Northern Territory
Preventable Chronic Diseases Strategy
- Overview and Framework

TERRITORY HEALTH SERVICES
Northern Territory Government

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Example One

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This is general information, correct at the time of publication to the best of our knowledge.

Introductory note

This document provides an overview of the NT Preventable Chronic Diseases Strategy. It should be read in conjunction with two other documents produced in August 1999: the Ministerial Statement delivered by Hon. Stephen Dunham MLA, Minister for Health, Family and Children's Services; and the PCDS Evidence Base (containing a description of the best buys and key result areas in chronic disease control).

This document will be useful in defining a progressive implementation agenda for the PCDS, and framing implementation plans, but does not itself contain a comprehensive implementation plan. The Ministerial Statement contains details about what has been achieved up till now, and the key directions for the future, including the linking of the PCDS with other major initiatives such as the Coordinated Care Trials.

The PCDS is being constantly reworked to incorporate new ideas and different viewpoints. It is now a key THS strategy and a departmental priority. Operational areas within THS have been asked to show how the PCDS framework and goals have been incorporated within their business plans. Health service providers have been asked to prioritise the prevention and management of chronic disease in their daily work plans, and to find suitable ways to implement the strategy locally. In the second half of 1999, the organisational centre for PCDS development within THS shifted from Public Health to Primary Health Care. This will mean greater engagement with primary care stakeholders and linkage to other crucial initiatives involving workplace reform.

Prioritisation of the agenda will be determined by what operational areas are currently doing and the marginal costs and benefits of shifting resources. As the implementation agenda further develops, a Monitoring and Evaluation Group will monitor the overall progress of the the PCDS across the key result areas and report to an Advisory Committee that will be responsible for changing the direction of implementation as indicated.

The NT PCDS will remain a 'working strategy', needing regular review as new evidence and new ideas arise. We welcome further comments on the strategy and its implementation. Any comments should be sent to the Community Physician, Centre for Disease Control, Territory Health Services, Block 4, Royal Darwin Hospital Campus, Tiwi NT 0810. Further papers on other aspects of the NT PCDS will follow.

Executive summary

The chronic disorders of *type 2 diabetes, renal disease, hypertension, ischaemic heart disease and chronic airways disease* can be grouped together from a public health perspective as they have *common underlying factors*, most notably poor nutrition, inadequate environmental health conditions, alcohol misuse and tobacco smoking. The origins of these diseases are set *in utero* and early childhood (most notably through low birth weight, malnutrition, and repeated childhood infections) and are worsened by lifestyle changes (weight gain, lack of physical activity and substance abuse). The diseases and their risk factors are also inextricably linked with the broader socio-economic determinants of health and quality of life, particularly education and employment. Lifestyle choices are often more reflective of unrelenting socio-environmental constraints rather than personal preferences. Therefore an *integrated, intersectoral and whole of life* approach is needed.

This group of chronic diseases affects the whole NT population, as unhealthy lifestyles are an Australia-wide problem, but Aboriginal and Torres Strait Islander Territorians are particularly affected, and are more likely to have multiple chronic diseases. The strategy outlined here is *relevant to the whole population*, indigenous and non-indigenous, urban and rural. The cost of not intervening early is too great - an inexorable rise in deaths, hospitalisations, disease complications and financial costs incurred in relation to events such as renal dialysis.

The PCDS sees the diseases and their underlying factors as *preventable*, but interventions are needed well before complications appear. Indeed, most hospitalisations represent a failure of community based management. Health care for people with chronic diseases is a mix of patient- and provider-initiated self care steps that need to be maintained over the patient's lifetime. The challenge is to create *systems that support self-care*, link community health services with hospital services and link medical care with a public health approach.

This strategy proposes a *three point framework* to guide THS activity in this area - *prevention, early detection and best practice management*. Evidence has been gathered about the most cost effective interventions available at this point in time (see Evidence Base), many of which have already been put into place, but some of which need strengthening. Implementation of this strategy will lead to a delay in onset and a reduced number of adverse health outcomes in the short to medium term, as well as a reduction in long-term financial costs, but the full impact of all the interventions will not be felt for some years. So this is a *staged long-term strategy* to overcome problems that themselves have arisen over many years.

Chronic diseases are often asymptomatic for long periods and therefore ‘hidden’. They constitute a risk to length and quality of life, but how important that risk is to an individual will depend on the other risks, priorities and values in that person’s life. Because they are *chronic, complex and challenging* at both an individual and population level, the control of chronic diseases constitutes the ultimate challenge for the ‘new public health’ approach. Recent work in East Arnhem on cultural perceptions of chronic disease has highlighted the importance of *raypirri* or self-discipline, in *finding the right balance* for one’s lifestyle and behaviour. This concept is potentially relevant to all Territorians. It also reflects the desire of THS to find the right balance between investments in prevention and cure.

The PCDS approach is innovative in its unremitting commitment to *integration* - an integrated theoretical framework that encompasses social and medical determinants of health; an integration of client, clinical (individual-level) and public health (population-level) perspectives; an integrated approach to the underlying risk factors for chronic disease; integration at the level of guideline development, care plans and standards of care for both individuals and their families; and an integrated approach across the continuum of need from health to illness, and across the continuum of care between community and hospital services, and between health and other government sectors. In so doing, it is strongly influencing the development of the National Framework for Chronic Disease Prevention.

This strategy is part of an ongoing commitment by THS to both policy development in this area *and to work in partnership with the community, other agencies and the private sector* to encourage healthy living, to create health-promoting environments and to increase the capacity of communities to control their own health services. THS recognises the need to redirect attention towards the high priority area of chronic diseases and to continuously review progress towards the set goals. More rapid and substantial progress will, however, be dependent on intersectoral collaboration with other agencies directed at the socio-economic determinants of health, and on more equitable Commonwealth funding for primary level health services and funding for services in rural and remote communities.

A vision of the future - strategic goal and objectives

Strategic Goal - 10 years
To reduce the projected incidence and prevalence of the five common chronic diseases in the NT (type 2 diabetes, hypertension, renal disease, ischaemic heart disease and chronic obstructive airways disease) and their immediate underlying causes (poor nutrition, inadequate environmental health, obesity, physical inactivity, alcohol misuse, tobacco smoking, childhood malnutrition and low birth weight) in the Northern Territory within ten years.

Strategic Goal - 3 years
To reduce the projected impact - hospitalisations, deaths and financial costs - of the five common chronic diseases in the NT in the Northern Territory within three years.

Objectives

- All Territorians will be aware of the impact of chronic diseases in their community and the steps they can take as individuals and as families to prevent the illnesses and their complications.

- There will be intersectoral action promoting good nutrition, adequate environmental health standards, greater physical activity, safe alcohol consumption and non-smoking. Such intersectoral action will take a whole-of-life approach supporting mothers, infants, children, adults and the elderly to remain healthy.

- Whole of government approach will lead to better educational outcomes and improved employment opportunities for the indigenous population.

- All health staff will have been oriented to chronic diseases and their underlying causes, and will receive ongoing, on-site support and training to improve their chronic disease management skills.

- There will be chronic disease programs operating in all health centres and general practices, aiming at early detection and best practice management, and staff will be designated to run these programs.

- All individuals with diagnosed chronic disease, together with their families, will discuss health education messages and behaviour modification strategies at the time of diagnosis and periodically thereafter.

- All clients will be offered care based on locally produced and up-to-date best practice guidelines.

- There will be updated population lists in all community health centres and a recall system, either paper-based or computerised, in all community health centres and general practices.

- Programs aimed at encouraging healthy living will be operating in urban, rural and remote communities. They may be run from health centres, schools, women's centres, community

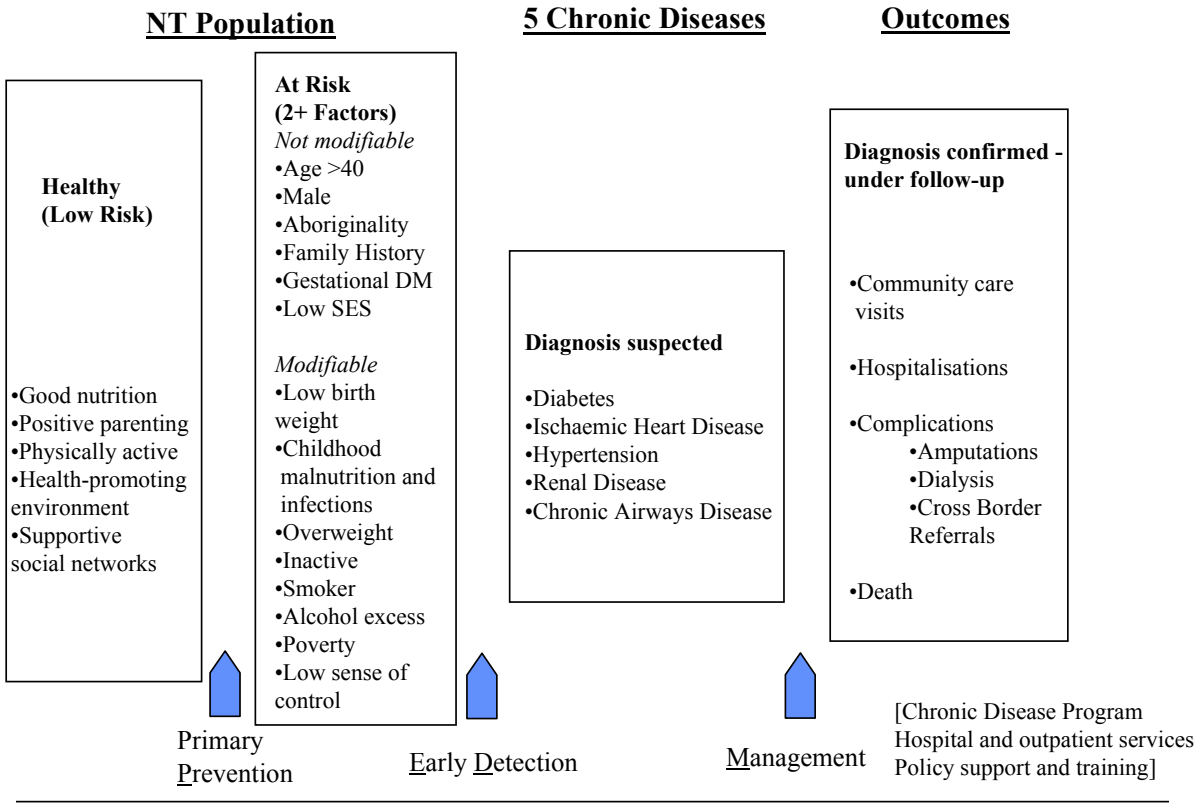
councils or elsewhere, but will be supported by health centre staff taking a primary health care approach and using a health promotion model.

- There will be a greater degree of community control over health services, through a variety of mechanisms.

- Non-government organisations in the wider society will be funded to deliver specific preventive programs, and Aboriginal community controlled health services will be funded to deliver key preventive programs, and early detection and best practice clinical management services, to defined segments of the population in specific locations.

- As a result of the above, the NT population will be better informed about lifestyle choices, the environment will be more health-promoting, and child and adult health outcomes will be improved.

Three point framework to guide implementation- prevention, early detection and best practice management



Notes on the framework

- The population is divided into a low-risk group and a high-risk group.

- The low-risk population is characterised by the presence of health-enhancing behaviours and environments.

⇒ When prevention type activities are directed at the low-risk group, this is commonly termed 'health promotion'.

⇒ Health promotion is also defined as the *process* of enabling individuals and communities to increase control over the determinants of health and thereby improve their health. Health promotion can then be seen to operate across the continuum of care.

- The high-risk population is characterised on the basis of the presence of well documented risk factors for chronic diseases, some modifiable and some not.

⇒ 'Aboriginality' is a 'proxy' risk factor, identifying a group at high risk, most probably because of a number of associated factors linked to socio-economic disadvantage. Nevertheless, it remains a useful means of targeting interventions in the NT context.

⇒ When prevention type activities are directed at the high-risk population, this is commonly termed 'risk factor modification'.

- Early detection, either through opportunistic or mass screening, leads to the early identification of people suspected to have one of the five diseases. Best practice screening and surveillance protocols are available to guide early detection programs. And once the diagnosis is confirmed, best practice management protocols must be applied. These have the potential to delay the onset and frequency of disease complications and to improve quality of life.

⇒ When prevention type activities are directed at the population with identified disease, this is commonly termed 'secondary prevention'.

- Data on the five chronic diseases named and on the specified outcomes are already routinely collected and so can be monitored.

- The framework diagram can also be 'read' from left to right as a representation of the life course from birth to death.

- The boxes in the framework diagram can also be tied to a number of 'settings': the low risk population are mainly encountered in the community and outside the health centre (except for acute and antenatal care); the high risk population are seen in the community, but may also be targeted by screening (either clinic-based or in the community); once the diagnosis of a chronic disease is suspected or confirmed, ongoing care becomes more health-centre based; and once complications develop, hospital care becomes more likely.

- DM stands for diabetes mellitus and SES for socio-economic status