthy Communities Initiative is aimed at adults who are not predominantly in the paid workforce and are at a high risk of developing chronic disease, particularly those experiencing socio-economic disadvantage. It aims to help reduce the prevalence of overweight and obesity within the target populations of participating communities by maximising the number of at-risk individuals engaged in physical activity and dietary education programs.

Under the Preventive Health Partnership, the Australian Government will also provide up to $294.4 million from 2011-12 for the Healthy Workers initiative to support workplace health programs that focus on increasing levels of physical activity and intake of fruit and vegetables, as well as decreasing rates of overweight and obesity, reducing harmful levels of alcohol consumption and increasing smoking cessation. Of this amount, up to $289.4 million

will be available to state and territory governments from 1 July 2011. The remaining $5 million is being used by the Australian Government to develop soft infrastructure to support the implementation of state and territory programs from July 2011. This includes the development of national standards and benchmarking, a National Healthy Workplace Charter and national awards for best practice in workplace health programs.

As part of the partnership, the Australian Government will provide up to $325.5 million over four years to state and territory governments from July 2011 for the Healthy Children initiative. Funding will be used to deliver programs for children aged from birth to 16 years that focus on increasing levels of physical activity and improving the intake of fruit and vegetables, as well as reducing rates of overweight and obesity in early childhood education and care environments and school settings.

The government's funding package under the COAG National Partnership Agreement on Preventive Health also includes a further $41 million over four years to extend the Measure Up campaign, which aims to motivate and actively encourage changes in behaviour to reduce the prevalence and impact of chronic disease through addressing lifestyle risk factors such as physical activity and nutrition.

G1.2 Support the work of the National Preventative Health Taskforce in developing national policy and strategy to improve nutrition and reduce alcohol and tobacco consumption, with a focus on reducing lifestyle related risks in socially and economically disadvantaged populations.

**Government response**

The Australian Government has demonstrated its commitment to reduce lifestyle related health risks, through better nutrition, increased physical activity, and other actions to reduce obesity, drug and alcohol abuse, and smoking.

The government's response to the report of the National Preventative Health Taskforce, Taking preventative action: a response to Australia: the healthiest country by 2020, published in May 2010, outlines a number of specific actions it will take in these areas. The response can be found at www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/report-preventativehealthcare

The government committed to the establishment of the Australian National Preventive Health Agency as part of the COAG National Partnership Agreement on Preventive Health. Legislation to establish the agency passed the Parliament in November 2010 and the agency commenced operation on 1 January 2011.

The agency will be the government's key adviser on preventive health issues and will support all Australian health ministers in their preventive health efforts. It will do this by providing evidence-based advice; supporting the development of evidence and data on preventive health programs and the effectiveness of interventions; supporting behavioural change through education and community awareness campaigns; and establishing guidelines and standards.

The agency will be responsible for delivering three key programs under the COAG National Partnership Agreement on Preventive Health:

- National social marketing campaigns relating to tobacco use and obesity ($102 million over four years)
- A preventive health research fund focusing on translational research ($13 million over four years) and
- An audit of the preventive health workforce and the development of a preventive health workforce strategy using the results of the audit ($0.5 million over two years).

Another key role of the agency will be to work in partnership with preventive health stakeholders, including government, industry and non-government organisations to achieve preventive health gains.

***Tobacco***

On 29 April 2010, the government announced a 25 per cent increase in the excise and excise-equivalent customs duty on tobacco products effective from 30 April 2010. This tobacco excise increase represents a substantial first step in responding to the National Preventative Health Taskforce report recommendations on tobacco. This measure alone is expected to reduce the consumption of tobacco by about six per cent and the number of daily smokers by approximately two to three per cent or some 87,000 Australians.

However, the government considers it important to look at the outcomes of this significant increase – in the context of all the other tobacco measures – before considering further adjustments. For example, whilst it is expected that this measure will significantly reduce smoking prevalence, the government is also conscious of possible financial stress on people who continue smoking.

Other measures announced on 29 April 2010 were:

- The introduction of mandatory plain packaging for tobacco products from 1 January 2012, a world first
- Legislation to bring restrictions on Australian internet advertising of tobacco products into line with restrictions on tobacco advertising in other media and
- Record investments in anti-smoking social marketing campaigns over the forward estimates period.

The government's funding package under the COAG National Partnership Agreement on Preventive Health also includes $61 million over four years for a national social marketing campaign to reduce smoking rates in Australia targeting the mainstream Australian population.

The National Tobacco Campaign – More Targeted Approaches ($27.8 million over four years from 2010-11) complements the National Tobacco Campaign and will target high-need and hard to reach groups. This includes people from culturally and linguistically diverse backgrounds, people with mental illness, pregnant women and their partners, people living in socially disadvantaged areas, and prisoners.

***Alcohol***

The Australian Government's National Binge Drinking Strategy includes $103.5 million over six years to June 2014, and comprises a range of measures to address the harms caused by excessive alcohol consumption.

### *Closing the Gap*

The government is also addressing lifestyle related risks in socially and economically disadvantaged populations, particularly Indigenous Australians.

Under the COAG National Partnership Agreement on Closing the Gap in Indigenous Health outcomes, the Australian Government is providing $805.5 million over four years for an Indigenous Chronic Disease Package to contribute to closing the gap in life expectancy. The prevention elements of the package include:

- $100.6 million for national action to reduce Indigenous smoking rates
- $37.5 million to help Indigenous Australians to reduce their risk of chronic disease and
- $22.7 million for local Indigenous community campaigns to promote better health.

G2.1 Implement culturally oriented and effective CVD rehabilitation within Indigenous communities, within mainstream and Aboriginal specific health services.

**Government response**

In early 2010, the government launched its statement on social inclusion A Stronger, Fairer Australia which sets out the government's vision and strategy for social inclusion now and into the future. The statement sets out a new approach to break down the barriers that stand between the most disadvantaged Australians and participation. The government is determined to address this disadvantage, which costs the entire nation in lower productivity, chronic health problems, welfare dependence and fractured communities.

Under the COAG National Partnership Agreement on Closing the Gap in Indigenous Health outcomes, the Australian Government is providing $805.5 million over four years for an Indigenous Chronic Disease Package. This package includes measures to: encourage earlier detection and better management of chronic disease in primary health care services; improve access to follow up care by specialists and allied health professionals; and increase the capacity of the primary care workforce to deliver effective health care to Aboriginal and Torres Strait Islander peoples.

There are a number of Australian Government initiatives in place through the Indigenous Chronic Disease Package that aim to support culturally appropriate care for Indigenous people.

- The Improving Indigenous Access to Mainstream Primary Care Program is providing $72.2 million over four years for 95 full time equivalent (FTE) Indigenous Health Project Officers and 86 FTE Aboriginal and Torres Strait Islander Outreach Workers in the Divisions of General Practice Network. The new workforce will provide a focus on Indigenous health issues in mainstream primary care and will result in better access to culturally sensitive mainstream primary care services for Aboriginal and Torres Strait Islander people.
- The Care Coordination and Supplementary Services Program is providing $87.3 million over four years to improve health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to coordinated and multidisciplinary care. Care coordination is provided by qualified health workers to patients with a chronic disease who have been enrolled and referred by practices

(mainstream or Aboriginal Medical Services) participating in the Practice Incentives Program (PIP) Indigenous Health Incentive.

- The PIP Indigenous Health Incentive commenced in May 2010, and aims to support general practices and Indigenous health services to provide better health care for Aboriginal and Torres Strait Islander people, including best practice management of chronic disease such as CVD, renal disease and diabetes. The incentive will improve the health of Aboriginal and Torres Strait Islander patients with chronic disease by providing general practices and Indigenous health services with financial support to develop health management plans and actively provide follow up care to patients.
- As at 1 July 2010, assistance with the cost of PBS medicines has been available to Indigenous patients receiving care at a general practice participating in the PIP Indigenous Health Incentive or non-remote Indigenous Health Services. This measure is targeted to those living with, or at risk of, chronic disease, and reduces or eliminates co-payments for eligible patients when purchasing PBS medicines.
- The Medical Specialist Outreach Assistance Program was established in 2000 to improve the access of rural and remote communities to medical specialist outreach services by complementing outreach specialist services provided by state and Northern Territory governments. The Medical Specialist Outreach Assistance Program Indigenous Chronic Disease measure, introduced from 1 July 2010, focuses on service delivery in outreach locations for a range of chronic conditions. In 2010-11, Medical Specialist Outreach Assistance Program plans to deliver 83 cardiovascular services and 23 Indigenous Chronic Disease measure related services to rural, regional and remote locations throughout Australia.
- The Urban Specialist Outreach Assistance Program is providing $4.5 million over four years to establish new and expand existing medical specialist outreach services that focus primarily on the management and treatment of chronic diseases such as CVD, renal disease and diabetes for Aboriginal and Torres Strait Islander people living in urban areas.

G2.2 Support the implementation within jurisdictions of national strategies and guidelines to address low intervention rates for Indigenous people presenting to hospital with heart disease and stroke.

**Government response**

While planning and delivery of hospital care has primarily been a state/territory responsibility, the Australian Government is working with states and territories to deliver better health and hospital care including the establishment of Local Hospital Networks and Medicare Locals, which will work together to ensure hospitals and health services provide better responsiveness to the specific health needs of the population within their catchment areas, including Aboriginal and Torres Strait Islander people. The Australian Government is also investing an additional $7.8 billion to address key pressure points in our health and public hospitals systems, including through initiatives to ensure quicker access to emergency departments and elective surgery.

In February 2010, the National Heart Foundation and the Australian Healthcare and Hospitals Association submitted its policy paper Better hospital care for Aboriginal and Torres Strait Islander people experiencing heart attack to the Australian Health Ministers' Conference (AHMC). The earlier draft was titled Disparities in hospital care for Indigenous

Australians – the case of acute coronary syndromes. The Australian Government is currently contributing to AHMC's consideration of this submission.

G2.3 Develop specific strategies to address poorer outcomes and lower intervention rates for people with higher levels of social and economic disadvantage.

**Government response**

The Australian Government will continue to work towards improved health outcomes for people who are not only socially and economically disadvantaged but also those who are geographically disadvantaged.

Two of the key principles underpinning health reform are that all Australians should have equitable access to high quality health care, including those living in regional and remote areas; and that Australia's health system should promote social inclusion and reduce disadvantage, especially for Indigenous Australians. Specific initiatives have also been outlined to boost the health workforce in rural communities. For the first time there will be support for up to 7,500 rural nurses and 1,000 rural allied health professionals over the next decade to take leave to access professional development courses to keep their skills up to date ($34 million over the first four years).

The Australian Government is also funding 34 projects under the Rural Primary Health Services Program Preventative Health Initiative to address chronic disease risk factors in rural, remote and very remote communities ($18 million over four years to June 2013). The community capacity building approach being used enables communities with high health needs to develop sustainable local solutions to address key social and environmental determinants of local health problems. Projects vary, with some focusing on specific groups in the community such as children, youth or men, while others take a whole-of-community approach.

G3.1 Test a range of linked strategies to improve the management of patients with cardiovascular disease, involving all health sectors (general practice, public health services, NGOs, other private providers) within identified communities.

**Government response**

The Australian Government recognises that a strong primary health care system, providing effective health care services locally to the community, is critical to the future success and sustainability of our entire health care system. This is particularly relevant to the prevention and management of chronic conditions such as CVD.

In 2010, the government launched Building a 21st Century Primary Health Care System - Australia's First National Primary Health Care Strategy. The National Primary Health Care Strategy is a first for Australia, providing a national road map to guide future primary health care policy and planning in Australia. It sets out key priority areas and essential building blocks that need to be in place to provide the foundation for an integrated high performing primary health care system fit for the future.

Specific initiatives under health reform include the establishment of Medicare Locals, a significant boost to the primary care health workforce and a national eHealth records system.

The first Medicare Locals, which will be part of a national network of primary health care organisations, will be established from 1 July 2011 to improve integration of primary health

care services and improve access to services. Medicare Locals will be independent legal entities with strong links to their local communities, health professionals, service providers and consumer and patient groups, enabling them to respond effectively to local needs.

Medicare Locals will work closely with Local Hospital Networks to deliver better integration and smoother transitions for patients across the entire health and hospital system. Local Hospital Networks will be single, or small groups of public hospitals, with a geographic or functional connection, large enough to provide a reasonable range of hospital services. With decision making being made at a local level, these networks will give communities, and clinicians, a greater say on how hospitals are run.

In addition, the government is implementing a range of initiatives to improve the quality of primary health care services, which will benefit people at risk of or affected by CVD.

- A $30 million pilot of the health reform measure Coordinated Care for Diabetes will commence from 1 July 2011. The pilot will test a new model of care which aims to provide greater flexibility in the delivery of primary health care services through general practice for the treatment and ongoing management of people with diabetes (which is a key risk factor for CVD). The pilot will assess how the reform can support a more consumer-centred approach to care through expanding the choices available to people with diabetes, and by providing more coordinated multidisciplinary education and care.
- The government's Australian Primary Care Collaboratives Program already includes a major focus on the management of coronary heart disease. The collaboratives program has a funding allocation of around $4 million per annum and has achieved positive results for patients with coronary heart disease. The program is currently being evaluated to assess its success and inform future directions.
- To provide multidisciplinary integrated health services close to home, the Australian Government will invest $370 million over three years from 2010-11 to establish an additional 28 GP Super Clinics and to upgrade around 425 existing general practices, primary health care and community health services, and Aboriginal Medical Services through Primary Care Infrastructure Grants. This builds on the government's previous investment of $280 million over five years, commencing in 2007-08, to establish 36 GP Super Clinics. GP Super Clinics bring together GPs, nurses, visiting medical specialists, allied health professionals and other health care providers to provide integrated multidisciplinary care in a single convenient location. This infrastructure will particularly benefit Australians with chronic and complex diseases, both from a preventive and treatment perspective.
- The government is also committed to the development of an MBS Quality Framework to strengthen the listing, pricing and review processes that underpin the MBS by ensuring that services are aligned with contemporary clinical evidence, represent best value for money and improve health outcomes for patients. Under this initiative, it will be possible to review MBS services for the treatment of a chronic disease, such as cardiovascular disease, to ensure MBS items align with clinical pathways and current evidence around treatment.

G4.1 Establish comprehensive stroke services (acute, post-acute and rehabilitation care) at every hospital admitting more than 200 acute stroke patients per year and in relevant smaller hospitals and strengthen networked access to Stroke Care Units for rural hospitals.

## Government response

While states and territories currently have responsibility for planning and provision of emergency department services in public hospitals, the Australian Government acknowledges that states and territories cannot alone address challenges arising from the rising demand for public hospital services. In response, the government is providing $66 billion over five years to the states and territories in support of the National Healthcare Agreement and to fund national partnerships. This package includes $60 billion under the National Health Care Specific Purpose Payments and additional funding for a National Partnership on Hospitals and Health Workforce Reform.

In addition, the Commonwealth is providing states and territories $250 million (under the National Partnership Agreement on Improving Public Hospitals) over four years to enhance the capacity in public hospital emergency departments. This additional funding provides the flexibility to states and territories to invest in areas of need in hospital emergency departments and this may include services for acute stroke patients.

The Australian Government has committed substantial resources to subacute care, including in the areas of rehabilitation, such as stroke and cardiac rehabilitation. The COAG 2008 National Partnership Agreement on Hospitals and Health Workforce Reform includes an Australian Government investment of $500 million to the states and territories in 2008-09 to increase the provision of subacute care services by five per cent per year over four years commencing in 2009-10 (or 20 per cent over the four years). For example, Western Australia has reported that North Metropolitan Area Health Secondary Stroke unit is to include increased allied health and medical staff, with an Early Supported Discharge and Outpatient service. The inpatient unit will be ten beds and will provide support and training in stroke rehabilitation to staff working in other metropolitan and regional sites.

As part of the COAG 2010 National Partnership Agreement on Improving Public Hospital Services, the Australian Government will provide up to $1.6 billion over four years from 2010-11 to establish and operate at least 1,316 new subacute care beds and bed-based equivalent community based services. States and territories are consulting stakeholders and providing implementation plans identifying priorities for allocation of the new beds.

The Australian Government is also supporting the improvement of health infrastructure through a $3.2 billion package announced under the 2009-10 Budget for health infrastructure projects, including $1.5 billion towards hospital infrastructure. The $1.8 billion Health and Hospitals Fund Regional Priority Round (which closed for submissions on 3 December 2010) provides, amongst other things, for health infrastructure in regional hospitals that could include facilities for stroke units. All applications to the fund are subject to assessment by the independent Health and Hospitals Fund Advisory Board.

Under the Australian Government's health reforms, hospitals will better assist people affected by heart disease and stroke through more services and reduced waiting times. The improvements will include:

- a four-hour target for emergency departments, to admit, transfer or discharge patients, where clinically appropriate
- access targets for elective surgery with 95 per cent of public elective surgery patients seen within clinically recommended times against agreed COAG targets

- more hospital beds to allow patients to access the right type of hospital or community care they need and
- strong national standards to improve the quality of hospital care across the country.

G4.2 Support public education campaigns to help people recognise the warning signs of CVD and seek emergency treatment.

**Government response**

Emergency response and acute care fall primarily within the responsibilities of state and territory governments, which undertake some work in public education. While there is evidence that well-resourced social marketing campaigns can be successful at improving awareness of health issues, there is a lack of evidence to date that such campaigns can shorten pre-hospital delays in seeking medical care for CVD symptoms. The justification and cost-effectiveness of this approach require careful consideration.

The importance of improving awareness of CVD was highlighted in the Australian Government's National Women's Health Policy 2010 ("the policy") that was released in December 2010. CVDs are the leading cause of death among women, the leading cause of life lost to premature death and among the top ten leading specific causes of burden of disease. However, women's awareness of CVD is low with 39 per cent of Australian women incorrectly believing breast cancer to be the leading cause of death. The warning signs of CVD in women often present differently to those experienced by men, with multiple symptoms such as back pain, jaw pain, nausea and anxiety being more common than chest pain. This often leads to a delay in treatment and poorer health outcomes.

The Australian Government has, under the National Women's Health Policy 2010, committed to act to address chronic disease such as CVD, through the control of risk factors such as obesity, smoking and lack of physical exercise, and by addressing the social determinants of poor health in at risk populations. The Australian Government will be working with all levels of government, professional organisations and peak health bodies where appropriate to raise awareness of women's health issues. The evidence base on how chronic diseases, such as CVD, are experienced by women is also being expanded through ongoing investment in the Australian Longitudinal Study of Women's Health. This includes an additional $5.3 million investment in the addition of a new younger cohort of women in 2011.

Under health reform, there will be additional support for people to seek help after-hours through the establishment of an after-hours GP telephone advice service. This service will make it easier for people to talk to a doctor after hours. From 1 July 2011, this service will provide medical advice over the phone after-hours from a registered nurse, and if necessary, a GP. People will be able to get advice on urgent medical conditions over the phone including the course of action required.

G5.1 Support an adequately resourced education campaign to increase awareness of high blood pressure and the importance of Absolute Risk Assessment (ARA) in the community and encourage people to seek ARA from their GP.

**Government response**

The Australian Government has made significant investments to address the risk factors for CVD and other chronic disease, and to promote healthy living in the community.

The government has made a commitment of $872 million over six years under the Council of Australian Governments (COAG) National Partnership Agreement on Preventive Health — the largest single commitment to health promotion by an Australian government.

This agreement includes a range of initiatives, which target the lifestyle risk factors for chronic diseases such as CVD, including:

- settings-based interventions in pre-schools, schools, workplaces and communities to support behavioural changes in the social contexts of everyday lives, and focusing on poor nutrition, physical inactivity, smoking and excessive alcohol consumption (including binge drinking)
- social marketing aimed at obesity and tobacco and
- the establishment of the Australian National Preventive Health Agency, which will work to address lifestyle risk factors, notably obesity, tobacco and the excessive consumption of alcohol.

The justification and cost effectiveness of government funding for a blood pressure mass awareness campaign is not proven, including its possible placement within the wider preventive health context.

G6.1 Use standards defined under the National Palliative Care Strategy to review existing palliative care services in order to assess and improve their capacity to provide appropriate care and timely access to those with end stage CVD.

**Government response**

The government has shown leadership through funding the development of a quality improvement structure for palliative care. It is the responsibility of the states and territories to review the quality of their palliative care services, including for patients with end stage CVD. Data suggests that around three per cent of current palliative care patients have a primary diagnosis of cardiovascular disease.

Some Australian Government funded projects provide quality improvement services to palliative care agencies. For example, the Palliative Care Outcomes Collaboration and the National Standards Assessment Project also collect and report data on care outcomes and service standards. The projects support continuous improvement in the quality and accessibility of care provided by palliative care services.

---

[1] Australian Bureau of Statistics – data accessed at www.abs.gov.au – 3303.0 Causes of Death, Australia 2008.

[2] Australian Institute of Health and Welfare (2010). Australia's Health 2010, page 141.