DRAFT OUTLINE NATIONAL CHRONIC DISEASE STRATEGY
Source: National Health Priority Action Council, April 2005

1. Introduction

The National Chronic Disease Strategy (NCDS) will address a critical area of action for Australia's health care system. During the last century the major causes of death in Australia have shifted to chronic disease. Most of the burden of disease and injury is estimated to be due to chronic disease[1] .

Chronic diseases presently make up more than 70% of Australia's overall disease burden due to death, disability and diminished quality of life, and this is expected to increase to 80% by 2020.[2] Currently 7 out of 10 presentations at general practice are related to chronic diseases[3]. People may present with multiple chronic diseases and risk factors, as well as coexisting depression (and related disorders)[4].

The impact of chronic disease is not limited to older people, but is also significant in age group 24-65 years. Some groups carry a disproportionate burden of chronic disease. These include Aboriginal and Torres Strait Islander Peoples, socio-economically disadvantaged groups and people in rural and remote areas[5].

The burden of chronic disease places significant pressure on Australia's health system and human and financial resources. With the further ageing of the population, this pressure is expected to increase.

Chronic diseases and their impact
Chronic diseases occur across the whole spectrum of illness, mental health problems, and injuries. Both communicable and non-communicable diseases can become chronic, although the term is generally applied to non-communicable diseases.

The Australian Institute of Welfare[6] gives the following list of elements that help to define chronic disease; Chronic diseases:

- have complex and multiple causes;
- usually have a gradual onset, although can have sudden onset and acute stages;
- occur across the life cycle, although they become more prevalent with older age;
- compromise quality of life through physical limitations and disability;
- are long-term and persistent, leading to a gradual deterioration of health; and
- while not immediately life-threatening, are the most common and leading cause of premature mortality.

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[1] Australian Institute of Health and Welfare 2004. *Australia's Health 2004.*
[2] National Public Health Partnership October 2001. *Preventing Chronic Diseases: A strategic Framework.*
[3] Australian Institute of Health and Welfare 2002. *Chronic Diseases and Associated Risk Factors in Australia, 2001*.
[4] Australian Government Department of Health and Ageing report July 2003. *A Scoping Study relating to the National Health Priority Area conditions coexisting with depression (and related disorders).*
[5] Australian Institute of Health and Welfare 2004. *Australia's Health 2004.*
[6] Australian Institute of Health and Welfare 2002. *Chronic Diseases and Associated Risk Factors in Australia, 2001*.

A number of the major chronic diseases can be prevented or their onset delayed. Others cannot be prevented on the basis of current knowledge, but their progression can be slowed and their associated complications reduced.

People with chronic diseases are more likely to use a range of health services and medicines frequently and over extended periods of time. This can change depending on the severity of the condition and the time in their life. People may have more than one risk factor for a chronic disease, more than one chronic disease, and may also have a mental disorder, such as depression.

A holistic approach to care, taking account of psychosocial issues, and support for self management approaches are key aspects of chronic disease prevention and management.

It can be difficult for patients to move across and between different parts of the health system and between different health professionals. This can affect their quality of life and overall health.

2. National Chronic Disease Strategy – Aims and Objectives

The national chronic disease strategy (NCDS) will be an umbrella strategy focusing on non-communicable chronic diseases, primarily physical diseases. However, the principles of the NCDS will apply more broadly to the range of chronic diseases, conditions, and injuries that may have a chronic course.

The national chronic disease strategy is being developed in the context of:
- burden of chronic disease; and
- the need for joint action at all levels of the health system;

The NCDS will emphasise a population health perspective to prevent and delay the onset of chronic diseases, and a clinical perspective to limit the progression and complications of disease.

Aim
The aim of the NCDS is to provide an overarching, consistent, and practical approach to the prevention, diagnosis, and management of chronic disease across Australia.

Objectives
The objectives of the NCDS are to:
- prevent and/or delay the onset of chronic disease;
- reduce the progression and complications of chronic disease;
- improve the quality of life for patients and their families and carers;
- reduce preventable hospital and residential aged care admissions;
- reduce inappropriate variations in practice;
- enhance the capacity of the health workforce; and
- improve the wellbeing of individuals living with chronic disease.

Principles
The following principles will underpin the NCDS:

Achieving person centred care
Person centred care respects and positions people at the centre of their own care, and relates to all their interactions and experiences of the health system—for a particular episode of care, in different healthcare settings, and across their lifespan. A person centred approach to care ensures that people are treated with respect, dignity and autonomy and are empowered make informed decisions and undertake the health actions that maximise their wellbeing.

Supporting self-management
Self-management empowers people to manage their own health care experiences to ensure that they are tailored to their unique needs.

Encompassing the continuum of care
Focusing on all aspects of health care including prevention, detection, management (self-management as well as approaches to reduce disease progression and complications), rehabilitation, residential aged care and end of life care.

Prioritising prevention
Addressing those risk factors that impact on many of the chronic conditions across the continuum of prevention and care.

Meeting the needs of special population groups
Responding to the needs of people from all cultural and linguistic backgrounds, people at all stages of the lifespan, and to those in all types of settings, for example, rural and remote communities. This includes addressing the particular needs of Aboriginal and Torres Strait Islander peoples, people with complex conditions, and people who are socio-economically disadvantaged.

Promoting integrated multidisciplinary care
Co-ordinating care planning, communication between health professionals, incorporation of psychosocial issues and comorbidities, and regular monitoring and reviews across a range of health care settings.

Working together in partnership and collaboration
Working collaboratively to achieve shared goals between government, non-government and the private sectors, primary and specialist care, and home, community and hospital and aged care settings.

Providing the most effective care
Basing health service delivery on the best available evidence at the time, and updating in response to emerging evidence.

Building on current best practice models
Adopting practical evidence-based approaches to the prevention and management of chronic disease to maximise uptake of effective interventions.

Monitoring progress
Building systems to monitor and measure progress against expected outcomes.

3 MAJOR THEMES OF THE NCDS

The main theme of the NCDS is continuity of care—across the continuum and across the elements of the health care system, including self-management. The NCDS will:

- focus on four **key action areas** -
  - prevention across the care continuum
  - strengthening early detection and early intervention
  - integration and continuity of care and
  - self-management.

- the NCDS will also address **four major areas for facilitating change** across the health system -
  - workforce capacity
  - strategic partnerships
  - investment and funding and
  - information technology and disease management systems.

The NCDS will also identify short-term and medium-term practical approaches to bring about improvements.

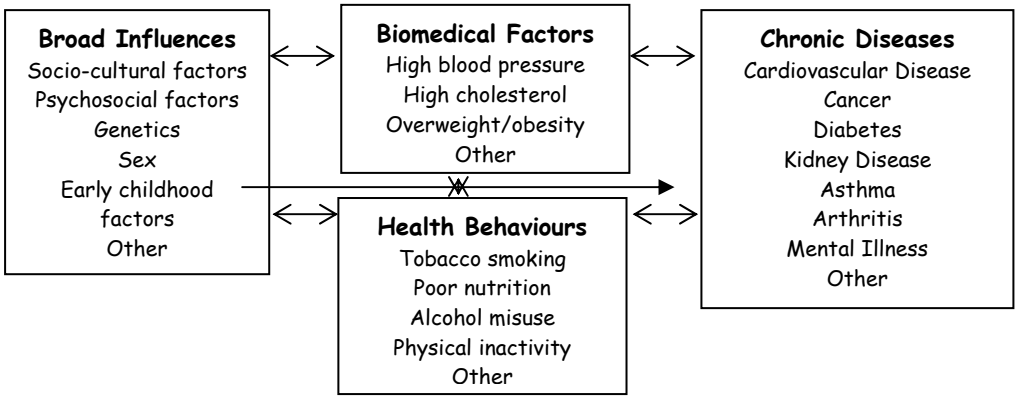
Prevention across the continuum
Significant gains can be made by focusing on the risk factors that underlie chronic disease in a systematic and well-integrated manner.

The range of risk factors amenable to intervention can be broadly grouped into two categories, behavioural and social risk factors, and biomedical risk factors. Cancer, cardiovascular disease, chronic obstructive pulmonary disease and type 2 diabetes have common and modifiable risk factors, notably high blood pressure, high blood cholesterol and obesity/overweight.

They are also linked by three related major behavioural risk factors, namely unhealthy diet, physical activity and tobacoo use. Psychosocial health can also impact on chronic diseases, including for peoples capacity to maintain healthy lifestyle approaches.

Health outcomes are likely to be most optimal when good health is promoted throughout life, beginning with the prenatal period and infancy. Children's experience early in life, including foetal exposure and adverse events, can strongly impact on their health and wellbeing later in life. Attitudes and behaviours formed early in childhood can be taken into adulthood.

Figure: Relationships of risk factors and chronic diseases[7]



Approaches that specifically target the specific population groups must be developed in conjunction with broader universal and environmental measures, which benefit the whole popuation. This work in turn needs to be set within the framework of a life course perspective and recognition of the contribution of psychosocial factors.

Promoting health and reducing risks requires focused, concerted, and sustained action at all levels. Within an overall framework for prevention, main areas for action include:

- Tracking action and monitoring performance;
- Raising awareness and stimulating action;
- Creating supportive environments;
- Starting before birth and in the first year of life and the years 1-4;
- Promoting health and well-being in the school years;
- Reducing further risks through every health care interaction; and
- Strengthening indigenous health and well-being.

Short and medium term ***practical actions*** within these areas might include:

- Working together to develop and implement a multiple approach, whole of population national initiative to support healthy nutrition and physical activity lifestyles.

- Facilitating activities in primary schools to support and strengthen sustained health promotion activities, including resources for curriculum development, and healthy food approaches, and improved local environments.

Strengthening early detection and early treatment

Strengthening early detection offers the opportunity to begin treatment at the early onset of disease (whether symptomatic or asymptomatic), and for some diseases can delay disease progression and severity and avoid unnecessary hospital admissions. In addition, early detection offers the opportunity to assess levels of risk by recognizing, and where possible, dealing with the underlying risk factors for chronic disease.

[7] Source: Adapted from Australian Institute of Health and Welfare 2002. *Chronic diseases and associated risk factors in Australia 2001*.

Not all chronic diseases are detected as early as possible in Australia. It is estimated for example, that only half of the people with Type 2 Diabetes are actually diagnosed and receiving treatment (AusDiab 2004). Furthermore, many chronic diseases are diagnosed at advanced stages of the disease which can compromise health outcomes overall.

Undetected, undiagnosed and untreated chronic disease can reflect:

- lack of knowledge or poor health literacy by consumers about the risks and/or symptoms of chronic disease;
- lack of recognition and the appropriate follow up response by health care providers to the risk factors for chronic disease and the manifestation or symptoms of disease; and
- poor access to, or use of, health care interventions (ie both diagnostic and treatment) at the asymptomatic and symptomatic stages.

Early detection and early treatment, where appropriate, can offer significant benefits at both an individual and population level and is a critical area in which to identify practical approaches under the NCDS.

A ***practical action*** in this area might include the development and implementation of effective risk factor identification and management processes – including access to services and building the capacity of service providers through, for example, the provision of resource materials (such as a checklist) for primary care screening processes.

Integration and Continuity of Care

The health system must perform four functions to provide integrated an continuous care in chronic disease management. These are:

- planning and developing services and systems of care that support integration and continuity of care that -
  - reflect the patient journey across the continuum of care.
  - involve consumers and communities in defining their own needs and priorities.
  - are coordinated across the range of services and sectors which are involved in chronic disease management and care across the continuum of care.
- enabling access to comprehensive and integrated services and systems of care with -
  - clearly defined points for entry to, and transition within, health and related services.
  - the full range of services and self management supports required for timely and well coordinated care available.
  - action across services and sectors to improve access to care and support, addressing cultural, physical disability, geographic, social, financial and eligibility barriers.
- providing care that is comprehensive, integrated and continuous that -
  - draws upon the evidence-base across different professional and consumer perspectives.
  - involves the combination of service providers required to meet the patient's needs.
  - includes an active role for the patient in goal setting and self-management.
  - has care that is structured (planned, coordinated, monitored and actively followed up where necessary) and takes a coordinated approach across co-morbidities.
  - is provided in settings that are culturally and clinically appropriate and convenient for the patient and carer.,
- taking action to improve integration and continuity of care
  - monitoring patterns of access to the range of health and related services and supports for self management for individuals and populations.

- monitoring integration and continuity of care for patients and patient/provider satisfaction with this.
- collaborates across organisations and sectors to improve quality.

Four broad strategies for improving integration and continuity of care might include, for example:

- developing some of the basic requirements for a more integrated system of care, such as data and patient registers;
- strengthening the support given by high level policy and programs to regional and local integration, including for appropriate networks of services at the local level;
- strengthening local and regional partnerships and capacity for supporting integration and continuity of care, for example to achieve local solutions; and
- supporting the development of more effective infrastructure and 'tools ' for integrating chronic disease care, for example, through standards and systems for secure transfer of data between providers.

Practical actions in the short and medium term might include areas such as:

- building primary health care partnerships and networks, including governance arrangements to facilitate effective partnerships;
- hand held patient records and better data collections to support planning and monitoring for integration and continuity of care and to inform service delivery and clinical improvements.

Self-management

Self-management is an integral and routine part of care planning and delivery, including for people with chronic diseases.

Fundamental to self-management is that people with a chronic disease are able to undertake the health care actions that optimise their well-being. This means facilitating a situation where people have the knowledge, skills and confidence to identify their health needs and take action to address them.

Self-management means that a person:

- understands the nature of their illness including any comorbidities and risk factors;
- has knowledge of their treatment options and is able to make informed choices regarding treatments;
- follows a treatment or care plan that has been agreed and negotiated with their health professionals, carers/family and other supports;
- actively participated in decision-making with health professionals, carers/family and other supports in terms of continuing care;
- monitors signs and symptoms of change in their health condition and has an action plan to respond to identified changes;
- manages the impact of the condition on their physical, emotional and social life and has good mental health and wellbeing as a result;
- adopts a lifestyles that addresses risk factors and promotes health by focusing on prevention and early intervention; and
- has confidence in their ability to use support services and make decisions regarding their health and wellbeing.

Importantly, self-management is not the sole responsibility of the person with the chronic disease. It is the role of the health professional to assist the person with a range of tasks that will promote effective self-management, based on the person's goals, wishes and capacities.

To support self-management the health system must provide ready access to appropriate systems of self-management support that are evidenced-based, and adequately resourced with trained staff. Staff must be culturally sensitive to the person's needs and support the belief in the person's ability to learn self-management skills.

Short and medium term ***practical actions*** for self-management might include:

- primary health care systems that incorporate multidisciplinary teams supporting patient and health professional partnerships relationships and self-management as part of routine integrated care planning process;
- education and training programs for health professionals and consumers.

Mechanisms to support the practical actions

Some mechanisms tin the identified areas for facilitating change may include, for example:

- workforce eduction and training, including in the areas of multidisciplinary care, prevention and self-management approaches, building collaborative partnerships and in communicating with each other and people about the condition.

- strong and committed partnership arrangements within the health sector (public and private) can improve care. Barriers need to be broken down between different parts of the health system and across professional and disease silos. Partnerships are needed to influence other sectors to address issues that may improve the health of the population.

- funding arrangements to support the delivery of services to achieve effective prevention and management of chronic diseases, with a particular focus on the practical actions, where possible.

- electronic health records, patient registries, decision support software, standards to allow data sharing and privacy, and broadband access may be useful tools to facilitate better chronic disease prevention and management.