Submission to the Public Consultation on the Draft National Preventive Health Strategy 2021-2030

Response to online public consultation questions

Stroke Foundation is a national charity that partners with the community to prevent stroke, save lives and enhance recovery. We do this through raising awareness, facilitating research, and supporting stroke survivors.

Stroke Foundation welcomes the opportunity to comment on the Draft National Preventive Health Strategy 2021-2030, and strongly supports prevention as a key pillar of Australia's long-term National Health Plan.

VISION

The Strategy includes a high-level vision that is outlined on page 8.

Do you agree with the vision of the Strategy?

Select one: **Strongly Agree**, Agree, No Opinion, Disagree, Strongly Disagree.

Please explain your selection.

Stroke Foundation strongly supports the Strategy's high-level vision. This vision reflects a life course approach, and highlights the importance of providing individuals with information to make effective decisions and take appropriate action for their health, identifying those at risk of disease, and targeting individuals displaying the early signs and symptoms of disease. Of particular importance is the vision's acknowledgement of the need to address the broader, non-medical factors that influence health outcomes.

AIMS

The Strategy outlines four high-level aims. Each aim includes a measurable target/s in order to track the Strategy's progress in achieving the vision. The aims and targets are outlined on page 8.

Do you agree with the aims and their associated targets for the Strategy?

Select one: **Strongly Agree**, Agree, No Opinion, Disagree, Strongly Disagree.

Please explain your selection.

Stroke Foundation strongly supports the Strategy's high-level aims and their associated targets, which are clearly articulated, and are appropriate for Strategy's 10-year timeframe. It is critical that the 'Blueprint for Action' that follows contains the necessary detail on how each of the targets will be achieved.

For many years, the economic benefits of increased spending on preventive health have been well known, yet governments have continued to focus spending on the treatment of illness and disease.

We recommend promoting Aim 4 'Investment in prevention is increased', to Aim 1, to signal how critical it is to the success of the Strategy.

Further comments on each of the aims are included below.

1. **Australians have the best start in life.**

   Stroke Foundation strongly supports this aim and its associated target. People begin accumulating their risk of stroke in childhood. For example, atherosclerosis, the build-up of fatty substances in the arteries, which can lead to stroke, is a slow, complex disease that typically starts in childhood and progresses with age. In Australia, the prevalence of obesity, a key risk factor for stroke, is increasing in children, due to a range of factors, including physical inactivity and poor diet.[1] Importantly, obesity in childhood usually persists or tracks into adulthood.[2] As such, starting stroke prevention early is best. To reduce the future burden of stroke, we need to identify prevention strategies that decrease the prevalence of obesity and other stroke risk factors in Australian children and young adults.

2. **Australians live as long as possible in good health.**

   Stroke Foundation strongly supports this aim and its associated target. We support the focus on preventing disease across the life-span, acknowledging that risk of disease changes as we age. We know that 80 percent of strokes can be prevented[3], and effective primary stroke prevention remains the best means for reducing the stroke burden in Australia. Health checks, which assesses an individual's disease risk, provide an effective early detection process, and enable primary care providers to identify, intervene and reduce an individual's risk of developing stroke. **As such, a focus on health checks for older Australians (similar to the target for Indigenous-specific general practitioner health checks in Aim 3), would strengthen Aim 2.**

3. **Health equity for target populations.**

   Stroke Foundation strongly supports this aim and its associated targets; however, we query why the target for Aboriginal and Torres Strait Islander people is focused only on increasing the rate of health checks, and not on additional years of healthy life lived, as is the case for the other two populations.

   We know there are vulnerable populations in the Australian community who experience greater risk factors, worse access to care, and increased morbidity and mortality compared with the general population. With respect to stroke, these populations include:

   - *Aboriginal and Torres Strait Islander people*: Indigenous Australians are 1.6 times more likely to be hospitalised for stroke, and 1.3 times more likely to die from stroke, as non-Indigenous Australians.[4]

[1] Australian Institute of Health and Welfare 2020. Australia's health 2020 data insights. Australia's health series no. 17. Cat. no. AUS 231. Canberra: AIHW.
[2] World Health Organization. Global Strategy on Diet, Physical Activity and Health. Why does childhood overweight and obesity matter? Available at: https://www.who.int/dietphysicalactivity/childhood_consequences/en/
[3] O'Donnell MJ et al; INTERSTROKE investigators. Global and regional effects of potentially modifiable risk factors associated with acute stroke in 32 countries (INTERSTROKE): a case-control study. Lancet. 2016; 388:761-775.
[4] Australian Institute of Health and Welfare 2020. Australia's health 2020: in brief. Australia's health series no. 17 Cat. no. AUS 232. Canberra: AIHW.

- *People from regional, rural and remote areas*: Regional Australians are 17 percent more likely to suffer a stroke than those in metropolitan areas.[5] Hospitalisation rates for stroke are 1.4 times higher in people from remote and very remote areas compared with major cities.[6]

- *People from low socioeconomic areas*: Australians living in the lowest socioeconomic areas are 2.3 times as likely to have a stroke, 1.4 times as likely to be hospitalised for stroke, and 1.3 times as likely to die from a stroke, as those living in the highest socioeconomic areas.[7]

Therefore, we strongly support the inclusion of each of these priority populations in this aim.

4. **Investment in prevention is increased.**

Stroke Foundation strongly supports this aim, and the commitment to increase investment in preventive health to 5 percent of total health system expenditure by 2030. Australia spends approximately $2 billion on prevention each year, equivalent to $89 per person.[8] This is significantly less than equivalent Organisation for Economic Co-operation and Development (OECD) countries such as Canada ($334 per person), the United States ($322 per person) and the United Kingdom ($154 per person) spend on preventive health.[9] Yet we know that for every dollar invested in prevention there is a $14 return.[10]

The target in this Strategy, which represents a more than three-fold increase in preventive health investment, is similar to the commitment made by the Western Australian Government to increase funding for prevention to 5 percent of the health budget by 2029.[11] We strongly encourage bipartisan support for this target, and similar commitments from other state and territory governments. Regular reporting on the progress towards the 5 percent target, and transparency on how this increased investment is being allocated to each of the focus areas, will be essential. Investment in programs and initiatives aimed at addressing the risk factors for preventable chronic diseases, such as stroke, will be critical.

PRINCIPLES

Six principles are included in the Strategy to underpin the Framework for Action by 2030. The principles are designed to guide implementation and strengthen current efforts. They are outlined on page 8.

Do you agree with the principles?

Select one: Strongly Agree, **Agree**, No Opinion, Disagree, Strongly Disagree.

Please explain your selection.

[5] Deloitte Access Economics. 2020. No postcode untouched, Stroke in Australia 2020.
[6] Australian Institute of Health and Welfare 2020. Australia's health 2020: in brief. Australia's health series no. 17 Cat. no. AUS 232. Canberra: AIHW.
[7] Ibid.
[8] Foundation for Alcohol Research and Education. Preventive health: How much does Australia spend and is it enough? FARE. 2017. Canberra, Australia.
[9] Ibid.
[10] Masters R et al. Return on investment of public health interventions: a systematic review. Journal of Epidemiology and Community Health. 2017; 71:827-834.
[11] Sustainable Health Review. 2019. Sustainable Health Review: Final Report to the Western Australian Government. Department of Health, Western Australia.

Stroke Foundation is broadly supportive of the Strategy's principles.

Further comments on each of the principles are included below.

1. **Multi-sector collaboration.**

   Stroke Foundation strongly supports multi-sector collaboration as a key principle of the Strategy, and recommends that this principle should also encompass collaboration across all levels of government. This 'Health in all Policies' approach, which acknowledges that health is not merely the product of health care activities, but is influenced by a wide range of social, economic, political, cultural and environmental determinants of health, will be critical to the success of the Strategy. Australia's response to the COVID-19 pandemic has demonstrated the value of, and need for, this approach, and there is an opportunity to learn, and apply the lessons from this experience, to preventive health more broadly.

2. **Enabling the workforce.**

   Stroke Foundation strongly supports this principle. Currently, our health system is focused largely on sickness, and treatment and management of disease, rather than on prevention and wellness. As such, this principle should reflect the need for investment in education and training, as well as in new funding models and models of care, to ensure the health workforce is enabled to embed prevention across the health system.

   As the burden of chronic disease continues to rise in Australia, it is essential that chronic disease risk assessment, management of disease risk, and early detection, are firmly embedded in the health system, particularly in primary and community care settings. This will help prevent disease progression, complications, and avoidable hospitalisations. In order to achieve this, more support should be provided to enable nurses and allied health professionals to work to their full scope of practice, so they are better able to deliver behavioural risk factor modification programs, and other evidence-based interventions, in primary and community care settings. In many regional and rural areas of Australia, where there is a chronic shortage of primary care services, there may be opportunities to capitalise on the knowledge and skills of other health professionals, including community pharmacists, and broaden their scope of practice, enabling them to conduct health checks, and identify individuals who are at high risk and in need of further assessment.

3. **Community engagement.**

   Stroke Foundation strongly supports this principle. Fundamental to the success of this Strategy is a commitment to partnering with the community, and utilising environments where people spend a significant amount of their time either living, working, studying, or playing, to drive local prevention initiatives that are responsive to community needs. **This principle could be strengthened by highlighting the need for consumer engagement,** which is referred to in other parts of the Strategy. The involvement of consumers as partners has a strong evidence base, and has delivered better services, programs, and outcomes, particularly for vulnerable population groups, who also represent a significant proportion of the population at risk of chronic disease.

4. **Empowering and supporting Australians.**

   Stroke Foundation strongly supports this principle. Importantly, the Strategy acknowledges that the ability of individuals to make the best possible decisions about their health, is not dependent solely on their own knowledge and skills, but also on 'environmental factors which impact individual autonomy'.

   One example of this is the challenge many in the community face when trying to lose weight. There is an increasing understanding that the causes of obesity are complex, and that an 'obesogenic environment', a collection of environmental factors which 'undermine the self-regulatory capacity that people have to make responsible decisions about personal diet and physical activity', is largely what is driving the rising rates of this condition.[12] These environmental factors include an increased availability, affordability and marketing of energy-dense foods, as well as a built environment that is designed to encourage more sedentary behaviour. Importantly, preventive health strategies that address both individual behaviours relating to diet and physical activity, as well as these environmental factors, are more likely to succeed.

   Therefore, we recommend changing this principle to 'Healthier environments that empower and support Australians'.

5. **Adapting to emerging threats and evidence.**

   Stroke Foundation strongly supports this principle. The success of the Strategy will depend largely on the availability of up-to-date, quality data on the impact of implemented preventive health programs and initiatives. It is critical that all funded programs have a mandatory monitoring and evaluation component built in, enabling modifications to be made as new data becomes available, and facilitating the delivery of more effective and cost-effective programs. This will also allow us to build a robust evidence base from which to identify programs and interventions that offer the greatest value in the Australian context, and which will inform future policy development and funding decisions in the preventive health area. It is also critical that existing population-wide, routine data collections and surveys, that provide information on the disease burden in Australia, continue to be funded, as this information will help inform our prevention priorities.

6. **The equity lens.**

   Stroke Foundation strongly supports this principle. The application of an equity lens, to better understand, and address, the disparate burden of chronic disease based on factors such as race, education, income, gender, sexual orientation, and living conditions, is a critical part of the Strategy. Importantly, while the Strategy does discuss the effect that economic determinants such as education, employment and income ('causes of causes') can have on health, and the need to improve access to services for those who are economically disadvantaged, there is no discussion of actions that could be taken to address economic disadvantage. Similarly, while the Strategy mentions the impact that historical and cultural factors such as racism and discrimination, colonisation and colonialism, and the Stolen

[12] Hobbs M, Radley D. Obesogenic environments and obesity: a comment on 'Are environmental area characteristics at birth associated with overweight and obesity in school-aged children? Findings from the SLOPE (Studying Lifecourse Obesity PrEdictors) population-based cohort in the south of England'. BMC Medicine. 2020; 18:59.

Generations are having on the health and wellbeing of Aboriginal and Torres Strait Islander people, there is no discussion of actions that could be taken to address these problems.

ENABLERS

Mobilising a prevention system is a key driver in achieving systemic change and better health outcomes for all Australians. Seven system enablers are identified in the Strategy that are critical to creating a more effective and integrated prevention system for Australia over the next 10 years. Each enabler is accompanied by desired policy achievements by 2030. The enablers and the policy achievements are outlined in more detail on pages 31-42.

Do you agree with the enablers?

Select one: **Strongly Agree**, Agree, No Opinion, Disagree, Strongly Disagree.

Please explain your selection.

Stroke Foundation is broadly supportive of the Strategy's system enablers.

Further comments on each of the enablers are included below.

1. **Leadership, governance and funding.**

   Stroke Foundation strongly supports this enabler, including the establishment of a 'national, independent governance mechanism' that will provide government with evidence-based advice, identifying the most effective and relevant preventive health programs, that will be funded through an 'ongoing, long-term prevention fund'. It remains unclear whether this prevention fund will be funded through existing budget resources, or through new revenue streams; however, opportunities do exist for government to generate revenue through the imposition of taxes on unhealthy foods or beverages, as has been done in other jurisdictions. This could include the implementation of a sugary drinks levy, which would raise an estimated $400 million per year[13], or a volumetric tax for all alcoholic drinks, which would raise an estimated $2.7 billion per year.[14]

2. **Prevention in the health system.**

   Stroke Foundation strongly supports this enabler; however, we believe that it should encompass chronic disease risk assessment, management of disease risk, and early detection of disease, and that this should be reflected in its policy achievements. This is detailed in Question 8.

3. **Partnerships and community engagement.**

   Stroke Foundation strongly supports this enabler. The Strategy has clearly acknowledged that commercial determinants of health can have a detrimental impact on public health, and that partnerships must be protected from undue influence by any form of vested commercial interest, including industries whose products and activities cause disease and ill health, such

[13] Veerman JL et al. The Impact of a Tax on Sugar-Sweetened Beverages on Health and Health Care Costs: A Modelling Study. PLoS ONE. 2016; 11:e0151460.
[14] Robinson E et al. Increasing the Price of Alcohol as an Obesity Prevention Measure: The Potential Cost-Effectiveness of Introducing a Uniform Volumetric Tax and a Minimum Floor Price on Alcohol in Australia. Nutrients. 2020; 12:603.

as the tobacco, food and beverage and alcohol industries. We strongly support the protection of public health policies and strategies, and preventive health actions, from real, perceived, or potential conflicts of interest, through a variety of measures, including transparent stakeholder engagement processes, conflict of interest registers, as well as limiting unhealthy industry engagement in policy development and implementation.

As mentioned earlier, Stroke Foundation strongly supports the Strategy's commitment to partnering with the community, and consumers, to design and deliver place-based, evidence-informed local prevention initiatives that are responsive to community needs.

4. Information and health literacy

Stroke Foundation strongly supports this enabler. The Strategy's focus on improving the health literacy of Australians is particularly important, as we know that people with low health literacy are less likely to seek preventive health care, and are more likely to miss medical appointments, misuse medication, and fail to follow the advice provided by their health providers. This leads to more adverse events, poorer health outcomes, higher rates of hospitalisation, a lower quality of life for individuals, and increased health care costs overall. We strongly support the Strategy's focus on supporting the health workforce to build their own health literacy capacity, as well as the provision of health care information that is tailored and translated for all Australians, including those from culturally and linguistically diverse (CALD) communities.

Since 2018, Stroke Foundation has been delivering its F.A.S.T. (Face, Arms, Speech, and Time) Community Education Program in Tasmania, where two in three people do not have the health literacy skills to manage their health and wellbeing.[15] As part of this program, which is funded by the Tasmanian Government, local volunteers have been raising awareness about the signs of stroke, and chronic disease prevention, through the delivery of StrokeSafe talks in the community, attendance at community events, and the distribution of F.A.S.T. collateral (bookmarks, fridge magnets, wallet cards and 'Understand and Prevent Stroke' booklets). A major focus of the program has been isolated, at-risk, and vulnerable communities, with poor health literacy, throughout the state.

In 2020, Stroke Foundation began a national F.A.S.T. Community Education Program, funded by the Federal Government, targeting eight CALD communities (Greek, Italian, Mandarin, Vietnamese, Arabic, Cantonese, Hindi and Korean) with tailored in-language resources, including StrokeSafe talks, digital videos edited for YouTube, Facebook and Instagram, and radio advertisements.

In July 2021, Stroke Foundation will roll out its F.A.S.T. Community Education Program in the ACT, through Canberra's Walk-in Health Centre network. In addition to delivering F.A.S.T. education for patients, this program will provide health professionals at Walk-in Centres with F.A.S.T training, including workshops, webinars, and online education modules.

5. Research and evaluation.

Stroke Foundation strongly supports this enabler. Please refer to the response to Principle 5 'Adapting to emerging threats and evidence'.

[15] Hello (Health Literacy Learning Organisations) Tas - A toolkit for developing your community service organisation's health literacy. Available at: https://www.hellotas.org.au/

6. **Monitoring and surveillance.**

   Stroke Foundation strongly supports this enabler. The Strategy has highlighted the need for population-wide, routine data collections and surveys, to be undertaken regularly, collecting data on anthropometric, biomedical, and wider systemic factors that underpin health and wellbeing. This will enable us to get a more accurate measurement of health and wellbeing in Australia, as well as the impact of preventive health actions. We also believe that the value of clinical quality registries in monitoring and surveillance should be reflected in this enabler, and its policy achievements. This is detailed in Question 8.

7. **Preparedness.**

   Stroke Foundation strongly supports this enabler. The current COVID-19 pandemic has highlighted how important health system preparedness is. We know that because of this pandemic, many Australians have delayed routine health checks and diagnostic tests. Importantly, this delay in preventive care could have a significant and lasting impact on our health system and community well beyond the end of COVID-19. It is critical we can learn from this experience and put in place strategies that will enable the preventive health system to adapt to, and more effectively deal with, similar challenges in the future.

   We strongly support the Strategy's recognition of the health risks posed by climate change, and the need for action to address these risks, including the development of a national strategic plan addressing the impacts of environmental health. The Strategy does not however discuss any actions to address climate change, and we believe this should be addressed in the document. This is detailed in Question 8.

Do you agree with the policy achievements for the enablers?

Select one: Strongly Agree**, Agree**, No Opinion, Disagree, Strongly Disagree.

Please explain your selection.

Stroke Foundation broadly supports the policy achievements for the enablers, and additional comments on individual enablers are included below.

2. **Prevention in the health system.**

   Stroke Foundation strongly supports the explicit recognition of risk assessment and early detection as a core part of embedding prevention in the health system, and believes that this should be reflected in the policy achievements for this enabler.

   An assessment of an individual's risk of chronic disease, and early detection of disease, is critical to halting or slowing disease progression, preventing avoidable complications, and providing treatment at an earlier stage, resulting in better health outcomes. Therefore, it is essential that chronic disease risk assessment, management of disease risk, and early detection, is firmly embedded in the health system. Strengthening primary care to support these and other preventive interventions will be key. Greater support, including the development and promotion of risk assessment tools and strategies, education, training, and capacity building, as well as new funding models and models of care, is needed for GPs, practice nurses, pharmacists, and allied health professionals, for the delivery of better

preventive health activities in primary care and community settings. All of these components are important not only for primary prevention, but for patients living with a chronic disease, helping them to manage their condition in the community, and avoid unnecessary hospital admissions.

6. **Monitoring and surveillance.**

   It is important that national data sets generated from population-wide, routine data collections and surveys, have adequate sample sizes, to ensure important analyses of priority populations (those with the greatest to gain) are able to be undertaken.

   In addition, we believe that the value of clinical quality registries in monitoring and surveillance should be reflected in the policy achievements. For example, disease registries can provide valuable data, including patient reported outcome measures, enabling us to gauge the impact of large preventive health programs which target specific disease areas such as stroke. Registries can also provide important data on the effectiveness of patient management strategies for those being managed for both primary and secondary disease prevention. An example of this was the REACH Registry, an observational longitudinal study of the management of people with, or at high risk of, atherothrombosis.[16] Prior to this study, little data existed in Australia to inform the clinical outcomes for this cohort of patients.

7. **Preparedness.**

   Importantly, while the Strategy does recognise the health risks posed by climate change, it does not discuss any actions to address climate change. For example, there is increasing evidence that air pollution is contributing to the burden of chronic disease and premature mortality, in particular from cardiovascular and respiratory causes.[17] Climate change may increase the frequency and duration of weather conditions that increase exposure to air pollution. Therefore, action taken to mitigate climate change will have the co-benefit of improving air quality and reducing the incidence of chronic disease, and this should be addressed in the Strategy.

FOCUS AREAS

The Strategy identifies seven focus areas, where a stronger and better-coordinated effort will enable accelerated gains in health, particularly for communities experiencing an unfair burden of disease. These focus areas have been identified to boost prevention action in the first years of the Strategy and to impact health outcomes across all stages of life. Specific targets and desired policy achievements are also identified for each focus area. The focus areas are outlined in more detail on **pages 43-65**.

Do you agree with the seven focus areas?

Select one: Strongly Agree, Agree, No Opinion, **Disagree**, Strongly Disagree.

Please explain your selection.

[16] Reid CM et al; REACH Registry Investigators. Outcomes from the REACH Registry for Australian general practice patients with or at high risk of atherothrombosis. Medical Journal of Australia. 2012; 196:193-197.
[17] Manisalidis I et al. Environmental and Health Impacts of Air Pollution: A Review. Frontiers in Public Health. 2020; 8:14.

Stroke Foundation strongly supports each of the seven focus areas identified in the Strategy, including increasing cancer screening and prevention; however, **we strongly recommend that an equivalent focus area for the assessment of risk, and early detection of chronic conditions such as stroke, heart disease, type 2 diabetes, and chronic kidney disease, be included in the Strategy.**

We also strongly recommend the inclusion of high blood pressure, high cholesterol, and high blood glucose as modifiable and treatable chronic disease risk factors. These risk factors are not addressed in the Strategy, despite contributing to greater disease burden than other risk factors, and having effective management options.

There are validated algorithms for identifying people at risk of developing cardiovascular disease (CVD) in primary care. In Australia, the Framingham risk equation, which provides an estimate of the likelihood of developing CVD over the next 5 years, is currently recommended.

Preventive treatments for CVD are cost-effective and safe. Evidence from large-scale randomised trials show that lipid- and blood pressure-lowering therapies lower the risk of CVD events and all-cause mortality. Modelling commissioned by Stroke Foundation, and undertaken by Deloitte Access Economics, has shown that reducing the rate of uncontrolled hypertension in the Australian population from its current rate of 23 percent, to a target rate of 17 percent, would have resulted in an estimated 1,217 strokes being avoided in 2020.[18] In addition, over five years, there would also be around 386 fewer deaths attributable to stroke.[19] The potential savings from meeting this benchmark in 2020 were estimated to be $1.3 billion over 5 years (in net present value terms).[20]

Systems to support follow-up and recall of patients can be implemented within existing primary care frameworks. There is evidence that multifaceted CVD prevention programs that pair absolute CVD risk assessment with patient education and appropriate follow-up are effective in reducing CVD events.

Further comments on each of the existing focus areas are included below.

1. **Reducing tobacco use**

   Stroke Foundation strongly supports this focus area. Tobacco use is a major risk factor for stroke. People who smoke are twice as likely to have a stroke compared with those who have never smoked[21, 22, 23, 24], and the more an individual smokes the greater their risk of stroke.[25] Importantly, an individual's risk of stroke decreases after they quit smoking, and stopping smoking has been shown to have both immediate and long-term health benefits.[26] Therefore,

[18] Deloitte Access Economics. 2020. The economic impact of stroke in Australia, 2020.
[19] Ibid.
[20] Ibid.
[21] United States Department of Health and Human Services. The health consequences of smoking: a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services, Centres for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office of Smoking and Health; 2004.
[22] United States Department of Health and Human Services. The health consequences of smoking – 50 years of progress: a report of the Surgeon General. Rockville, MD: US Department of Health and Human Services, Centres for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office of Smoking and Health; 2014.
[23] Thun MJ et al. 50 year trends in smoking-related mortality in the United States. New England Journal of Medicine. 2013; 368:351-364.
[24] O'Donnell MJ et al; INTERSTROKE investigators. Risk factors for ischaemic and intracerebral haemorrhagic stroke in 22 countries (the INTERSTROKE study): a case-control study. Lancet. 2010; 376:112-123.
[25] United States Department of Health and Human Services. The health consequences of smoking – 50 years of progress: a report of the Surgeon General. Rockville, MD: US Department of Health and Human Services, Centres for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office of Smoking and Health; 2014.
[26] IARC. IARC Handbooks of cancer prevention, Tobacco Control, Vol 11: Reversal of risk after quitting smoking. Lyon, France: International Agency for Research on Cancer; 2007.

we are strongly supportive of any measures that will reduce the prevalence of smoking in the Australian community.

2. **Improving access to and the consumption of a healthy diet**

   Stroke Foundation strongly supports this focus area, and the Strategy's dual focus on reducing the consumption of unhealthy foods and improving the consumption of healthy diets.

3. **Increasing physical activity**

   Stroke Foundation strongly supports this focus area, and the Strategy's dual focus on reducing sedentary behaviour and increasing physical activity.

6. **Reducing alcohol and other drug harm**

   Stroke Foundation strongly supports this focus area. Alcohol consumption is a risk factor for stroke, with recent, large population studies demonstrating that stroke incidence increases steadily with the amount of alcohol consumed[27], and even moderate alcohol consumption increases the risk of having a stroke.[28] The World Health Organization has identified effective interventions to address the harmful use of alcohol as one of its 'Best Buys'.[29]

7. **Protecting mental health**

   Stroke Foundation strongly supports this focus area.

Do you agree with the targets for the focus areas?

Select one: Strongly Agree, Agree, No Opinion, **Disagree**, Strongly Disagree.

Please explain your selection.

While Stroke Foundation broadly supports the targets for the existing focus areas, the Strategy would be strengthened through the inclusion of a new focus area, with associated targets, addressing the significant burden of chronic disease that exists beyond cancer. **As such, we recommend the inclusion of specific targets to increase risk assessment and early detection of other chronic diseases.** Targets could identify the proportion of the eligible Australian population meeting the RACGP Red Book Guidelines[30] for risk assessment and early detection of chronic conditions, through absolute CVD risk assessment, screening for pre-diabetes and kidney disease, and regular blood pressure and cholesterol checks. For example, previously, the Australian Health Policy Collaboration has recommended the Australian Government establish a target of 90 percent of 45-74-year olds (from 35 years for Aboriginal and Torres Strait Islander people) receiving an absolute CVD risk assessment within five

[27] Wood AM et al. Risk thresholds for alcohol consumption: combined analysis of individual participant data for 599 912 current drinkers in 83 prospective studies. Lancet. 2018; 391:1513–1523.
[28] Millwood IY et al; China Kadoorie Biobank Collaborative Group. Conventional and genetic evidence on alcohol and vascular disease aetiology: a prospective study of 500 000 men and women in China. Lancet. 2019; 393:1831-1842.
[29] World Health Organization. 'Best Buys' and other recommended interventions for the prevention and control of noncommunicable diseases updated (2017) Appendix 3 of the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020. Available at: https://www.who.int/ncds/management/WHO_Appendix_BestBuys_LS.pdf?ua=1
[30] The Royal Australian College of General Practitioners. Guidelines for preventive activities in general practice. 9th edn, updated. East Melbourne, Vic: RACGP, 2018. Available at: https://www.racgp.org.au/getattachment/1ad1a26f-9c8b-4e3c-b45b-3237272b3a04/Guidelines-for-preventive-activities-in-general-practice.aspx

years, in line with guidelines.[31] This target was thought to be achievable, based on the experience in New Zealand.[32] 'Guidelines for the Management of Absolute CVD Risk'[33], last published in 2012 by the National Vascular Disease Prevention Alliance, are currently being updated.

Further comments on each of the existing focus areas are included below.

1. **Reducing tobacco use**

   Stroke Foundation strongly supports these targets; however, it is unclear why the smoking target for all Australians relates to daily smoking, while the target for Aboriginal and Torres Strait Islander people relates only to current (daily and non-daily) smoking.

2. **Improving access to and the consumption of a healthy diet**

   Stroke Foundation strongly supports the targets in the Strategy.

3. **Increasing physical activity**

   Stroke Foundation strongly supports the current target in the Strategy; however, we believe that a single target for this focus areas does not adequately reflect the necessary life-course approach to addressing physical inactivity in Australia. We believe that this focus area would be strengthened by the inclusion of additional targets, consistent with the approach used in the WHO Global Action Plan on Physical Activity 2018-2030, which has been endorsed by the Australian Government, and other global and national physical activity consensus documents.

6. **Reducing alcohol and other drug harm**

   Stroke Foundation strongly supports the targets in the Strategy.

7. **Protecting mental health**

   While Stroke Foundation welcomes the target of 'Towards zero suicides for all Australians', it will be critical to track, and report on, progress towards this target in the interim.

Do you agree with the policy achievements for the focus areas?

Select one: Strongly Agree, Agree, No Opinion, **Disagree**, Strongly Disagree.

Please explain your selection.

Stroke Foundation believes the Strategy would be further strengthened through the inclusion of a new focus area, addressing the need for risk assessment, management of risk and early detection of chronic disease that exists beyond cancer, including the following policy achievements:

- Mass media campaigns, which are used to increase community awareness, uptake of risk assessment and ongoing management of risk.

[31] Dunbar JA et al. Heart Health: the first step to getting Australia's health on track. Australian Health Policy Collaboration: Melbourne, Victoria University, October 2017.
[32] Ibid.
[33] National Vascular Disease Prevention Alliance. Guidelines for the management of absolute cardiovascular disease risk. 2012.

- Education and health promotion initiatives, which are delivered to raise awareness of the modifiable risk factors that lead to preventable chronic disease.
- An increased focus on Aboriginal and Torres Strait Islander people, and low socioeconomic, CALD, and rural and remote populations, through targeted, localised and culturally appropriate engagement.
- Health care providers are supported and engaged to encourage and support people to assess and manage chronic disease risk.
- Interventions focused on increasing chronic disease risk assessment, and early detection, are developed based on evidence built through research, data, and evaluation.
- Engagement strategies are informed by existing and new data, to drive behavioural change, and support chronic disease risk assessment and ongoing management of risk.
- The quality and analysis of national data is improved, leading to improved services and higher rates of risk assessment.
- The evidence base supporting new risk assessment (screening) programs is developed further, enabling safe and cost-effective approaches to be considered by the Government.

Further comments on each of the existing focus areas are included below.

1. **Reducing tobacco use**

   Stroke Foundation strongly supports the policy achievements detailed in the Strategy, many of which have demonstrated effectiveness and a high return on investment, and are oriented around the World Health Organization's Framework Convention on Tobacco Control. In particular, we welcome the attention on product regulation and supply. This will need to be strengthened by additional detail in the Blueprint for Action, and should consider recent proposals in New Zealand to reduce the number of retail outlets selling tobacco to less than 5 percent of the current number, license all retailers, restrict retail outlets to specific store types, introduce a smoke-free generation policy, regulate to make cigarettes less addictive and appealing by reducing nicotine content to very low levels, and prohibit filters and innovations that increase the appeal of cigarettes.[34]

2. **Improving access to and the consumption of a healthy diet**

   As outlined in the Strategy, unhealthy, energy-dense foods, and beverages, which are a major contributor to chronic disease risk, now make up more than one-third of Australians' daily energy intake. This is due to a combination of increased availability, affordability, and marketing. We strongly support the policy achievements detailed in the Strategy, a number of which are oriented around the World Health Organization's Best Buys[35] for the creation of environments that support healthy food choices. **The policy achievements focused on reducing the salt, sugar and saturated fat intake in diets, through reformulation of packaged**

[34] New Zealand Ministry of Health. Proposal for a Smokefree Aotearoa 2025 Action Plan, released 15 April 2021. Available at: https://www.health.govt.nz/publication/proposals-smokefree-aotearoa-2025-action-plan

[35] World Health Organization. 'Best Buys' and other recommended interventions for the prevention and control of noncommunicable diseases updated (2017) Appendix 3 of the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020. Available at: https://www.who.int/ncds/management/WHO_Appendix_BestBuys_LS.pdf?ua=1

and processed foods, and front-of-pack food labelling in the form of the Health Star Rating System, should be strengthened by government taking a regulatory (mandatory) approach.

3. Increasing physical activity

We strongly support the policy achievements detailed in the Strategy. Importantly, the Strategy acknowledges the need to address a key element of the obesogenic environment, a built environment that is designed to encourage more sedentary behaviour, and includes opportunities to create environments that encourage increased physical activity, to ensure individuals are supported to make healthier choices. The Strategy also acknowledges the value of utilising the environments where people spend a significant amount of their time (place-based approaches), either living, working, studying, or playing, to promote physical activity.

We believe that this focus area would be strengthened by the inclusion of a policy achievement focused on the development of a national physical activity plan, which would bring Australia into line with almost all other developed nations.

6. Reducing alcohol and other drug harm

Stroke Foundation strongly supports policy achievements in the Strategy that are focused on addressing current norms and behaviours around alcohol consumption in Australia, and limiting the availability (particularly with regard to the emerging trend of home delivery) and advertising of alcohol. **This focus area could be strengthened by the inclusion of a policy achievement focused on ensuring alcoholic products are appropriately priced to reflect their societal cost.** Increasing the price of alcohol through taxation is one of the most effective ways to reduce alcohol consumption and associated harms. The implementation of a volumetric tax (where products are taxed based on alcohol content) for all alcoholic drinks would establish an economic incentive to produce and consume low alcohol products, and would raise an estimated $2.7 billion per year.[36]

7. Protecting mental health

As mentioned in the Strategy, there is a significant body of epidemiological research that demonstrates the intersectionality between mental health conditions and chronic diseases such as stroke. One-third of survivors of stroke will experience depression[37], and between 18 and 25 percent will experience anxiety.[38] Individuals with a mental health condition are at a greater risk of developing and dying from a chronic disease,[39, 40] due to a variety of factors, including a high prevalence of risk factors such as smoking.[41] **As such, this focus area could be strengthened by the inclusion of a policy achievement focused on developing a more integrated approach to the prevention of mental health conditions, that links into and reinforces efforts to prevent chronic disease.**

[36] Robinson E et al. Increasing the Price of Alcohol as an Obesity Prevention Measure: The Potential Cost-Effectiveness of Introducing a Uniform Volumetric Tax and a Minimum Floor Price on Alcohol in Australia. Nutrients. 2020; 12:603.
[37] Hackett ML, Pickles K. Part I: Frequency of depression after stroke: An updated systematic review and meta-analysis of observational studies. International Journal of Stroke. 2014; 9:1017-25.
[38] Campbell Burton CA, et al. Frequency of anxiety after stroke: A systematic review of observational studies. International Journal of Stroke. 2012; 8:545-59.
[39] Lawrence, D et al. The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population-based registers. British Medical Journal. 2013; 346:f2539.
[40] Keeping Body and Mind Together. Improving the physical health and life expectancy of people with serious mental illness. 2015. Melbourne: The Royal Australian and New Zealand College of Psychiatrists.
[41] Harris B et al. Australia's mental health and physical health tracker. Technical paper No. 2018-06. 2018. Melbourne: Australian Health Policy Collaboration.

CONTINUING STRONG FOUNDATIONS

There are many effective and well-designed prevention-based programs and strategies developed by government, non-government organisations and communities that are currently in progress. This element of the Framework for Action acknowledges the immense activity that is already under way to better prevent illness and disease in Australia. It is outlined further on **page 66**.

Do you agree with this section of the Strategy?

Select one: Strongly Agree, **Agree**, No Opinion, Disagree, Strongly Disagree.

Please explain your selection.

As discussed in the Strategy, there are existing preventive health programs and interventions, many being delivered at a state or local level, that have been shown to be both effective and cost-effective, and could be scaled-up for greater impact.

One such example is the *My Health for Life* program, an evidence-based, free, Queensland Government-funded behaviour modification program, for people at high-risk of developing a chronic disease. Stroke Foundation is partnering with the Healthier Queensland Alliance and the Queensland Government to deliver this program, which enables chronic disease to be detected early, helping participants to reduce their risk of developing stroke, heart disease and type 2 diabetes, and avoid unnecessary hospital admissions, delivering savings to the health system. To date, 16,658 Queenslanders have enrolled in the program, 10,620 participants have completed the program, and over 210,000 chronic disease risk assessments have been undertaken. At the completion of the program, 70 percent of participants had reduced their waist circumference, and 49 percent met Australian physical activity guidelines. Six months after completion of the program, 48 percent of participants had further decreased their waist circumference, and 83 percent of participants met Australian physical activity guidelines. As a result of the significant impact *My Health for Life* has had, there is a strong commitment from the Queensland Government to continue funding this program. The ability of the Strategy to learn from, and build on, initiatives such as this, will be critical to its success.

The National Strategic Action Plan for Heart and Stroke, developed by the Stroke Foundation and Heart Foundation, sets out strategic, evidence-based, cost-effective, and patient-focused actions that will save lives. This Strategy will play an important role in implementing the prevention measures outlined in this Action Plan over the coming years.

Finally, further information is needed on how this Strategy will intersect with the Primary Health Care 10 Year Plan, as this remains unclear. An important part of this Strategy will involve strengthening primary care to support more effective delivery of preventive health activities in primary care settings. As such, both the National Preventive Health Strategy and the Primary Health Care 10 Year Plan would be strengthened by demonstrating how these strategies will work together.

OTHER

Please provide any additional comments you have on the draft Strategy.

In summary, Stroke Foundation welcomes, and strongly supports, this Strategy, and applauds the Government's commitment to increasing investment in preventive health to 5 percent of total health system expenditure by 2030. We strongly encourage bipartisan support for this target, and similar commitments from state and territory governments.

The effective implementation of this Strategy will be vital to its success. The Blueprint for Action to follow will be critical, providing a clear and comprehensive plan on how the Strategy's targets and policy achievements will be realised over the next 10 years. It is crucial that the Blueprint is adequately resourced, and we would welcome ongoing engagement as the document is developed.

Stroke Foundation is however concerned that a focus area dedicated to risk assessment and early detection of chronic disease, beyond cancer, and associated targets and policy achievements, has not been included in the Strategy. Given the delay and disruption that has occurred with regard to vital health screening, and routine health checks and diagnostic tests, during the COVID-19 pandemic, the inclusion of such a focus area is more important than ever.