

## Targeted approaches for reducing inequities in chronic disease

*Disease prevention, access to services, and continuity of care are the important areas*

HEALTH INEQUITIES are systematic differences in health status between different groups in the population, and may or may not be changeable. Health inequity is taken here to mean inequalities that “are unnecessary, avoidable, unfair and unjust”.<sup>1</sup> Inequities in health usually relate to socioeconomic position, ethnicity or sex. Examples associated with chronic disease in Australia include:

- Higher mortality rates from cardiovascular disease, diabetes, and renal disease among Aboriginal and Torres Strait Islander populations;<sup>2</sup>
- Higher mortality rates from coronary heart disease, stroke, and chronic respiratory conditions among lower socioeconomic groups;<sup>3</sup> and
- Higher mortality rates from vascular diseases, suicide and accidental death, and lower survival from cancer among people with mental illness.<sup>4</sup>

One estimate of the size of this effect is that, if disease and injury incidence and mortality in all areas were reduced to the level in the least disadvantaged quintile, the potential savings in lost years of “healthy” life would be 17% of the total disease burden.<sup>5</sup>

Only some inequalities in mortality are *potentially* avoidable through the activities of the health and related sectors; analysis of these can indicate opportunities to reduce health inequities. Interventions against potentially avoidable mortality can be divided into three levels: primary (preventing a condition from developing; eg, by treating hyperlipidaemia), secondary (preventing the worsening of a condition at an early stage; eg, screening for and treating early disease), and tertiary (curing disease or extending life through treatment).<sup>6</sup> An analysis of trends in avoidable deaths in New South Wales from 1980 to 2000 showed:

- The burden of potentially avoidable mortality decreased overall and across all socioeconomic status (SES) groups during the 20 years; however, the rate of reduction was higher in the highest SES group than in both the lowest SES group and the rest (middle 60%) of the population. Ischaemic heart disease, lung cancer and colorectal cancer contributed most to this burden in 2000.
- About half the potentially avoidable deaths are preventable through primary prevention, a quarter through secondary prevention (mainly ischaemic heart disease, stroke, and colorectal cancer), and a quarter through tertiary prevention and rehabilitation (mainly ischaemic heart disease).
- The proportion of primary preventable causes rose slightly, indicating a relatively greater reduction in causes associated with secondary and tertiary interventions during the period.<sup>7</sup>

Information on inequities other than mortality is not extensive in Australia, owing to lack of suitable data collections. One study suggests timely and effective ambulatory care (encompassing preventive care and early disease management) may reduce the risk of hospitalisation by prevent-

ing an illness, controlling an acute episodic illness, or managing a chronic condition.<sup>8</sup>

Hospitalisation rates in NSW and Victoria for conditions potentially avoidable through ambulatory care were similar (6.2% and 7%, respectively).<sup>7,8</sup> The five most common such conditions were angina; asthma; chronic obstructive pulmonary disease; convulsions and epilepsy; and ear, nose and throat infections.

### Targeting disease prevention

Potential health system responses to health inequities include health promotion, higher treatment levels for targeted populations, more effective treatment (eg, given earlier, or with better compliance) and improved use of resources through better coordination and information sharing.<sup>9</sup> The data above indicate that, although a multi-pronged approach will be necessary, the largest population benefit will be through making prevention programs more effective. Well-documented differences in chronic disease risk behaviours include higher prevalence of smoking, obesity, and high blood pressure in low SES groups.<sup>3</sup>

How prevention strategies can be more effective among low SES groups is the subject of much controversy and little systematic research. Many authors believe that traditional approaches to health promotion will not be effective because the capacity to make “healthy” choices is strongly linked to environmental and social factors that accompany poverty and disadvantage. Determinants of health can be considered at upstream (social, physical, economic and environmental), midstream (psychosocial and health behaviour), and downstream (individual) levels.<sup>10</sup> Health promotion within clinical services has traditionally focused on the individual level, although public health preventive activities have generally had the most effect when implemented at upstream levels. Given the limitations of the existing evidence for reducing socioeconomic health inequities, interventions that have been effective with other health problems are a good starting point.<sup>11</sup>

### Targeting access inequities

Australian data on potential differential access to services are limited and largely confined to geographic access for people in rural and remote areas. There is no whole-of-population dataset that systematically looks at the quality and effectiveness of care for chronic disease in groups experiencing health inequities. However, studies suggest there is much room for improvement. For example, in 98 000 general practitioner encounters, holders of health-care cards (who are on aged, disability, unemployment or other low-income pensions) were more likely to have chronic diseases and fewer preventive measures (such as Pap smears).<sup>12</sup> At the tertiary care level, patients of lower SES

### Requirements for addressing health inequities in the care of people with chronic disease

- *Better data* on health inequities across the continuum of care, to produce key indicators for regular monitoring. The available data already indicate that a high priority should be given to prevention and management of cardiovascular disease.
- *Appropriate use of data* in decision making. The National Health and Medical Research Council (NHMRC) has recognised the potential for clinical practice guidelines to affect health inequities both positively and negatively, and has produced a guide on how to use socioeconomic evidence when developing guidelines.<sup>14</sup>
- *Greater investment in prevention*, with particular attention to disadvantaged groups. Funding for programs needs to recognise the lack of primary healthcare infrastructure to deliver prevention in many disadvantaged communities and the need to make longer-term funding commitments (5–10 years) for such programs.
- *Local or regional initiatives* to ensure active coordination of all care.
- *Funding mechanisms* that provide better access to non-medical therapies such as podiatry and dietetics.

had less access to invasive procedural treatments following admission for coronary heart disease in Queensland.<sup>13</sup>

As our healthcare system is oriented to acute care, chronic care treatments that reduce disability (eg, joint replacement surgery) are likely to have lower priority and therefore be more difficult to access. Such inequities of access may be greater for dental care, physiotherapy, speech therapy, dietetics and podiatry, which are not subsidised outside public hospitals. Thus, in redistributing resources for health problems where inequities exist, it is important to ensure that the investment is made where the effect is likely to be greatest.

### Targeting continuity of care

Achieving continuity of care across healthcare sectors is a major problem in the care of people with chronic disease, especially those disempowered by way of income, language, or culture. Delivery of care and support services by multiple professionals and agencies compounds the problem. Appropriate rationalisation of such arrangements and good coordination of care can lead to better outcomes.

Any attribute of our healthcare system that impairs any health outcome will be compounded for people who are

poor or otherwise disadvantaged. Indeed, it will be difficult to redress health inequities for people with chronic disease without addressing the broader problems in the system. However, without specific attention to health inequities in research, planning and policy (see Box), the current differences will not go away, and may even increase.

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