POLICY BRIEF

Chronic Illness Care for Indigenous Australians: Implications for Policy from the ABCD Project

Chronic disease is a major cause of ill health for Indigenous Australians.[1] A greater focus on management and prevention is needed to improve health outcomes for this group. Primary health care services are working to re-orient their systems to address the demands of chronic illness care more effectively. At the same time, decision makers need evidence on how to strengthen policy that supports health services to improve the way they organise and deliver care. In Indigenous communities—where the burden of chronic disease is disproportionately high, the service sector is more complex and workforce shortages more acute—there are additional challenges for policy in assisting services to deliver optimal chronic disease care.

The Audit and Best Practice for Chronic Disease Project (ABCD) is a Continuous Quality Improvement (CQI) initiative tailored to meet the needs of Aboriginal primary health care services. This policy brief summarises the key messages emerging from the ABCD experience, and highlights the policy challenges and suggested policy options for addressing these.

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Key messages from ABCD

- Successful partnerships between state governments, health services and a university have been established to support Aboriginal Health Services in developing CQI processes that improve the quality of systems for delivering clinical best practice. These partnerships provide vital resources and in-kind support that assist Aboriginal Health Services to implement chronic disease policy. Such partnerships should be strengthened and resourced.
- State/territory level chronic disease policies, enable jurisdictions to tackle chronic conditions in a more integrated way that encompasses prevention, promotion and management strategies. There is a need for further effective implementation of these policies.
- CQI processes could be further embedded in state and territory health authorities by building CQI processes and responsibilities into business plans and position descriptions.
- Chronic disease multidisciplinary teams require an inter-professional, cross-cultural skills mix that includes educators, clinicians, health promotion and Indigenous staff.
- Aboriginal Health Workers (AHWs) should be more involved in chronic disease care. AHWs' career pathways need to be developed to include specific roles in chronic disease prevention, early identification and management.
- Uniform reporting frameworks support the implementation of chronic disease programs. Alignment of reporting requirements will support the implementation of system-wide best practice in care, and create efficiencies for services.
- Communication of health data across sectors (between levels of government, between government departments, and between the government, private and Aboriginal community controlled sectors) is limited and is an area for improvement.
- Prevention activity is underdeveloped. With improved coordination between disease specific agencies, non-government organisations (NGOs) should be well placed to contribute to the delivery of prevention programs.

Evidence and theory

The aim of the ABCD project is to improve chronic illness outcomes in Indigenous primary health care settings by assisting services to improve their systems for the delivery of best practice care. There is considerable evidence that primary health care systems need to be reoriented if they are to address effectively increasing demands for care.[2] Drawing on Wagner's Chronic Care Model and the World Health Organization's Innovative Care for Chronic Conditions Framework, the ABCD project supports services to assess and improve the development of their service systems.

ABCD research shows that systems development in Indigenous health services is comparable with many primary care settings in Australia and internationally. This suggests that health centres are keeping abreast with the world in developing systems for chronic illness care. In addition, improvement in systems is positively associated with improvements in the quality of diabetes care, including with the control of HbA1c, blood pressure and cholesterol. Implementation of multiple system components is also associated with higher quality of care and better outcomes.[3]

Policy challenges

- Overcome critical problems related to high staff turnover in remote health centres. This is perhaps the single biggest challenge for effective and sustainable delivery of chronic illness care.
- Expand the delivery of chronic disease care, particularly in remote clinics where acute care is still the dominant demand.
- Adapt work patterns, through training and reorientation of systems, to the requirements of effective chronic disease management rather than to those of acute care.
- Assist remote communities to develop infrastructure that supports effective self-management and the adoption of healthy life styles.
- Improve coordination among non-government organisations that have a specific disease focus in order to strengthen their contribution to prevention programs.
- Increase Medicare expenditure in remote communities, which is well below the national average despite implementation in the past 10 years of the S100.
- Improve communication of health data across different health sectors to assist the coordination of chronic illness care.

Policy options

Strengthen partnerships: Utilise existing government processes and structures to strengthen partnerships. For example, include chronic disease prevention and control as a specific item in the Indigenous component of the Commonwealth/State Health Agreements.

Integration of policies: Focus whole-of-government strategies on prevention. As an important new program in this area, the Australian Better Health Initiative should be evaluated with respect to new prevention initiatives, whole-of-government approaches to prevention of obesity and chronic diseases should be explored, and new roles for NGOs developed.

Workforce: Develop specific chronic disease prevention and care roles for Aboriginal Health Workers within multidisciplinary primary care teams.

Financing: Further reform Medicare to allow for funding of team based care and cycles of care. Ensure that financial incentives are aligned with best practice care. Develop compensatory mechanisms for those jurisdictions where there is a significant gap between national and jurisdictional levels of MBS funding to ensure more equitable funding for chronic illness care.

Improved information systems: Implement the national service development reporting framework and monitor evidence–practice gaps in crucial chronic disease process indicators nationally. Include chronic disease indicators into Overcoming Indigenous Disadvantage Key Indicators.

REFERENCES

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