

3.04 Chronic disease management

The management of chronic disease among the Aboriginal and Torres Strait Islander population

Data sources

Data on chronic disease management come from the Service Activity Reporting (SAR) data collection and the Healthy For Life data collection.

Healthy for Life Program

Healthy for Life (HFL) program is an ongoing program funded by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) of the Australian Government Department of Health and Ageing (DoHA). The program aims to improve the capacity and performance of primary health-care services to deliver high-quality maternal and children's health services and chronic disease care to Aboriginal and Torres Strait Islander people through population health approaches using best practice and quality improvement principles.

Services participating in the HFL Program are required to submit de-identified, aggregate service data for 11 essential indicators covering maternal health, child health and chronic disease care on a regular basis (6 and 12 months) as well as information about the characteristics of their service and organisational infrastructure. For the January to June 2007 reporting period 59 HFL services submitted data to the AIHW.

Divisions of General Practice National Performance Indicators

The National Performance Indicators (NPI) are reported in the Divisions of General Practice Annual Reports submitted to DoHA, and are part of the National Quality Performance System (NQPS). The NQPS is an integral aspect of the Government's primary health policy framework, which focuses on five National Priority Areas (NPAs): governance; prevention and early intervention; access; integration; and chronic disease (diabetes, mental health and asthma). The NPAs are tackled through 51 NPIs, which reflect expectations of the Divisions network, and assist members to measure progress and improve planning processes. Data on the first full cycle of reporting were submitted in the 2005–06 Annual Reports, and provide a benchmark for Division performance.

Service Activity Reporting database

The SAR collects data from approximately 150 Australian Government-funded Aboriginal and Torres Strait Islander primary health-care services and is held at the DoHA. It is estimated that these services provide GP services to around 40% of the Indigenous population. Service-level data on health care and health-related activities are collected by survey questionnaire over a 12-month period.

Response rates to the SAR by Aboriginal and Torres Strait Islander primary health-care services in 2005–06 were around 99%.

Note that the SAR only includes Aboriginal and Torres Strait Islander health organisations that receive at least some Australian Government funding to facilitate access to primary health care.

Data on the management of specific chronic diseases, such as rheumatic heart disease, coronary artery disease and Type II diabetes, were unable to be provided at present. For the purpose of this measure, chronic disease management is defined as the clinical management of a disease that has been diagnosed.

Analyses

Aboriginal and Torres Strait Islander primary health-care services

Healthy For Life data

In 2006–07, 59 services that were funded through the HFL program provided data on chronic disease management in 2006–07.

- In 2006–07, the most commonly used strategies for chronic disease management by Healthy For Life services were use of recognised guidelines (76%) and systematic or opportunistic follow-up of abnormal results (both 75%) (Table 3.04.1).
- Client education (68%) was the most common strategy for client self-management of clients' chronic disease, followed by goal setting (58%) and staff training (54%).
- Over two-thirds (68%) of services provided routine clinical reviews and 71% provided a team-based approach to chronic disease management.

Table 3.04.1: Proportion of services funded through the HFL program that had strategies for chronic disease management, 2006–07

Criteria assessed	Yes	No	No response
	Per cent		
1. A population-based approach			
a. A condition register used for recall and reminder	64	15	20
b. Use of recognised guidelines	76	5	19
2. A team-based approach	71	12	17
3. Clinical review, behavioural, social and environmental risk assessment			
a. Systematic	61	22	17
b. Opportunistic	70	10	20
6. Routine clinical reviews	68	14	19
7. Follow-up of abnormal results			
a. Systematic	75	9	17
b. Opportunistic	75	5	20
9. Systematic approach to client self-management			
a. Staff training	54	27	19
b. Goal setting	58	24	19
c. Client education	68	15	17
d. Hand held records	27	53	20
e. Support for involvement of family	49	29	22
f. Peer support	31	46	24

(a) 'Management' includes health promotion, prevention of complications, clinical care and advocacy.

Note: Data were provided by 59 services.

Source: AIHW, Healthy for Life data collection.

Type II diabetes clients – HbA1c levels

HbA1c levels reflect the mean glycaemia over the preceding 2–3 months and the test is performed in accredited laboratories.

HbA1c levels are defined in accordance with the NPCC as:

- a. Less than or equal to 7% (normal)
- b. Greater than 7% but less than or equal to 8%
- c. Greater than 8% but less than 10%
- d. Greater than or equal to 10%

The recommended HbA1c levels are less than or equal to 7% for diabetics – a higher target is to be expected for the elderly (65 years and over), pregnant women, and for patients with severe hypoglycaemia.

For the period 1 January to 30 June 2007, 25 services who were part of the HFL program provided data on whether HbA1c tests were undertaken for Indigenous clients with Type II diabetes in the last 6 months and 11 services provided data on the HbA1c test results of Indigenous clients.

- Of the 4,522 Indigenous adults with Type II diabetes who are regular clients of the HFL services, 1,991 (44%) had an HbA1c test in the last 6 months. The proportion of Indigenous adults with Type II diabetes who had an HbA1c test in the last 6 months varied by remoteness, being highest in remote areas (54%) and lowest in urban areas (30%) (Table 3.04.2).

Table 3.04.2: Number and proportion of Indigenous regular clients^(a) who are diagnosed with Type II diabetes who had an HbA1c test in the last 6 months, by remoteness, 1 January to 30 June 2007

	Urban	Regional	Remote	Total
Number of Indigenous regular clients with Type II diabetes who had an HbA1c test in the last 6 months	457	860	674	1,991
Total number of Indigenous regular clients with Type II diabetes	1,534	1,730	1,258	4,522
Proportion of Indigenous regular clients with Type II diabetes who had an HbA1c test in the last 6 months (%)	30	50	54	44

(a) Indigenous adults aged 15 years and over who are regular clients of the HFL service.

Notes

1. Data were provided by 25 services.
2. Remoteness was determined using the HFL Services Remoteness Accessibility Remoteness Index of Australia 13 November 2007.

Source: AIHW, Healthy for Life data collection.

- Of the 840 Indigenous adults with Type II diabetes who are regular clients of the HFL service and had a HbA1c test in the last 6 months (and for which information was available on their HbA1c result), 28% had a HbA1c result less than or equal to 7%, and 31% had a result greater than or equal to 10% (Table 3.04.3).
- Clients living in remote areas had the highest proportion of HbA1c results that were greater than or equal to 10% (33%).

Table 3.04.3: Number and proportion of Indigenous regular clients^(a) diagnosed with Type II diabetes, by HbA1c result^(b), by remoteness, 1 January to 30 June 2007

	Urban	Regional	Remote	Total
Number of Indigenous regular clients with Type II diabetes who had an HbA1c test in the last 6 months				
≤ 7%	56	13	168	237
> 7% to ≤ 8%	43	6	98	147
> 8% to < 10%	36	15	148	199
≥ 10%	42	9	206	257
Total	177	43	620	840
Proportion of Indigenous regular clients with Type II diabetes who had an HbA1c test in the last 6 months (%)				
≤ 7%	32	30	27	28
> 7% to ≤ 8%	24	14	16	17
> 8% to < 10%	20	35	24	24
≥ 10%	24	21	33	31
Total	100.0	100.0	100.0	100.0

(a) Indigenous adults aged 15 years and over who are regular clients of the HFL service.

(b) HbA1c result in the last 6 months.

Notes

1. Data were provided by 11 services.

2. Remoteness was determined using the HFL Services Remoteness Accessibility Remoteness Index of Australia 13 November 2007.

Source: AIHW, Healthy for Life data collection.

In 2006–07, 14 HFL services reported information on the average HbA1c result of clients diagnosed with Type II diabetes who had an HbA1c test in the last 6 months. This data is presented in Table 3.04.4 below.

- Of the 890 Indigenous regular clients of HFL services with Type II diabetes who had an HbA1c test in the last 6 months whose last HbA1c result was recorded, the average HbA1c result was 8.4%.
- The average HbA1c result was 8.9% in urban areas, 8.3% in remote areas and 7.8% in regional areas.

Table 3.04.4: Average HbA1c result for Indigenous regular clients^(a) diagnosed with Type II diabetes who had an HbA1c test in the last 6 months, by remoteness, 1 January–30 June 2007

	Urban	Regional	Remote	Total
Total number of Indigenous regular clients with Type II diabetes who had an HbA1c test in the last 6 months whose last HbA1c result was recorded	177	112	601	890
Average HbA1c result (%)	8.9	7.8	8.3	8.4

(a) Indigenous adults aged 15 years and over who are regular clients of the HFL service.

Notes

1. Data were provided by 14 services.

2. Remoteness was determined using the HFL Services Remoteness Accessibility Remoteness Index of Australia 13 November 2007.

Source: AIHW, Healthy for Life data collection.

Type II diabetes clients – blood pressure tests

Blood pressure is elevated in many people with Type II diabetes. Increased blood pressure levels have been associated with a spectrum of health problems occurring later in people with diabetes – notably cardiovascular disease (especially stroke), eye damage and kidney damage.

The target blood pressure for people with Type II diabetes is less than or equal to 130/80 mm Hg (Jerums & Colagiuri 2004).

For the period 1 January to 30 June 2007, 22 services that were part of the HFL program provided data whether blood pressure tests were undertaken for Indigenous clients with Type II diabetes in the last 6 months.

- Of the 2,402 Indigenous adults with Type II diabetes who are regular clients of the HFL services, 1,472 (61%) had a blood pressure test in the last 6 months. Around two-thirds (66%) of Indigenous adults with Type II diabetes living in remote areas had a blood pressure test in the last 6 months, compared with 59% in regional areas and 58% in urban areas (Table 3.04.5).

Table 3.04.5: Number and proportion of Indigenous regular clients^(a) diagnosed with Type II diabetes who had a blood pressure test in the last 6 months, by remoteness, 1 January–30 June 2007

	Urban	Regional	Remote	Total
Number of Indigenous regular clients with Type II diabetes who had a blood pressure test in the last 6 months	169	801	502	1,472
Total number of Indigenous regular clients with Type II diabetes	291	1,350	761	2,402
Proportion of Indigenous regular clients with Type II diabetes who had a blood pressure test in the last 6 months (%)	58	59	66	61

(a) Indigenous adults aged 15 years and over who are regular clients of the HFL service.

Notes

1. Data were provided by 22 services.
2. Remoteness was determined using the HFL Services Remoteness Accessibility Remoteness Index of Australia 13 November 2007.

Source: AIHW, Healthy for Life data collection.

- Of the 2,797 Indigenous adults with Type II diabetes who are regular clients of the HFL service and had a blood pressure test in the last 6 months, 1,377 (49%) had a blood pressure less than or equal to 130/80 mmHg. The proportion of Indigenous adults with Type II Diabetes who had a blood pressure less than or equal to 130/80 mmHg was highest for clients living in remote areas (58%), followed by regional areas (37%) and urban areas (30%) (Table 3.04.6).

Table 3.04.6: Number and proportion of Indigenous regular clients^(a) diagnosed with Type II diabetes who had a blood pressure test in the last 6 months whose result was less than or equal to 130/80mmHg, by remoteness, 1 January–30 June 2007

	Urban	Regional	Remote	Total
Number of Indigenous regular clients with Type II diabetes with a blood pressure test less than or equal to 130/80mmHg	50	330	997	1,377
Number of Indigenous regular clients with Type II diabetes	169	899	1,729	2,797
Proportion of Indigenous regular clients with Type II diabetes with a blood pressure test less than or equal to 130/80mmHg (%)	30	37	58	49

(a) Indigenous adults aged 15 years and over who are regular clients of the HFL service.

Notes

1. Data were provided by 26 services.
2. Remoteness was determined using the HFL Services Remoteness Accessibility Remoteness Index of Australia 13 November 2007.

Source: AIHW, Healthy for Life data collection.

Coronary heart disease clients – blood pressure tests

A client has high blood pressure if their systolic blood pressure is greater than or equal to 140 mmHg; and their diastolic blood pressure is greater than or equal to 90mmHg (NPCC Guidelines).

For the period 1 January to 30 June 2007, 27 services who were part of the Healthy For Life program provided data whether blood pressure tests were undertaken for Indigenous clients with coronary heart disease in the last 6 months and 24 services provided data on blood pressure test results of Indigenous clients.

- Of the 1,865 Indigenous adults with coronary heart disease who are regular clients of the HFL service, 1,267 (70%) had a blood pressure (BP) test in the last 6 months. The proportion of coronary heart disease clients who had a blood pressure test in the last 6 months was highest among clients living in urban areas (71%), followed by remote areas (70%) and regional areas (57%) (Table 3.04.7).

Table 3.04.7: Number and proportion of Indigenous regular clients^(a) diagnosed with coronary heart disease who had a blood pressure test in the last 6 months, by remoteness, 1 January–30 June 2007

	Urban	Regional	Remote	Total
Number of Indigenous regular clients with coronary heart disease who had a BP test in the last 6 months	539	177	551	1,267
Total number of Indigenous regular clients with coronary heart disease	764	312	789	1,865
Proportion of Indigenous regular clients with coronary heart disease who had a BP test in the last 6 months (%)	71	57	70	68

(a) Indigenous adults aged 15 years and over who are regular clients of the HFL service.

Notes

1. Data were provided by 27 services.
2. Remoteness was determined using the HFL Services Remoteness Accessibility Remoteness Index of Australia 13 November 2007.

Source: AIHW, Healthy for Life data collection.

- Of the 964 Indigenous adults with coronary heart disease who are regular clients of the HFL service and had a blood pressure test in the last 6 months, 533 (55%) had a blood pressure of less than 140/90 mmHg. Proportions were highest among clients living in urban areas (59%), followed by regional areas (57%) and remote areas (53%) (table 3.04.8).

Table 3.04.8: Number and proportion of Indigenous regular clients^(a) diagnosed with coronary heart disease who had a blood pressure test in the last 6 months that was less than or equal to 140/90mmHg, by remoteness, 1 January–30 June 2007

	Urban	Regional	Remote	Total
Number of Indigenous regular clients with coronary heart disease who had a blood pressure test less than or equal to 140/90mmHg	138	102	293	533
Total number of Indigenous regular clients with coronary heart disease who had a blood pressure test in the last 6 months	234	179	551	964
Proportion of Indigenous regular clients with coronary heart disease who had a blood pressure test less than or equal to 140/90mmHg (%)	59	57	53	55

(a) Indigenous adults aged 15 years and over who are regular clients of the HFL service.

Notes

1. Data were provided by 24 services.
2. Remoteness was determined using the HFL Services Remoteness Accessibility Remoteness Index of Australia 13 November 2007.

Source: AIHW, Healthy for Life data collection.

Divisions of General Practice National Performance Indicators data

Information on the management of patients with diabetes is available from the Divisions of General Practice National Performance Indicators. In 2005–06, 40% of Divisions of General Practice in Australia had a systematic approach to support general practices and GPs to capture and record Indigenous status for patients with diabetes who were on the practice register/recall/reminder systems. A further 29% of Divisions were in the process of developing a system for general practices to record Indigenous status for patients with diabetes, 5% did not have a system in place or one in development, and 26% did not report on this Indicator (DoHA 2007).

Specific information on HbA1c and cholesterol results among patients with diabetes is available for the 2006–07 period and is presented below.

- Of the 107 Divisions for whom online reports were available in 2006–07, 80 (75%) reported data on the most recent HbA1c result in the past 12 months among patients with diabetes on practice reminder systems. Of these:
 - 51% had recorded their Indigenous diabetes patients' most recent HbA1c result. About 19% of Indigenous patients on the practice diabetes register had an HbA1c result of 7% or less. When patient's for whom HbA1c was not measured or recorded was excluded, 37% of Indigenous patients on the practice diabetes register had a result of 7% or less.
 - 75% had recorded their non-Indigenous diabetes patients' most recent HbA1c status in the past 12 months. Approximately 43% of non-Indigenous patients on the practice diabetes register had an HbA1c result of 7% or less. When patient's for whom HbA1c was not measured or recorded was excluded, 58% of non-Indigenous patients on the practice diabetes register had a result of 7% or less (Table 3.04.9).
- Of the 107 Divisions who reported on the diabetes domain in 2006–07, 78 (73%) reported data on the most recent total cholesterol among patients with diabetes. Of these:
 - 56% had the cholesterol recorded for their Indigenous patients. About 15% of Indigenous patients on the practice diabetes register had a cholesterol result of less than 4.0 mmol/L. When patient's for whom cholesterol was not measured or recorded was excluded, 26% of Indigenous patients with diabetes had a cholesterol result of less than 4.0 mmol/L.

- 35% had the cholesterol recorded for their non-Indigenous patients. Approximately 10% had a cholesterol result of less than 4.0 mmol/L. When patient's for whom cholesterol was not measured or recorded was excluded, 28% of non-Indigenous patients with diabetes had a cholesterol result of less than 4.0 mmol/L (Table 3.04.10).

Table 3.04.9: Most recent HbA1c in past 12 months among patients on practice diabetes register, by Indigenous status, 2006–07

	Indigenous	Non-Indigenous	Origin Missing
	Per cent		
7% or less	19.1	43.4	35.6
Between 7% and 10%	24.1	28.3	22.5
10% or more	8.0	3.7	3.7
Total measured/ recorded	51.2	75.4	61.8
Not measured/ recorded	48.8	24.6	38.2

Source: National Performance Indicators for Divisions of General Practice.

Table 3.04.10: Most recent cholesterol test in past 12 months among patients with diabetes on register, by Indigenous status, 2006–07

	Indigenous	Non-Indigenous	Origin Missing
	Per cent		
Less than 4.0mmol/L	14.5	9.9	15.5
4.0mmol/L or more	41.5	24.9	31.0
Total measured/ recorded	55.9	34.8	46.5
Not measured/ recorded	44.1	65.2	53.5

Source: National Performance Indicators for Divisions of General Practice

Service Activity Reporting data

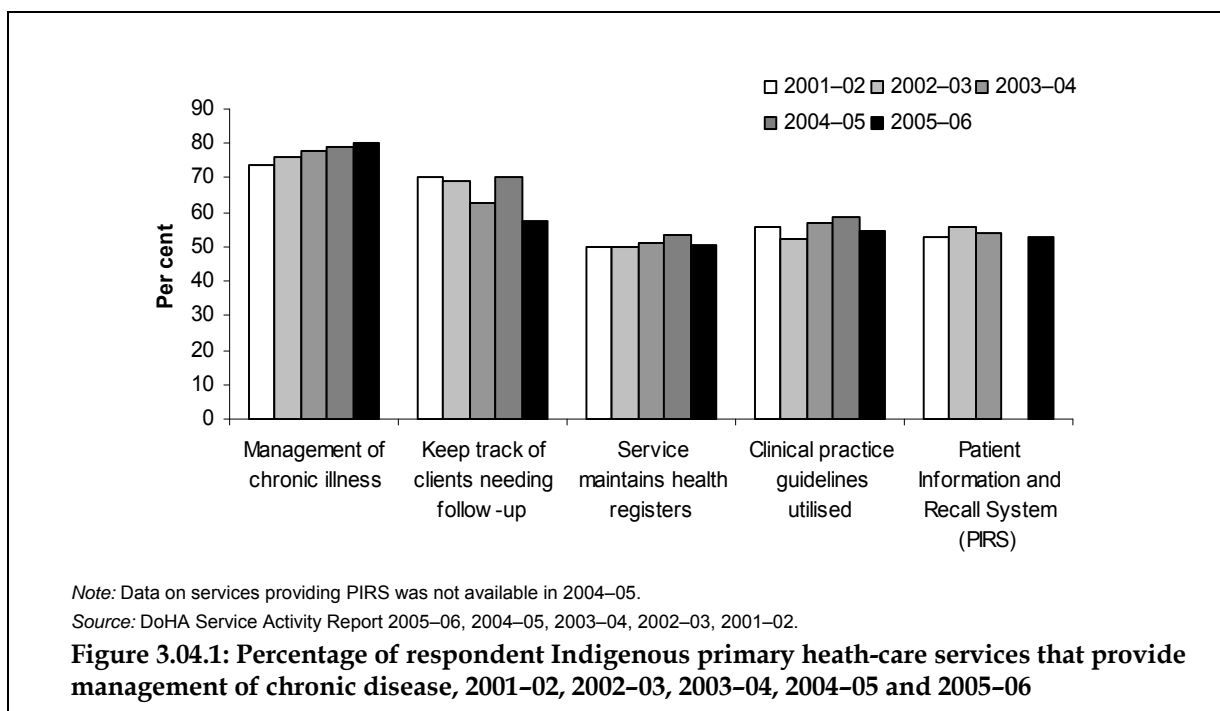
- In 2005–06, there were 150 respondent Aboriginal and Torres Strait Islander primary health-care services included in the SAR. Not all services provide clinical care. Approximately 82% of these services had a doctor working at the service.
- Approximately 80% of Indigenous primary health-care services provided management of chronic illness, 57% reported keeping track of clients needing follow-up (for example, through monitoring sheets/follow-up files), 51% reported they maintained health registers (for example, chronic disease register) and 55% utilised clinical practice guidelines. About 53% of Indigenous primary health-care services reported they used the Patient Information and Recall Systems (PIRS), which automatically provide reminders for follow-up and routine health checks.
- There were 1,235 chronic disease management groups run by Indigenous primary health-care services around Australia, attended by 13,490 people. More than half of Indigenous primary health-care services provided the chronic disease management activities of chronic disease management groups (57%), mothers and babies groups (56%), sport/recreation/ exercise groups (51%), cooking and nutrition (51%), and men's groups (60%) (Table 3.04.11).
- There was a slight increase in the proportion of Indigenous primary health-care services providing management of chronic illness between 2001–02 and 2005–06 (from 74% to 80%) (Figure 3.04.1). There was a drop from 70% to 57% in the proportion of services

keeping track of clients needing follow-up during this period. There was little change in the proportion of Indigenous primary health-care services providing other chronic disease management activities between 2001-02 and 2005-06.

Table 3.04.11: Percentage of respondent Indigenous primary health-care services providing chronic disease management activities and use of the Patient Information and Recall System, 2005–06

	Per cent
Chronic disease management activities	
Management of chronic illness	80
Keep track of clients needing follow-up (e.g. through monitoring sheets/follow-up files)	57
Maintains health registers (e.g. chronic disease register)	51
Clinical practice guidelines used (e.g. Central Australian Remote Practitioners Association, diabetes guidelines)	55
Patient Information and Recall Systems (PIRS)	
PIRS which automatically provides reminders for follow-up and routine health checks	53
Chronic disease management groups	
Counselling groups	46
Chronic disease management groups	57
Antenatal groups	31
Mothers and babies group	56
Tobacco use treatment/prevention groups	39
Alcohol use treatment/prevention groups	47
Other substance use treatment/prevention	35
Cultural groups	49
Sport/recreation/physical exercise groups	51
Cooking and nutrition groups	51
Men's groups	60
Other groups	54

Source: DoHA Service Activity Report 2005–06.



Additional information

Acute rheumatic fever and rheumatic heart disease

Registrations of acute rheumatic fever

- During 2004 there were 35 registrations of people with acute rheumatic fever (ARF) in the Top End of the Northern Territory and 24 in Central Australia. All registrations in Central Australia, and all but two in the Top End, were for Indigenous Australians. In both registers, 29% of cases were recurrences.
- The peak age of incidence of acute rheumatic fever is 5-14 years. In 2004, 63% of all cases of acute rheumatic fever occurred in this age group and all cases reported occurred in Indigenous children.

For more information on acute rheumatic fever see Measure 1.06.

Secondary prevention of rheumatic heart disease

The immediate aim in the management of acute rheumatic fever/rheumatic heart disease (RHD) is to identify cases of acute rheumatic fever, and once identified, to prevent the progression to rheumatic heart disease through secondary prevention measures. Secondary prevention refers to the early detection of disease and implementation of measures to prevent recurrent and worsening of disease and poorer outcomes.

Secondary prophylaxis with benzathine penicillin G (BPG) is the only RHD control strategy shown to be cost effective at both community and population levels and is recommended for all people with a history of ARF or RHD. Four-weekly BPG dosages is the current treatment of choice, except in patients considered to be at high risk, for whom 3-weekly administration is recommended. Pharmacokinetic data suggest that prolonging the dosing interval beyond 4 weeks may increase the risk of breakthrough ARF, so regular and timely adherence to the dosing regimen is important. Where BPG is contraindicated, alternatives are available,

although these are considered to be less effective. Secondary prophylaxis should be continued in all people with ARF or RHD for a minimum of 10 years after the last episode of ARF or until the age of 21 years (whichever is the longer period). Those with moderate or severe RHD should continue secondary prophylaxis up to the age of 35–40 years. The fundamental goal for the long-term management of chronic RHD is to prevent, or at least forestall valve, surgery. Prophylaxis with BPG to prevent recurrent ARF is therefore a crucial strategy in managing patients with a history of ARF and RHD (NHFA and CSANZ 2006). Adherence to secondary prophylaxis has been problematic in remote Aboriginal and Torres Strait Islander communities. For example, in 2005 in the Top End of the Northern Territory, 28% of patients on secondary prophylaxis missed half or more of their scheduled BPG injections over a 12-month period, although around half of all episodes of ARF were recurrences. This suggests that adherence to prophylaxis is very poor. The main reason for poor adherence in remote Indigenous communities is thought to be related to the availability and acceptability of health services, rather than personal factors such as injection refusal, pain of injections, or a lack of knowledge and understanding of ARF and RHD (NHFA and CSANZ 2006).

Data quality issues

Healthy For Life data

For the January to June 2007 reporting period, 59 services submitted data as part of the Healthy For Life Program. Not all of these services were able to provide data for all of the essential indicators and service profile questions.

Divisions of General Practice National Performance Indicators data

The National Performance Indicators (NPI) are reported in the Divisions of General Practice Annual Reports submitted to DoHA, and are part of the National Quality Performance System (NQPS). Although no single Division reported against all the NPIs, all indicators were reported against in the 2005–06 Annual Report. Much of the data provided involved inconsistencies, errors or omissions, however, and could not be used. Divisions were required to report on at least one domain within the chronic disease priority area, and of the 119 Divisions across Australia 104 completed at least some part of the diabetes sections.

Service Activity Reporting (SAR) data collection

Response rates to the SAR by Aboriginal and Torres Strait Islander primary health-care services were around 99% in 2005–06. The SAR collects service-level data on health care and health-related activities by survey questionnaire over a 12-month period. Although this data collection provides valuable information, it needs to be recognised that there are limitations that have to be considered when using these data. Particular issues include:

- *The SAR only includes Aboriginal and Torres Strait Islander health organisations that receive at least some Australian Government funding to facilitate access to primary health care.*
- *The SAR questionnaire collects a broad set of indicators for the services and did not aim to provide a comprehensive set of statistics on the activities of the services or their needs.*
- *Data provided are often estimates and, although these are thought to be reasonable, there has been no audit to check the accuracy of these figures.*

In relation to the statistics for this performance measure, these data provide a rough guide to service activity in this area, but do not attempt to measure quantity or quality.

References

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