

# The Chronic Disease Strategy for Australia

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*There is a considerable mismatch between evidence and policy*

Chronic diseases now have a major impact on Australian society, accounting for about two-thirds of health care expenditure (more than \$35 billion) in 2000–01. Last November, the Australian Health Ministers' Conference endorsed a national strategic policy approach to manage and improve chronic disease prevention and care in the Australian population. The approach has three elements: a national chronic disease strategy; a set of five national service improvement frameworks; and a blueprint for nationwide surveillance of chronic diseases and associated determinants.<sup>1</sup>

The policy focuses attention on five chronic disease groups: asthma, cancer, diabetes, cardiovascular diseases and musculoskeletal conditions. These have been identified because they are common and lead to substantial levels of disability among Australians. The authors propose a multilayered strategy aimed at preventing or delaying the onset of chronic diseases, intervening early in disease processes to minimise harm and improve quality of life, ensuring integration and continuity of care, and encouraging the active participation of people in their own health care.

People living with chronic medical conditions are clear about the elements they require from a modern health care system. They need access to high quality information about their condition, care which is continuous and well coordinated, effective management of their symptoms and — perhaps most importantly — help in managing the social, economic and psychological consequences of their symptoms.<sup>2</sup>

This ambitious Australian strategy is timely and well considered. If successfully implemented, it will go a long way towards meeting these requirements. The key question is, what must be done to translate it from a worthy set of words to an effective set of deeds? What steps must be taken to give it the best chance of success?

First, there is a need to promote chronic illness on the agendas of policymakers so that the necessary political and economic changes can be made to the Australian health care system.<sup>3</sup> Structures must be put in place to reduce health care inequalities and to maximise efficient resource allocation. It is not yet clear whether such structures are best situated at federal or at state level, nor what role the private sector should play. Assuming a degree of competition is both inevitable and healthy, it may be best to base such decisions not (as historically) on answers to the question “who pays?”, but rather on answers to the question “who provides best value?”<sup>4</sup>

Second, primary health care must change. General practice will have a key role to play, especially in the early detection of disease and in providing integration and continuity of care. Registers and recall systems for patients with chronic diseases will need to be set up, preferably in electronic form. The Australian Government's HealthConnect program, which enables health care providers to connect to business grade and advanced broadband arrangements, may provide a useful basis for efficient chronic disease care, insofar as it enhances the ability of health providers to share information about patients.<sup>5</sup> Primary care teams will have to standardise medical procedures, provide information on local services and

## The Australian National Chronic Disease Strategy

- The National Chronic Disease Strategy is a nationally agreed agenda to encourage coordinated action in response to the growing impact of chronic disease on the health of Australians and the health care system.
- It has five health priority areas:
  - asthma
  - cancer
  - diabetes
  - heart, stroke and vascular disease
  - osteoarthritis, rheumatoid arthritis and osteoporosis.
- It is structured to reflect the phases of illness:
  - reducing risk
  - finding disease early
  - managing acute conditions
  - long-term care
  - care in the advanced stages of disease.
- Implementation of the strategy will be the responsibility of individual jurisdictions. ◆

make links with patient self-management programs. These activities will need to be carefully coordinated for each patient.

Australian general practice is not currently configured to deliver this strategy to maximum effect. Models of good practice, such as the South Australian HealthPlus experiment,<sup>6</sup> show what can be done with the injection of energy and imagination, and the provision of adequate resources (particularly at the care coordination level), but there remains a substantial mismatch between evidence and policy.<sup>7</sup> It will be necessary for managers and practitioners to resolve the complex structural problems inherent in realigning a fee-for-service system that is designed to provide acute medical care towards a managed care system which must inter alia provide adequate financial support for high-quality electronic information systems, and generate funding models which enhance multi-disciplinary care rather than encouraging individualistic approaches to health care delivery. Recent policy developments in the United Kingdom offer useful guidance, and provide evidence for their success.<sup>8</sup>

Third, new programs of education will have to be put in place for patients and carers, and also for health professionals. Education for patients and carers can be provided to an extent through the mass media or via the Internet,<sup>9</sup> but the main focus is likely to be through the expansion of facilitated self-management or “expert patient” programs.<sup>10</sup> It is important to ensure that such programs enable patients with chronic diseases to actively engage in promoting their own health, and to make effective links with relevant health professionals. They must also avoid the tendency of becoming the preserve of a motivated minority, as this increases the risk of health inequalities.<sup>11</sup>

The focus of health care education has already begun to change, with a gradual shift of location from hospital to community, and

increased recognition of the value of scientific perspectives drawn from psychology and sociology. Learning outcomes also need to be reviewed, as symptom control and quality-of-life issues become the priority in effective management of chronic medical conditions. The next generation of health care professionals will have to become more experienced in pain management and in understanding the psychosocial aspects of long-term conditions, the needs of carers, best practices for coordinating care, and how to work well in partnership with patients.<sup>12</sup>

Finally, there will be a need for new research. Care coordinators are likely to be central to new models, but we do not yet know enough about their best role definitions, nor their economic costs and benefits. Do self-management programs work best when run by and for patients, or when they habitually involve health professionals? What are the principal barriers to a reorientation of general practice to meet the needs of patients with chronic diseases, and how can they be overcome? Questions about the cost-effectiveness of new models of chronic care also need to be asked. To address these questions, researchers must better understand the context in which they are operating: how health care functions as a complex adaptive system,<sup>13</sup> and the processes which enable (or hinder) the implementation of new technologies into routine clinical practice.<sup>14</sup>

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