8 Opportunities and future directions

As discussed earlier in this report, heart, stroke and vascular disease constitutes a major public health burden in Australia. Coronary heart disease is one of the major causes of death in those aged less than 70 years and stroke is one of the principal causes of serious long-term disability. Since these diseases particularly affect older people, their public health impact will increase with the progressive ageing of the population. In addition, as discussed in Chapter 6, certain groups in the population have significantly higher mortality from heart, stroke and vascular disease than others, especially Indigenous Australians.

The estimates described in Chapter 5 indicate that there could be about 38 per cent fewer coronary events and 41 per cent fewer coronary deaths in people aged 35–79 years in Australia, if the prevention and treatment interventions considered in this report were fully implemented. Reductions in the average levels of cholesterol and blood pressure and the prevalence of smoking and physical inactivity are important for the whole population. In addition, more widespread and appropriate use of effective drug therapy would produce significant reductions in morbidity and mortality.

The size of the burden and the extent of knowledge suggest that further efforts have great potential to make progress. Since conditions such as diabetes and some cancers share lifestyle-related risk factors with heart, stroke and vascular disease, it is to be expected that prevention in the cardiovascular area will also have an impact on other major public health problems.

Achieving the potential improvement in cardiovascular health will require new approaches and sometimes new systems to support them. This action will involve governments at all levels, the private sector, and non-government and community organisations. Governments should focus in particular on the settings, environment and public policies that affect the broad determinants of health. These include education, employment, occupation, income and housing, all of which affect people's knowledge, attitudes and opportunities to change health behaviours.

Governments have a number of broad levers at their disposal to foster better programs and practice and to discourage inappropriate practice — expenditure on programs, initiatives and incentives; regulation; the provision and use of information; leadership; and coordination.

In particular, the Australian Health Care Agreements for 1998–2003 confirm the cooperative relationship between the Commonwealth and the States in funding and the continuing reform of public hospital and related health service delivery. While the Agreements do not specifically address the cardiovascular NHPA, they have some potential to advance the objectives of the NHPA initiative. For example, the Commonwealth/State Working Party on Quality Enhancement and the National Health Development Fund under the Australian Health Care Agreements could consider whether the work in the NHPAs should be specifically addressed in State strategic plans.

Opportunities and future directions

This chapter makes suggestions for how a number of levers could be employed within the following priority areas for cardiovascular health:

- establishing a secure long-term national focus on cardiovascular health from which policies and activities can emanate;
- coordinating primary prevention across NHPAs;
- establishing a national mechanism for development, review and implementation of better-practice guidelines that is linked to local planning and quality improvement practices;
- ensuring that any national focus on heart, stroke and vascular disease includes a specific focus on stroke to address additional stroke-related issues;
- tackling the underlying causes of inequalities in health among populations with worse cardiovascular health than the general population; and
- continuing and expanding the activities of the National Centre for Monitoring Cardiovascular Disease.

National focus on cardiovascular health

There is a wide range of activity at all levels, and an immense capacity to improve the health of Australians through further improvements in cardiovascular health. Although cardiovascular health is an NHPA, it lacks a secure long-term national focus from which policies and activities can emanate. National approaches exist for other NHPAs, and major achievements have occurred with other national programs such as HIV control and screening for cervical cancer.

A similar multidisciplinary approach should be established to help coordinate the prevention and guide the management of heart, stroke and vascular disease. It should involve government, non-government organisations, colleges of health professionals and consumer groups. There could also be provision for regular review of progress and future opportunities.

To ensure a strategic long-term approach to heart, stroke and vascular disease, a national program area within the Commonwealth Department of Health and Aged Care should be established. The Commonwealth could also provide secretariat support to a national expert advisory group on heart, stroke and vascular disease prevention and management issues. This group would provide advice to Health Ministers through existing mechanisms such as the NHPC and the NPHP.

Areas that need to be considered include:

- developing a national cardiovascular strategy as part of a longer term planning process;
- encouraging integration of primary prevention activities across national strategies for other diseases;
- identifying priority areas for cardiovascular research and commenting on funding mechanisms;
- exploring the role and feasibility of information technology to facilitate approaches to prevention and treatment;
- recommending infrastructure and projects for support and funding;

- investigating ways to reduce socio-economic differences in cardiovascular health, with an emphasis on the special needs of Indigenous populations; and
- encouraging mechanisms to forge partnerships between public health and clinical service providers.

Coordination of primary prevention across National Health Priority Areas

There are highly developed, largely evidence-based programs already defined or under development to address risk factors for heart, stroke and vascular disease, through strategies developed by governments and non-government organisations such as the National Stroke Foundation and the NHF.

National action will be most effective in any of these areas if there is coordination across different program areas, consistent health messages and adequate funding.

The primary prevention messages relating to health and lifestyle across the major health issues are virtually the same. This means that the one, consistent set of messages can be applied across the different programs relating to cardiovascular health, cancer and diabetes. To do this requires strong coordination and secure, long-term funding. There is already preliminary work on a National Primary Prevention Strategy aimed at the major non-communicable diseases. The strategy is being developed by the Commonwealth Department of Health and Aged Care. It integrates physical activity, diet, tobacco and alcohol issues and provides a base on which to build future prevention activities.

Important points in developing a national integrated primary prevention strategy are:

- primary prevention takes many years to have full effect and should be maintained long term;
- actions aimed at primary prevention of chronic disease will not achieve this full effect until due attention is paid to social and economic causes that lead to social inequalities in health; and
- these actions will need partnerships between the health sector and other sectors and agencies.

The work of the National Strategies Working Group of the NPHP should contribute much to this area. The NPHP is a working arrangement involving the Commonwealth Government and State and Territory Governments, to plan and coordinate national public health activities. It seeks to encourage better coordination across the country, to provide a more systematic and strategic approach to public health priorities and to help develop new directions and major national initiatives.

Currently there is no funding infrastructure in place to address these coordination issues. There are, however, several innovative proposals that could be further explored and which could draw together processes and principles established under existing arrangements. These would include principles for pooling funds developed under the Coordinated Care Trials, and cost and benefit-sharing principles.

National mechanism for development, regular review and implementation of better-practice guidelines

There is a substantial gap between accepted best practice and usual practice in the management of patients with heart, stroke and vascular disease. The gains that could accrue from better practice have been described earlier in this report, in the areas of management and secondary prevention. The focus of guideline development has so far been on clinical practice. However, there is also a need for evidence-based guidelines to advise public health practice.

Identifying areas of inappropriate practice is also important, where population screening or treatments are unnecessary or even harmful. For many years the PBS has had a requirement that new medicines added to the Schedule must be demonstrated to be cost-effective for the condition for which they are listed. In addition, MSAC's work in assessing new medical technologies and procedures may play an important role in identifying areas of inappropriate or costly practice.

The Health Advisory Committee of the NHMRC has continued with the development of clinical practice guidelines, a process previously undertaken by the Quality of Care and Health Outcomes Committee. Clinicians are being involved in guideline development and implementation. The role of information technology in informing consumers about treatment options and the progress of their care is also being considered. The Health Advisory Committee has prepared *A Guide to the Development, Implementation and Evaluation of Clinical Practice Guidelines* (NHMRC 1998) to assist organisations to develop guidelines for NHMRC endorsement.

The guideline development process should involve the following stages:

- review of relevant best-practice guidelines that have been implemented or are in the process of being implemented in Australia;
- consideration of links with international bodies (for example, whether a similar guideline developed overseas could be adapted for use in Australia);
- development of the guideline document by a multidisciplinary group including consumers, and consultation with all stakeholders (non-government organisations such as the NHF, Stroke Foundation, Royal Colleges and Divisions of General Practice could play a key role, as will the Expert Advisory Group on Quality and Safety in Australian Health Care);
- incorporation of the best available evidence, assessed for level, quality, relevance and strength;
- endorsement by the NHMRC and other clinical bodies, such as specialist societies;
- widespread and effective dissemination;
- development of an infrastructure for implementation; and
- regular review and updating.

It should be recognised that many of the issues central to implementing change in practice are service design issues and require the involvement of State and local planners, and non-government groups such as Divisions of General Practice, to

ensure uptake. A nationally coordinated process to ensure regularly updated systematic reviews and guidelines are available should be linked to local planning and quality improvement processes for implementation.

Focus on stroke

Stroke is a major public health problem in Australia, but the area has received less emphasis and funding than coronary heart disease. Many issues in stroke will be addressed by improvements in the coordination of preventive activities and the development, implementation and review of best-practice guidelines, suggested above. However, any national program for coordinating the prevention and management of heart, stroke and vascular disease should include a specific focus on stroke, to address the following additional issues.

- Improve community understanding of the nature and management of stroke through public awareness campaigns (for example Brain Attack coordinated by the National Stroke Foundation). Emergency aspects should be highlighted within these programs.
- Increase levels of knowledge about the management of stroke among general practitioners, general physicians, neurologists, geriatricians and rehabilitation specialists by coordinating educational sessions through organisations such as the National Stroke Foundation and the Stroke Society of Australia.
- Increase levels of knowledge about the continuing management of stroke among nursing and paramedical staff and members of Aged Care Assessment Teams.
- Improve emergency transport to hospitals. Strokes should be a priority for ambulance services Australia wide. Standards for coordination of triage within emergency rooms should be improved through collaboration between the National Stroke Foundation, the Stroke Society of Australia and emergency physician societies.
- Increase the number of stroke units nationwide. Stroke units should be present in every major hospital with an accreditation system established, as suggested in National Stroke Guidelines and Victorian Stroke Guidelines.
- Maximise functional level and independence following stroke. Ensure an appropriate level of continuing care through improved patient evaluation and education and better coordination across the range of services. Better coordination between State and Territory and Commonwealth bodies is required to ensure improved access to the level of care appropriate for recovery stage, level of disability and age.

Special populations

Populations in which cardiovascular mortality or disease burdens are higher or more problematic have many common issues. For these populations, it is particularly important to tackle the underlying causes of inequalities in health, such as the interplay of risk factors and social and economic circumstances. Policy initiatives to address health inequalities will require coordination across sectors of government.

Opportunities and future directions

Indigenous Australians

As described earlier, the cardiovascular health of Indigenous Australians is much worse than that of non-Indigenous Australians.

Current efforts may be insufficient to allow a real prospect of achieving the nationally agreed 10-year target of a 50 per cent reduction in mortality from coronary heart disease in Indigenous populations or of achieving the related targets for risk factors.

There should be a strategic and coordinated approach to the development and implementation of prevention programs and primary health care in Indigenous populations. This should be a priority for funding and attention.

A set of minimum essential services for heart, stroke and vascular disease, as part of a wider set of services for chronic diseases, needs to be developed to support the activities of health service providers.

Funding

Governments developing funding for programs for the control of heart, stroke and vascular disease in Indigenous populations should consider all health financing arrangements to ensure a secure long-term approach. The Commonwealth should continue exploring possible mechanisms through:

- current OATSIH work with the National Aboriginal Community Controlled Health Organisation, and State and Territory health departments on an inventory of current programs, expenditure on these programs and future financial requirements. This should include primary health care and primary prevention;
- the findings of the joint Health Financing Working Group in its evaluation of options for improving access to Commonwealth health program funding for Indigenous people and its consideration of ways to overcome the barriers faced by this group in accessing the MBS and PBS; and
- investigation of cost-shared Commonwealth/State funding under Medicare for national Indigenous cardiovascular control initiatives becoming part of a wider set of programs for addressing health and social issues for Indigenous people.

Workforce

Formal programs should be further developed to strengthen the capacity of Indigenous providers and rural health workers, particularly in the field of public health. Incentive programs currently available for general practitioners should be extended to all health professionals working in remote Indigenous communities.

Service delivery

Barriers and access to services (cultural and geographical) need to be further identified and addressed. Mainstream health services should offer culturally appropriate health services.

Decentralised management and service delivery models should be supported and introduced. The fundamental principle of community control in health service delivery should be supported.

Rheumatic heart disease

With funding from the Commonwealth, a coordinated rheumatic heart disease control program should be expanded into all affected regions within two years, based on an evaluation of the Northern Territory program as a possible template and further knowledge of the epidemiology of acute rheumatic fever and rheumatic heart disease in Indigenous Australians.

Remote populations

Many of the specific strategies for Indigenous populations (above) will also improve infrastructure and programs for remote populations. It should be noted however, that the Commonwealth and States and Territories are currently developing a framework document, titled *Healthy Horizons*, which will replace both the National Rural Health Strategy 1994 and the update document to the 1996 Strategy.

The current draft of *Healthy Horizons* identifies as one of its priority goals the improvement of 'highest health priorities first'. By using *Healthy Horizons* as a broad framework, it is recommended that State and Territory Governments and communities consider specific strategies related to improving cardiovascular health in rural and remote areas such as:

- ensuring that a consistent supply of affordable fresh fruit and vegetables is available. This may involve means of reducing transport costs, subsidies, grants for upgrade of storage facilities and support for production of locally grown produce;
- increasing the emphasis on anti-smoking programs, especially the prevention of uptake among youth;
- developing strategies for nursing, allied health and Aboriginal health workers that are equivalent to the General Practice Incentives Program, which aim towards a competent and continuous remote health workforce through financial support in relocation, accommodation, and retention strategies such as continuing education programs (or financial support) and locum services;
- developing and implementing basic standards of essential primary health care services including clinical and public health components;
- upgrading the community service obligations of telecommunications service providers to include data transfer facilities such as facsimile, email and Internet to remote populations; and
- ensuring that new information systems are based on those that already exist, and include standard treatment protocols for opportunistic screening, recall and review.

The Commonwealth Government, through OATSIH and the Rural Health program area, should ensure that there is collaboration and cohesion between the various Aboriginal Health and Primary Health Care services being developed.

Socio-economically disadvantaged populations

A key aim of public policy in the next millennium must be to design cross-sectoral interventions that improve the health of the socio-economically disadvantaged and reduce the social inequalities in health status.

The Commonwealth-funded National Collaboration on Health and Socio-economic Status is looking at the evidence and implications for policy and practice of the relationship between health and personal and social control, and the importance of social networks in health creation.

Policy initiatives are needed that:

- improve living and working conditions; and
- influence people's health-related attitudes and behaviours, through sensitive interventions that combine education and support with action at other policy levels, and facilitate access to health and social services according to need.

A strategic approach should include:

- research to investigate variations in cardiovascular health across populations that are not explained fully by known risk factors or advances in treatment;
- establishing new partnerships to encourage community development in public health interventions eg with communities, voluntary organisations and employers; and
- development of new indicators for monitoring risk conditions.

Monitoring and information management

The National Centre for Monitoring Cardiovascular Disease is developing an integrated information system that will cover major aspects of prevention, treatment, management and mortality for individual heart, stroke and vascular conditions, as well as monitoring differences between population groups. It has already established a comprehensive mortality surveillance system and produced a baseline report on the medical care of heart, stroke and vascular disease in Australia. Major gaps and deficiencies in data for monitoring heart, stroke and vascular disease are being addressed and the Centre has initiated the development of national data standards for risk factors. The Centre plans to meet demand for up-to-date information on heart, stroke and vascular disease through a regular bulletin and Internet access to data.

There is an urgent need for a national risk factor prevalence survey which includes taking blood samples from participants, and which collects information relevant to all NHPAs. There has been no such 'blood survey' since the last conducted by the National Heart Foundation in 1989. Thus, there is no way of knowing trends in such important determinants of heart, stroke and vascular disease as blood cholesterol. It is important that sufficient funds be allocated to complete this essential component of the national monitoring system as soon as possible.

It is also recommended that the national cardiovascular monitoring system gives special attention to monitoring cardiovascular conditions other than coronary heart disease, such as stroke, heart failure, peripheral vascular disease, angina and related coronary syndromes.

Other methods of information management should include linkage of patient-related medical data, and the use of technology to promote the uptake of accurate and current clinical guidelines.

- The establishment of a unique patient identifier to facilitate record linkage will need Commonwealth oversight to coordinate State and Territory activities. The process would be aided by a Commonwealth-coordinated conference to set up the terms of reference and timelines, with AIHW being the appropriate body to supervise and coordinate further development.
- There should be further evaluation of portable medical records (health care cards).
- The introduction of computerised clinical records into general practice needs to be encouraged and supported. The Practice Incentives Program payment formula will be amended in mid-1999 to encourage greater use of clinical computing, in the first instance through an incentive to adopt electronic prescribing.
- The further development of telemedicine should be focused on areas of clinical need.
- Information technology should facilitate education of and encourage communication with health professionals working in remote regions.

Recommendations

- A national focus on cardiovascular health should be established, through a national program area within the Department of Health and Aged Care. This would support a Cardiovascular Health Advisory Committee, which would advise Commonwealth Government and State/Territory Governments through existing mechanisms such as the National Health Priority Committee and the National Public Health Partnership.
- Approaches to primary prevention should be integrated nationally through the National Public Health Partnerships and the framework for the National Primary Prevention Strategy, and resourced at the level required for effective action.
- A nationally coordinated mechanism to ensure regularly updated systematic reviews and guidelines are available should be linked to local planning and quality improvement processes for implementation.
- A national approach to cardiovascular health should include a focus on stroke, which involves all relevant stakeholders and addresses specific stroke-related issues across the continuum of care.
- There should be a strategic and coordinated approach to the development and implementation of prevention programs and primary health care in special population groups, especially Indigenous populations, with sufficient funds and infrastructure for this purpose. All programs must be appropriate to local needs and conditions.
- There should be continued funding of the national system for monitoring cardiovascular disease, through the Australian Institute of Health and Welfare, and funds allocated for the conduct of a national risk factor prevalence survey which includes taking a blood sample from participants.