

Preventable Chronic Disease Strategies in Aboriginal and Torres Strait Islander Peoples

2001

Preamble – Aboriginal and Torres Strait Islander Health

Aboriginal and Torres Strait Islander peoples, Indigenous Australians, have the poorest health of any group living in this country. Life expectancy at birth is between 16 and 19 years less than for non-Indigenous Australians. Standardised mortality ratios are more than three times the expected rate and death rates between 25-54 years of age are 5-8 times that seen in non-Indigenous Australians.

In Indigenous communities, higher levels of disadvantage lead to a higher prevalence of risk factors, greater disease burden and worse experience of illness.

Despite the huge disparity in health outcomes, Indigenous Australians receive an additional 8% in per capita health spending only, most of which is spent in the hospital sector.

Chronic Disease in Indigenous Australian Communities

Chronic diseases are the leading causes of premature death in both Indigenous and non-Indigenous Australian communities. These include diseases of the circulatory system (including hypertension, heart disease and stroke), respiratory disease, chronic renal failure, diabetes and cancer. In Indigenous Australian communities there are higher levels of chronic disease, which occur much earlier in life. Such chronic diseases, together with injuries, are also responsible for the increased rates of hospitalisation which are approximately 2.5 times that seen in non-Indigenous Australians.

Aboriginal concepts of health are holistic. In fact there is not even a specific word for health, let alone for body part specific diseases. The word "health" as it is used in Western society almost defies translation but the nearest translation in an Aboriginal context would probably be a term such as 'life is health is life'.² An effective approach to the management of chronic disease in Aboriginal communities must be holistic.³

General Principles – Chronic Disease

Chronic disease is variously defined. A classic definition is: "chronic diseases are long in duration—often with a long latency period and a protracted clinical course; of multifactorial aetiology; with no definite cure". The clinical notion of chronicity is reflected in the epidemiological characteristics of most chronic diseases: gradual changes over time, asynchronous evolution and heterogeneity in population susceptibility.⁴

Most chronic diseases have common risk factors and determinants. These include in particular, at different lifestages: low birth weight; inadequate living environments that fail to promote healthy lifestyles; poor nutrition; educational disadvantage; alcohol misuse and tobacco smoking. Aetiological factors tend to cluster and interact in an individual and community to determine the level of disease burden and illness. There is a higher prevalence of such factors among Indigenous Australians.⁵

The international trend towards a holistic approach to risk evaluation and preventive management, as opposed to disease centred approaches, appears logical based on evidence from animal-experimental, observational, and clinical trial evidence.⁶ The broad spectrum of common chronic conditions and accompanying disability and suffering are potentially preventable by tackling common aetiological factors.

Yet current Western funding models and programs are fragmented and are generally linked to specific diagnoses around discrete body parts and systems, rather than to community needs.

Chronic illness impact and holistic care

Chronic illness, that is the subjective and unpleasant experiences accompanying chronic conditions, involves the total human environment, including financial, sexual, legal, marital or psychological states. Such involvement acts synergistically to compound outcomes and costs of care irrespective of diagnostic classification.^{7 8} The ill, and their family, may require assistance with physical matters such as transportation and housework and may also face major threats to their identities, through stigmatisation and discrimination.^{9 10 11}

Holistic or non-disease-centred chronic illness care addresses biopsychosocial needs of the sufferer and their family.¹² The central importance of self-care, and systems that support self-care is now widely recognised.¹³ Supportive care that is well co-ordinated can improve outcomes.

Living with a chronic illness involves the individual, their family and their community.¹⁴ Individual needs should be managed in an integrated and culturally coherent manner within the context of the community.¹⁵ Community controlled preventive programs in Aboriginal communities have been demonstrated to achieve significant improvements in risk factors and health outcomes.¹⁶

Funding of Chronic Disease

Current funding programs are predominantly fragmented approaches to prevention, treatment and support, because they are located around discrete pathologies, body parts and systems.

The National Public Health Partnership, for example, recognises a large number of National Strategies related to specific chronic diseases, despite common preventive care and disease management issues across these diseases. Efforts are being made to coordinate and map such strategies, and also to integrate approaches across the National Health Priority Areas (which include diabetes, cardiovascular disease and cancer). Despite this, there are still multiple non-integrated programs being targeted at specific communities, and this contrasts with a generic approach to care such as that provided by Aboriginal Medical Services and General Practice.

Model Preventable Chronic Disease Strategy for Indigenous Australian Communities

A model strategy for Indigenous Australian communities needs to develop an integrated approach in an appropriate cultural context.¹⁷ Such a strategy would address linked conditions of diabetes, high blood pressure, renal disease, ischaemic heart disease and chronic airways disease through an understanding of common aetiological factors and community values. Indigenous community-controlled medical services endeavour to deliver such care through a comprehensive primary health care approach. Territory Health Services has also provided a potential model through the development of its Preventable Chronic Diseases Strategy.¹⁸

Aetiological factors and determinants would be addressed across the pre-natal, childhood, adolescent and adult life stages. Such factors include malnutrition-infection, developmental impairment and lifestyle factors such as smoking, alcohol, diet and education. At the level of medical care, such a model should adopt best practice principles for disease and condition-specific interventions. It would deliver medical care in such a way that hospital admissions do not reflect failed primary health care, nor occur as a result of poor communication between hospital and community at the time of discharge.

In such a model, medical care would take account of the social context of chronic disease and include referral to self-care and rehabilitation programs to ameliorate the consequences of chronic disease.

The AMA:

1. recognises that the medical profession should take a leading role in identifying and responding to the nature and challenges of chronic disease in Aboriginal and Torres Strait Islander people in the next 20 years.

2. recognises that chronic diseases are a major source of morbidity for Aboriginal and Torres Strait Islander people. The AMA particularly notes the importance of shaping chronic disease prevention, treatment and chronic illness care to Indigenous Australian ways of living, and the importance of setting up systems that support self-care.
2. recognises that the onset of poor health, particularly chronic disease and illness, is inextricably linked to social and cultural factors as well as biological factors.
3. advocates that disease based and fragmented policy and funding strategies in relation to chronic disease prevention and management be superseded by holistic, culturally appropriate approaches justified by current evidence.
4. will lobby for appropriate integrated funding models, as well as appropriate funding levels in partnership with NACCHO and other appropriate bodies.
5. will actively support and promote integrated chronic disease strategies and programs.

References:

1. Acheson D. 1998. *Independent Inquiry into Inequalities in Health Report, UK*. The Stationery Office, UK
2. Senate Employment, Workplace Relations, Small Business and Education References Committee. 2000. The Impact of Health on Education. The relationship between poor economic status, health and education. Chapter 8. Katu Kalpa – *Report on the inquiry into the effectiveness of education and training programs for Indigenous Australians*. Commonwealth of Australia.
3. National Aboriginal Health Strategy Working Party. *A National Aboriginal Health Strategy*. AGPS Canberra 1989
4. Rothenberg R. and Koplan J. 1990:267. Chronic disease in the 1990s. *Annual Review of Public Health* 11:267–96
5. Weeramanthri T. and Edmond K. *The NT Preventable Chronic Diseases Strategy - the Evidence Base*. Darwin: Territory Health Services, 1999.
6. Poulter N. Coronary heart disease is a multifactorial disease. *Am J Hypertens* 1999 Oct;12(10 Pt 2):92S-95S
7. Stein R. and Jessop D. 1989. What diagnosis does not tell us: the case for a non-categorical approach to chronic illness in childhood. *Social Science and Medicine* 29:769–78
8. Lorig K, Sobel D, Stewart A, Brown B, Bandura A, Ritter P, Gonzalez V, Laurent D, and Holman H. 1999. Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization: a randomized trial. *Med Care*. Jan; 37(1):5-14
9. Corbin, J., Strauss, A. 1988. *Unending Work and Care: Managing Chronic Illness at Home*. San Francisco: Jossey-Bass
10. Jessop, D. and Stein, R. 1994. Providing comprehensive health care to children with chronic illness. *Pediatrics* 93:602–7
11. Curtin, M., Lubkin, I. 1986. What is chronicity? In *Chronic Illness: Impact and Interventions*, (ed.) Lubkin, I. Boston: Jones and Bartlett
12. Perrin E, Newacheck P, Pless B, Drotar D, Gortmaker S, Leventhal J, Perrin J, Stein R, Walker D, and Weitzman M. 1993. Issues involved in the definition and classification of chronic health conditions. *Pediatrics* 91:787–93.
13. Holman H and Lorig K. 2000. Patients as partners in managing chronic disease. *BMJ* 320: 526-527
14. Martin, C. 1998. *The care of chronic illness in general practice*. PhD Thesis, Australian National University
15. Hoy WE, Baker PR, Kelly AM, Wang Z Reducing premature death and renal failure in Australian aboriginals. A community-based cardiovascular and renal protective program. *MJA*. 2000 May 15;172(10):473-8
16. Rowley KG, Daniel M, Skinner K, Skinner M, White GA, O'Dea K. Effectiveness of a community-directed 'healthy lifestyle' program in a remote Australian aboriginal community. *Aust N Z J Public Health*. 2000 Apr;24(2):136-44.
17. Couzos, S and Murray, R. *Aboriginal Primary Health Care An Evidence-based approach*. Oxford University Press. 1998

18. Weeramanthri T. Morton S. Hendy S. Connors C. Rae C. and Ashbridge D. *The NT Preventable Chronic Diseases Strategy - Overview and Framework*. Darwin: Territory Health Services, 1999.

Reproduction and distribution of AMA position statements is permitted provided the AMA is acknowledged and that the position statement is faithfully reproduced noting the year at the top of the document.