

## Chronic illness in the middle years

MIDDLE AGE IS WHEN the accumulated interactions of genetic predisposition, environment and lifestyle commonly start to impact on health. Ischaemic heart disease and chronic obstructive pulmonary disease, for example, often become symptomatic in these years. The World Health Organization predicts that by 2020 these two conditions will be among the five leading causes of disease burden globally. Ischaemic heart disease is already the leading cause of disability in Australia and is the most common cause of death among Indigenous Australians.

Over the past three decades, it has become clear that aggressive medical and surgical treatment of ischaemic heart disease improves quality of life and reduces mortality.<sup>1</sup> Medical treatment improves quality of life in chronic obstructive pulmonary disease.<sup>2</sup> Exercise rehabilitation and lifestyle modification are beneficial in both conditions, even after symptoms develop. Stopping smoking remains the key to reducing mortality from chronic pulmonary disease, and is similarly important in ischaemic heart disease.

The WHO has pointed out that across the world most healthcare systems fail to implement fully the knowledge we already have to redress the growing problem of chronic illness. Five deficiencies are identified:

- Care is fragmented and focused on acute and emergent symptoms;
- The patient's role in management is not emphasised;
- Follow-up is sporadic;
- Community services tend to be ignored; and
- Prevention is underused.

Although there have been significant developments in Australia in recent years, including the introduction of Enhanced Primary Care Medicare items (which allow general practitioners to devote more time to managing chronic illness), as well as initiatives by states and territories, the deficiencies identified by the WHO are all too evident in many parts of the Australian healthcare system.

And yet we know what is needed.<sup>3</sup> Continuity of care, by a single general practitioner if possible, can provide the basis of a therapeutic alliance and enhance adherence to an agreed treatment plan. In a condition such as ischaemic heart disease, which may require treatment with multiple drugs, the patient–doctor relationship is an important factor in promoting and sustaining adherence.<sup>4</sup> In chronic obstructive pulmonary disease, where the single most effective treatment is lifestyle change, many patients are helped by support in goal setting, action planning and discussion of the reasons for relapse.

Patients and their families need access to information and resources to help them deal with chronic illness on a day-to-day basis, as well as contingency plans for when problems arise. Optimal management of some chronic diseases, such as diabetes mellitus and asthma, depends on patients having the means for self-monitoring their condition. Most chronic diseases require regular medical review for optimal management, and evidence suggests that active and sustained follow-up is associated with improved outcomes.<sup>3</sup>

Of course, the care of chronic disease requires input from patients, family and non-medical health professionals, as well as from general practitioners and other specialists. If this extended healthcare team is to function optimally, then all members require timely access to relevant information. Clinicians must be able to obtain details of treatment and the results of investigations by others, and emerging solutions such as the electronic health record will fill this need. As we wait for this technology to mature, innovations such as the New South Wales patient-held “My Health Record” plug a significant gap.

These developments alone will not rectify the appallingly high morbidity and mortality of Indigenous Australians in the 45–64-year age group. Indeed, it is inappropriate to describe these as the “middle years”, when most Aboriginal people die during them. It is a national disgrace that the median age at death of Indigenous Australians remains almost a quarter-century less than that of the remainder of the population. However, there are some promising developments.

The revised National Strategic Framework for Aboriginal and Torres Strait Islander Health is expected out this year; it is hoped it will build on and expand the scope of the current Primary Health Care Access Program, and will also look beyond the health sector to the need for a national infrastructure plan to rectify the continuing deficiencies in many communities in water supply, sanitation, education and other basic services.<sup>5</sup> The Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework has already been published;<sup>6</sup> if fully implemented, this will do much to enhance the capacity of the health sector to respond to the needs of Indigenous Australians. In addition, the health of the population as a whole will be greatly improved if politicians find the will to do far more to reduce smoking and to combat the growing epidemic of obesity in Australia today.



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