

AUSTRALIAN CHRONIC DISEASE PREVENTION ALLIANCE



Response to the MBS Review Taskforce - Report from the General Practice and Primary Care Clinical Committee: Phase 2

March 2019

The Australian Chronic Disease Prevention Alliance (ACDPA) welcomes the opportunity to respond to this review and demonstrate our support for Integrated Health Checks to identify and manage risk of preventable chronic diseases.

Recommendations

ACDPA's response relates specifically to Health Assessment Medicare Benefits Schedule (MBS) items in the General Practice and Primary Care Clinical Committee report.

ACDPA urges the Committee to recommend:

- A. A dedicated MBS item and/or enhancing existing items to explicitly include Integrated Health Checks (comprising absolute cardiovascular disease risk assessment, a type 2 diabetes check and a kidney disease test) to support implementation and uptake of clinical guidelines.
- B. Aligning MBS health assessment items with clinical guidelines, specifically in relation to the recommended target groups, tests, age of commencement and frequency.
- C. Providing support for the ongoing management of patients in primary care who are identified at moderate to high-risk through Integrated Health Checks.
- D. Providing support for a marketing/awareness campaign with elements targeting both the public and general practice/primary care, to improve utilisation of health assessment items for eligible populations.
- E. Further collection of evidence on health assessments, based on international evaluations and local evidence relevant to the Australian context.

Support for Integrated Health Checks

- A. A dedicated MBS item and/or enhancing existing items to explicitly include Integrated Health Checks (comprising absolute cardiovascular disease risk assessment, a type 2 diabetes check and a kidney disease test) to support implementation and uptake of clinical guidelines.**

ACDPA acknowledges the recent cross-party commitments to establish an MBS item for heart health checks in primary care, incorporating assessment of family history, behavioural and biomedical risk factors to estimate 5-year risk of disease, with support for lifestyle changes and/or medication to reduce risk.¹

Building on this announcement, ACDPA recommends that the proposed heart health checks form part of an Integrated Health Check for vascular diseases, including heart disease, stroke, type 2 diabetes and chronic kidney disease. These diseases share common risk factors and often common therapeutic approaches, such as the management of hypertension, and also interact to increase risk.

Integrated Health Checks for vascular disease would enable early detection in primary care and management of risk in the community to reduce risk of disease, slow or even reverse disease progression, and reduce complications and unnecessary hospitalisations. There are potential benefits at an individual level in improved quality of life and reduced burden of disease, as well as at the health system level with reduced expenditure for vascular disease-related hospitalisations.

B. Aligning MBS health assessment items with clinical guidelines, specifically in relation to the recommended target groups, tests, age of commencement and frequency.

ACDPA recommends that MBS items for Integrated Health Checks, including MBS item 715 for Aboriginal and Torres Strait Islander health assessments, be aligned with the evidence-based clinical guidelines.

These include: the Royal Australian College of General Practitioners (RACGP) *Guidelines for preventive activities in general practice (Red Book)*,² RACGP & National Aboriginal Community Controlled Health Organisation (NACCHO) *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*,³ and relevant disease prevention and management guidelines.^{4,5,6}

The RACGP *Guidelines for preventive activities in general practice (Red Book)* identify the target groups, recommended tests, age of commencement and frequency for risk assessment:

Table 8.1.1. Cardiovascular disease: Identifying risk			
Population group	What should be done?	How often?	References
Adults aged ≥45 years not known to have cardiovascular disease (CVD) or not clinically determined to be at high risk	Calculate absolute CVD risk* 45–74 years (II, B)	Every two years† (IV, C)	34
Aboriginal and Torres Strait Islander peoples aged ≥35 years not known to have CVD or not clinically determined to be at high risk	Assess absolute CVD risk (may underestimate risk; IV, C)	Every two years (IV, C)	

Cardiovascular disease – assessment recommended for those aged 45 years and over; and 35 years and over for Aboriginal and Torres Strait Islander peoples.

Table 8.5.1. Stroke: Identifying risk

Who is at risk?	What should be done?	How often?	References
High absolute risk: <ul style="list-style-type: none"> • Calculated >15% absolute risk, clinically determined high risk or pre-existing cardiovascular disease (CVD) • Previous stroke (especially with co-existent atrial fibrillation [AF] or high grade [70–99%] symptomatic carotid stenosis) • Previous transient ischaemic attack (TIA) 	Question about symptoms of TIA. If TIA, stratify risk of stroke and consider anticoagulation* (I, A) If AF, determine cause of AF and treat according to cardiovascular and thromboembolic risk (II, B) Manage behavioural and physiological risk factors actively. Treat with antihypertensive and lipid-lowering medications unless contraindicated or clinically inappropriate (II, B)	Every 12 months (IV, C)	34, 51 66–68

Stroke – assessment recommended for those aged 45 years and over.

Table 8.4.1. Type 2 diabetes: Identifying risk

Who is at risk?	What should be done?	How often?	References
Increased risk: <ul style="list-style-type: none"> • ≥40 years of age • Aboriginal and Torres Strait Islander peoples aged ≥18 years 	AUSTRISK* (III, B)	Every three years (III, C)	56
High risk: <ul style="list-style-type: none"> • ≥40 years of age and being overweight or obese (refer to Section 7.2. Overweight) • AUSTRISK score of 12 or more • Consider screening the following groups because they may be at increased risk for diabetes at an earlier age or lower body mass index (BMI): <ul style="list-style-type: none"> – first-degree relative with diabetes – high-risk race/ethnicity (Indian subcontinent or Pacific Islanders) – all people with a history of a previous cardiovascular event (eg acute myocardial infarction or stroke) – women with a history of gestational diabetes mellitus – women with polycystic ovary syndrome – patients on antipsychotic drugs • Those with impaired glucose tolerance test or impaired fasting glucose (not limited by age) 	Fasting blood glucose (III, B) OR glycated haemoglobin (HbA1c)	Every three years (III, C)	57–59
	Fasting blood glucose (III, B) or HbA1c	Every 12 months (III, C)	58

Type 2 diabetes – assessment recommended for those aged 40 years and over; and 18 years and over for Aboriginal and Torres Strait Islander peoples.

Table 8.6.1. Kidney disease: Identifying risk

Who is at risk?	What should be done?	How often?	References
High risk: <ul style="list-style-type: none"> Smoking Obesity (body mass index [BMI] >30 kg/m²) Family history of kidney failure Diabetes Hypertension Aboriginal or Torres Strait Islander peoples aged >30 years Established cardiovascular disease (CVD), coronary heart disease (CHD) or peripheral vascular disease (PVD) History of acute kidney injury 	Blood pressure (BP), albumin-to-creatinine ratio (ACR) and estimated glomerular filtration rate (eGFR; III, A) If ACR is positive, arrange two further samples for urine ACR over two months (III, B) If eGFR <60 mL/min/1.73 m ² , repeat within seven days	Every one to two years* (IV, C)	79–88, 92–94 57, 88–91

Kidney disease - assessment recommended for those aged 30 years and over.

In conjunction with this recommendation, ACDPA highlights the need for funding to update the *Guidelines for the management of absolute cardiovascular disease risk (2012)*⁷ and corresponding online *Australian absolute cardiovascular risk calculator* www.cvdcheck.org.au, which assists GPs to calculate patient risk. The guideline development was led by the National Vascular Disease Prevention Alliance (now part of ACDPA), and its implementation was supported by RACGP and the National Prescribing Service. It was also supported by the Australian Primary Care Collaboratives program as part of its quality improvement program.

The guidelines received endorsement by the National Health and Medical Research Council from 2012 to 2017. Funding for an update is urgently required to ensure clinical assessment of absolute cardiovascular risk is made according to current best practice guidelines.

C. Providing support for the ongoing management of patients in primary care who are identified at moderate to high-risk through Integrated Health Checks.

ACDPA recommends that support be provided through primary care to enable people identified at moderate to high-risk of vascular disease to reduce their risk through lifestyle modifications and/or medication. This could include referrals for: smoking cessation services; weight management, including bariatric surgery for the severely obese; exercise and behaviour change programs; and medication for those at high-risk, in accordance with guidelines and in consultation with their GP.

For example, the *My Health for Life*⁸ program in Queensland is a free, evidence-based behaviour modification program for patients at high-risk of developing a chronic disease, delivered by the Healthier Queensland Alliance (Diabetes Queensland, Heart Foundation, Stroke Foundation, Queensland Aboriginal and Islander Health Council, Ethnic Communities Council of Queensland, Primary Health Networks (PHN) Queensland) with funding from the Queensland Government.

The program is designed to support positive lifestyle changes in order to reduce an individual's risk of developing conditions such as type 2 diabetes, heart disease, stroke, high cholesterol and high blood pressure. It covers areas such as: healthy eating and physical

activity; achieving and maintaining a healthy weight; reducing alcohol consumption; and quitting smoking.

The program includes six sessions over six months, delivered by qualified health professionals trained as *My Health for Life* facilitators. The program also offers culturally tailored group programs for Aboriginal and Torres Strait Islanders, Pacific Islanders, and Mandarin, Cantonese, Vietnamese, and Arabic speaking communities.

More than 7,500 people have enrolled in the program and around 4,500 have completed it. Currently over 100 participants per week are completing the program, making changes to their lifestyle including losing weight, and more than 200 locally-based healthcare organisations are actively involved in delivering the program in their communities, targeting prevention as a key activity.

D. Providing support for a marketing/awareness campaign with elements targeting both the public and general practice/primary care, to improve utilisation of health assessment items for eligible populations.

ACDPA recommends that support be provided to increase awareness of Integrated Health Checks amongst general practice and the community, and increase uptake of health checks. Along with GP education, there are opportunities to incentivise utilisation of Integrated Health Checks for the target population by including these checks in the Quality Improvement Incentive (QII) program.

The current uptake of absolute cardiovascular risk assessment by GPs is estimated at around 30% of the eligible population in Australia,⁹ and checks for type 2 diabetes and kidney disease are not routinely conducted, resulting in undiagnosed and untreated disease until it has significantly progressed.

Evaluations of recent international programs highlight opportunities to increase health checks amongst eligible populations, including through national commitments, targets, modest incentives for primary care providers, and monitoring and reporting on progress.

Internationally, both the UK and New Zealand have established national programs to provide integrated health checks to target groups. The New Zealand *More Heart and Diabetes Checks* program was established in 2012 to provide health checks for cardiovascular disease and diabetes. A national target of 90% coverage of the eligible population was set and reached by 2014-15, with interim targets of 60% coverage by July 2012 and 75% coverage by July 2013. Uptake was monitored and primary care providers were offered modest incentives to reach targets.¹⁰

The UK NHS Check was established in 2009 as a 'world-leading' program to assess risk factors and prevent disease and complications. The program aims to prevent heart disease, stroke, diabetes and kidney disease, as well as raise awareness of dementia. Coverage has increased to 48% of the targeted eligible population, and uptake has increased to around 1.5 million receiving a check each year. A recent review of the program noted that the assessments "provide a significant opportunity to reduce early death, disability and health inequalities."¹¹

E. Further collection of evidence on health assessments, based on international evaluations and local evidence relevant to the Australian context.

ACDPA supports the suggested collection of data from Primary Health Networks to build the evidence base and provide a broader understanding of the long-term benefits of health checks in the Australian context. Research shows that public health interventions provide good value for money, with a return of \$14 for every dollar invested, in addition to the return of the original investment back to the wider health and social economy.¹²

Modelling suggests that heart health checks alone could prevent 76,500 cardiovascular disease events over the next five years, as well as saving \$1.5 billion during this time.¹³ Benefits are likely to extend to large reductions in other vascular diseases due to shared risk factors and interacting disease risk. For example, research shows that the number of strokes would almost be halved (48 per cent) if high blood pressure alone was eliminated.¹⁴ Long-term benefits of Integrated Health Checks would likely include further reductions in disease progression and complications due to screening for type 2 diabetes and chronic kidney disease.

The burden of chronic disease

Chronic disease is described as Australia's greatest health challenge, due to its personal, social and economic impacts. One in two Australians have a chronic disease and one in four have at least two chronic conditions.¹⁵ Almost 40 per cent of potentially preventable hospitalisations in 2013-14 were due to chronic conditions.

Chronic disease accounted for 36 per cent of national health expenditure in 2008-09.¹⁶ As the population ages, these costs are anticipated to grow. Yet one-third of disease burden could be prevented by addressing modifiable risk factors.¹⁷ Integrated Health Checks provide an opportunity for early risk assessment in primary care and support to manage risk factors, with the potential to prevent disease progression and complications, and reduce preventable hospitalisations.

Cardiovascular disease (CVD)

More than four million Australians are living with CVD and there are more than 43,000 deaths per year from CVD, many of them preventable.¹⁸ Aboriginal and Torres Strait Islander people are 1.8 times as likely to die from heart disease and 1.4 times as likely to die from stroke compared to non-Indigenous Australians.

The direct healthcare costs of CVD are substantial, particularly to governments. At \$8.8 billion a year, CVD is the most-costly disease group, accounting for 10.4 per cent of direct healthcare expenditure, including \$4.5 billion in hospital admissions and \$1.65 billion in pharmaceuticals.¹⁹ CVD is forecast to remain the most expensive disease group, projected to rise to more than \$22 billion in 2032-33.²⁰

Type 2 diabetes

There are currently more than 1.1 million people with type 2 diabetes registered with the National Diabetes Services Scheme.²¹ This has climbed from just over 430,000 in 2001.²²

There may also be as many as 500,000 Australians living with silent, undiagnosed type 2 diabetes.

Diabetes has a major impact on the Australian economy, costing around \$14.6 billion per annum.²³ This is forecast to rise to \$30 billion by 2025 unless the number of people developing type 2 diabetes is reduced. Diabetes-related complications, including blindness, limb amputation, kidney failure and heart disease, are also major contributors to the burden of disease in Australia.

Kidney disease

Over 1.7 million Australian adults have at least one clinical sign of chronic kidney disease.²⁴ However less than 10 per cent of these people know they have the condition, meaning there are over 1.5 million Australians who are unaware that they are living with indicators of chronic kidney disease. One in three Australians are at increased risk of developing chronic kidney disease.²⁵ Diabetes is the most common cause of end-stage kidney disease, accounting for 36 per cent of all new cases. Hypertension accounts for around 14 per cent of new cases.²⁶

In 2012, the total costs attributable solely to pre-end-stage kidney disease were estimated at \$4.1 billion, made up of \$2.5 billion in direct healthcare costs, \$700 million in direct non-healthcare costs, and \$900 million in government subsidies.²⁷ Dialysis and transplantation for end-stage kidney disease are estimated to cost over \$1 billion each year.²⁸

About the Australian Chronic Disease Prevention Alliance (ACDPA)

The Australian Chronic Disease Prevention Alliance (ACDPA) incorporates the former National Vascular Disease Prevention Alliance (NVDPA) and brings together Cancer Council Australia; Diabetes Australia; National Heart Foundation of Australia; Kidney Health Australia; and the Stroke Foundation. These leading Australian non-government health organisations share a commitment to reducing the growing incidence of chronic disease in Australia attributable to modifiable risk factors. ACDPA members collectively advocate for prevention, integrated risk assessment and effective management of chronic disease risk.

¹ Medicare to fund a new Heart Health Check from April 1.

<https://www.news.com.au/national/medicare-to-fund-a-new-heart-health-check-from-april-1/news-story/d7b4fc98638a3023ee57de17ad7bb735>

² Royal Australian College of General Practitioners. 2018. Guidelines for preventive activities in general practice. 9th edn, updated. East Melbourne, Vic: RACGP.

³ National Aboriginal Community Controlled Health Organisation and The Royal Australian College of General Practitioners. National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people. 3rd edn. East Melbourne, Vic: RACGP, 2018.

⁴ The Royal Australian College of General Practitioners. General practice management of type 2 diabetes: 2016–18. East Melbourne, Vic: RACGP, 2016.

⁵ Chronic Kidney Disease (CKD) Management in General Practice (3rd edition). Kidney Health Australia, Melbourne, 2015.

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- ⁹ National Heart Foundation of Australia submission. 2018. Absolute Cardiovascular Risk Assessment Algorithm and Guideline update.
- ¹⁰ Allen + Clarke 2016. More Heart and Diabetes Checks Evaluation. Final report.
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- ¹⁹ Institute for Health Metrics and Evaluation 2018, *Global Burden of Disease Study 2017 (GBD 2017) Results*, Global Burden of Disease Collaborative Network, Seattle, <http://ghdx.healthdata.org/gbdresults-tool>.
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- ²² Australian Bureau of Statistics. Australian Social Trends, December 2007. Cat. no. 4102.0. Canberra, 2007.
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- ²⁸ Cass A, Chadban S, Gallagher M et al. The economic impact of end-stage kidney disease in Australia: Projections to 2020. *Kidney Health Australia*, Melbourne, Australia; 2010