



### Submission from the National Stroke Foundation CEO Dr Erin Lalor

Stroke is preventing Australia from meeting one of the challenges of our maturing population – the need to ensure people age well and continue to add value to the community. With the average age of Australians rising the number of strokes will increase each year unless action is taken.<sup>1</sup>

In 2008, Australians will suffer almost 60,000 new and recurrent strokes – one stroke every 10 minutes.<sup>2</sup> One in five people having a first-ever stroke will die within one month and one in three will die within a year.<sup>3</sup>

This urgent, national problem requires changes in systems, thinking and attitudes to introduce best practice stroke care. Australia needs a nationally co-ordinated prevention campaign to reduce the incidence of stroke – Australia's second single biggest killer after coronary heart disease and a leading cause of disability.<sup>4</sup>

We do not have a data monitoring system. Priority areas are unfunded. The federal-state-territory divide makes it difficult to influence and coordinate change in hospital care.

Active prevention means educating Australians about stroke to ensure we all know our risk factors and we can recognise the symptoms of stroke.

We need systems to ensure prompt hospital admission, diagnosis and treatment to reduce death and disability after stroke; including stroke unit care, aspirin as soon as possible after ischaemic stroke and the use of tissue plasminogen activator (tPA) within three hours of an ischaemic stroke.

Stroke prevention, treatment and post-stroke care vary in different parts of Australia. A nationally coordinated prevention and treatment plan will improve inter-government cooperation to reduce gaps in existing services and allow health systems to learn from each other. More stroke units in Australia's hospitals will mean improved health outcomes and cost savings.<sup>5</sup>

Greater use of clinical guidelines for acute stroke care, rehabilitation and recovery is required to improve the skills of the stroke workforce. Delivery of evidence-based stroke treatment saves lives and reduces disability.

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<sup>1</sup> AIHW: Senes, S 2006. How we manage stroke in Australia

<sup>2</sup> AG Thrift (personal communication). Estimates obtained using NEMESIS data (assuming no change in incidence), and Australian Bureau of Statistics estimates of a changing population.

<sup>3</sup> Thrift AG, Dewey HM, Macdonell RAL, McNeil JJ, Donnan GA 2000. Stroke incidence on the East Coast of Australia: the North East Melbourne Stroke Incidence Study (NEMESIS). Stroke 31 (9):2087-2092.

<sup>4</sup> Australian Institute of Health and Welfare 2006. Australia's Health 2006.

<sup>5</sup> 'Cost-effective' was defined as an incremental cost-effectiveness ratio below a threshold of \$30,000 per DALY as this is the level at which policy makers would consider this as 'value for money'.



## Submission to Australia 2020 Summit

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Dramatic improvement is needed to improve the quality of life for 90 percent of the nearly 350,000 people living after stroke in Australia, four out of five of whom have a disability and are likely to have difficulty caring for themselves, communicating or moving outside their homes. Often, they are socially isolated and depression is common. They need better access to services including peer support, self management programs, telephone counselling and educational material.

Far-reaching decisions leading to investment in the prevention of stroke, detection and early intervention and provision of acute and long-term care requires solid information about the health of Australians. We need to be able to monitor and predict the future health of the population, using five-yearly surveys, which include physical measurements and blood tests, the linking of existing data sources to provide a complete picture of the nation's health status and to benchmark and monitor achievements of the national health reform agenda.