

3.16 Care planning for clients with chronic diseases

The use of care planning for the management of chronic disease among the Aboriginal and Torres Strait Islander population

Data sources

Data on care planning come from the 2004–05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), the Service Activity Reporting (SAR) data collection and the Healthy For Life (HFL) data collection.

Note that these data sources only provide part of the picture of the use of care planning for the management of chronic disease among the Indigenous population. Data on care-planning Medicare items will provide a more complete picture of care planning once the voluntary Indigenous identifier is more complete.

National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)

The 2004–05 NATSIHS collected information from 10,439 Indigenous Australians of all ages. This sample was considerably larger than the supplementary Indigenous samples in the 1995 and 2001 National Health Surveys. The survey was conducted in remote and non-remote areas of Australia and collected a range of information from Indigenous Australians about health-related issues, including health-related actions, health risk factors, health status, socioeconomic circumstances and women's health. It is planned to repeat the NATSIHS at 6-yearly intervals, with the next NATSIHS to be conducted in 2010–11. Selected non-Indigenous comparisons are available through the 2004–05 National Health Survey (NHS).

Healthy for Life Program

The 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 Indigenous 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.

Service Activity Reporting (SAR) data collection

The SAR collects data from approximately 150 Australian Government-funded Indigenous primary health-care services and is held at the Australian Government Department of Health and Ageing (DoHA). It is estimated that they 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 Indigenous primary health-care services are usually between 97% and 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.

Analyses

Service Activity Reporting data

The 2003–04 SAR collected all data items relevant to care planning. The 2004–05 and 2005–06 SAR reports did not collect information on four relevant data items (services where the hospital regularly provides or facilitates information on the condition of the patient who has been admitted; services where the hospital regularly provides or facilitates information to a patient's family on the condition of the patient who has been admitted; discharge planning for Indigenous patients is well coordinated between the hospital and the service; and services that provide or facilitate antenatal shared care arrangements). These data items have been re-instated in the 2006–07 SAR.

Data presented below is from the 2003–04 SAR and the 2005–06 SAR. Data is not yet available for the 2006–07 SAR.

- In 2003–04, approximately 93% of Indigenous primary health-care services provided care planning, 63% reported keeping track of clients needing follow-up (for example, through monitoring sheets/follow-up files), 60% reported that the hospital provided information on the condition of the patient who had been admitted, 57% used clinical practice guidelines and 56% reported that discharge planning was well coordinated between the hospital and the service (for example, provision of medicines, arrangements for transport, liaison with GP and family). About 54% of Indigenous primary health-care services reported they used Patient Information and Recall Systems (PIRS), which automatically provide reminders for follow-up and routine health checks (Table 3.16.1a; Figure 3.16.1).
- In 2005–06, approximately 61% of Indigenous primary health-care services provided shared care arrangements for the management of people with chronic conditions, 57% of services kept track of clients needing follow-up, 54% of services used clinical practice guidelines, 53% of services used Patient Information Recall Systems and 51% of services maintained a health register (Table 3.16.1b).

Table 3.16.1a: Number and proportion of respondent Aboriginal and Torres Strait Islander primary health-care services that provide care planning, 2003–04

	No.	Per cent
Services that provide or facilitate shared care arrangements for the management of people with chronic conditions	69	50.0
Services where the hospital regularly provides or facilitates information on the condition of the patient who has been admitted	83	60.1
Services where the hospital regularly provides or facilitates information to a patient's family on the condition of the patient who has been admitted	52	37.7
Discharge planning for Aboriginal and Torres Strait Islander patients is well coordinated between the hospital and the service (e.g. provision of medicines, arrangements for transport, liaison with GP and family)	77	55.8
Services that provide or facilitate antenatal shared-care arrangements	82	59.4
Services that keep track of clients needing follow-up (e.g. through monitoring sheets/follow-up files)	87	63.0
Services that maintain a health register (not specific to chronic diseases)	71	51.4
Services that use clinical practice guidelines (not specific to chronic diseases)	79	57.2
Services that use Patient Information Recall Systems (PIRS), which automatically provide reminders for follow-up and routine health checks	75	54.3
Total services that provide care planning^(a)	128	92.8
Total services	138	100.0

(a) Total services that provide at least one of the activities listed.

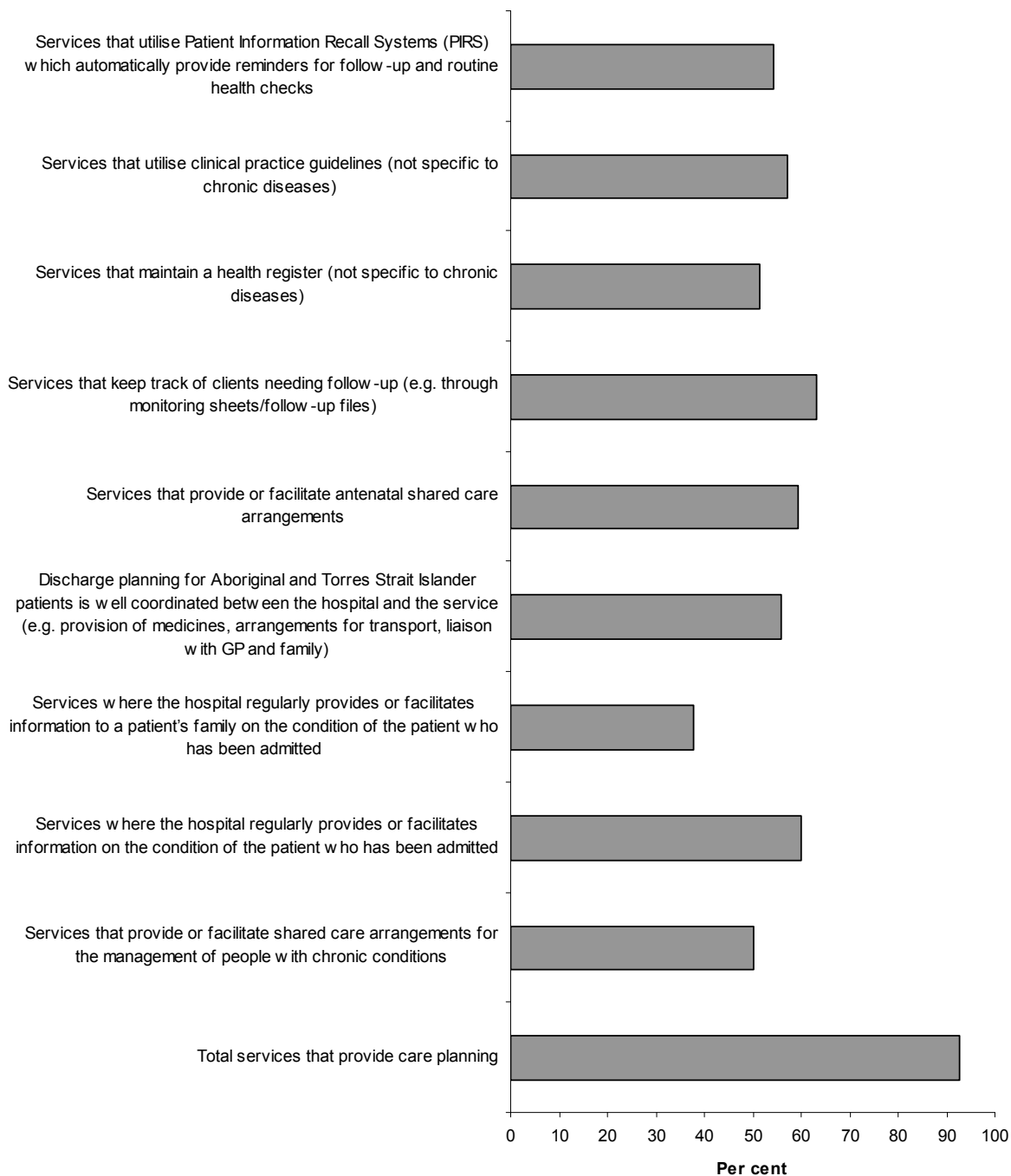
Source: DoHA Service Activity Report 2003–04.

Table 3.16.1b: Number and proportion of respondent Aboriginal and Torres Strait Islander primary health-care services that provide care planning, 2005–06

	No.	Per cent
Services that provide or facilitate shared care arrangements for the management of people with chronic conditions	92	61.3
Services that keep track of clients needing follow-up (e.g. through monitoring sheets/follow-up files)	86	57.3
Services that maintain a health register (not specific to chronic diseases)	76	50.7
Services that use clinical practice guidelines (not specific to chronic diseases)	82	54.7
Services that use Patient Information Recall Systems (PIRS), which automatically provide reminders for follow-up and routine health checks	80	53.3
Total services that provide care planning^(a)	n.a.	n.a.
Total services	150	100.0

(a) Total services that provide at least one of the activities listed.

Source: DoHA Service Activity Report 2005–06.



Source: DoHA Service Activity Report 2003-04.

Figure 3.16.1: Proportion of respondent Aboriginal and Torres Strait Islander primary health-care services that provide care planning, 2003-04

Asthma action plans

The 2004–05 NATSIHS collected self-reported data on the number of Indigenous and non-Indigenous Australians in non-remote areas with long-term health conditions, such as asthma, and whether the person has a written action plan. Data on asthma action plans by Indigenous status, age and state/territory are presented below.

- In 2004–05, approximately 17% of Indigenous Australians living in non-remote areas reported asthma as a long-term condition. Indigenous Australians were almost twice as likely as non-Indigenous Australians to report asthma as a long-term condition.
- In 2004–05, similar proportions of Indigenous and non-Indigenous Australians with asthma living in non-remote areas reported having written asthma action plans (25% and 22%, respectively) (Table 3.16.2).
- Indigenous Australians aged 0–4 and those aged 55 years and over were the most likely to have a written asthma action plan (44% and 35%, respectively).
- New South Wales had the highest (31%), and Western Australia the lowest (17%), proportion of Indigenous Australians reporting having a written asthma action plan (Table 3.16.3).
- In 2004–05, the majority of Indigenous and non-Indigenous Australians with written asthma action plans reported the source of their plan to be a doctor (91% and 95%, respectively) (Table 3.16.4).

Table 3.16.2: Whether persons in non-remote areas have a written asthma action plan, by Indigenous status and age group, 2004–05

Age group (years)	Does have a written asthma action plan	Does not have a written asthma action plan	Never heard of a written asthma action plan	Total ^(a)	Total with asthma	Total persons with asthma
	Per cent					No.
0–4						
Indigenous	44.1	51.6	2.8	100.0	12.3	5,621
Non-Indigenous	33.4	61.4	3.6	100.0	7.2	85,612
5–14						
Indigenous	33.7	63.0	2.9	100.0	17.7	15,801
Non-Indigenous	37.1	57.9	3.3	100.0	13.4	339,310
<i>Total aged 0–14</i>						
<i>Indigenous</i>	36.5	60.0	2.9	100.0	15.9	21,422
<i>Non-Indigenous</i>	36.4	58.6	3.4	100.0	11.4	424,922
15–24						
Indigenous	12.8	75.9	8.6	100.0	17.6	12,396
Non-Indigenous	21.4	73.1	5.3	100.0	12.6	327,611
25–34						
Indigenous	17.8	75.8	5.8	100.0	19.5	9,705
Non-Indigenous	18.1	77.2	4.7	100.0	10.6	288,858
35–44						
Indigenous	20.3	71.0	5.5	100.0	13.6	5,519
Non-Indigenous	18.9	77.0	4.1	100.0	8.7	249,056
45–54						
Indigenous	14.4	74.9	8.1	100.0	21.8	6,294
Non-Indigenous	18.7	76.2	5.1	100.0	9.0	241,475
55 years and over						
Indigenous	34.7	54.7	10.4	100.0	18.7	4,441
Non-Indigenous	18.1	73.4	7.8	100.0	9.1	407,322
Total non-age-standardised						
Indigenous	24.6	68.0	5.9	100.0	17.2	59,777
Non-Indigenous	22.8	71.5	5.1	100.0	10.2	1,939,245
Total age-standardised^(b)						
Indigenous	24.7	66.9	6.9	100.0	17.7	..
Non-Indigenous	22.4	71.9	5.2	100.0	10.2	..
Rate ratio	1.1	0.9	1.3	..	1.7	..

(a) Total includes 'not known if has a written asthma action plan', which represents 1.5% of Indigenous Australians and 0.5% of non-Indigenous Australians with asthma in non-remote areas.

(b) Totals are directly age-standardised using the 2001 Australian standard population.

Source: AIHW analysis of 2004–05 NATSIHS and 2004–05 NHS.

Table 3.16.3: Whether persons in non-remote areas have a written asthma action plan by Indigenous status and state/territory, 2004–05

Jurisdiction	Does have a written asthma action plan	Does not have a written asthma action plan	Never heard of a written asthma action plan	Total ^(a)	Total with asthma	Total persons with asthma
	Per cent					No.
New South Wales						
Indigenous	31.0	61.6	7.0	100.0	18.0	22,331
Non-Indigenous	23.5	73.3	2.5	100.0	9.2	595,171
Rate ratio	1.3	0.8	2.8	..	2.0	..
Victoria						
Indigenous	22.9	70.1	6.3	100.0	4.7	5,904
Non-Indigenous	26.5	65.8	7.5	100.0	7.7	496,570
Rate ratio	0.9	1.1	0.8	..	0.6	..
Queensland						
Indigenous	22.3	69.6	5.1	100.0	11.5	16,150
Non-Indigenous	20.4	73.6	5.6	100.0	6.1	390,422
Rate ratio	1.1	0.9	0.9	..	1.9	..
Western Australia						
Indigenous	16.6	72.8	10.3	100.0	5.6	6,808
Non-Indigenous	15.1	80.2	4.1	100.0	3.1	198,044
Rate ratio	1.1	0.9	2.5	..	1.8	..
South Australia						
Indigenous	22.1	70.4	3.0	100.0	2.9	3,517
Non-Indigenous	22.2	73.1	4.6	100.0	2.5	164,221
Rate ratio	1.0	1.0	0.7	..	1.1	..
Tasmania and ACT						
Indigenous	28.5	64.1	7.0	100.0	3.0	4,084
Non-Indigenous	20.3	67.7	11.8	100.0	1.3	85,930
Rate ratio	1.4	0.9	0.6	..	2.3	..
Northern Territory^(b)						
Indigenous	24.8	72.1	3.1	100.0	0.7	983
Non-Indigenous	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Rate ratio
Australia						
Indigenous	24.7	66.9	6.9	100.0	17.7	59,777
Non-Indigenous	22.4	71.9	5.2	100.0	10.2	1,939,245
Rate ratio	1.1	0.9	1.3	..	1.7	..

(continued)

Table 3.16.3 (continued): Whether person(s) in non-remote areas have a written asthma action plan by Indigenous Status and state/territory, 2004–05

- (a) Includes 'not known if has a written asthma action plan', which represents 1.5% of Indigenous Australians and 0.5% of non-Indigenous Australians with asthma in non-remote areas.
 (b) Non-Indigenous data for Northern Territory not presented because of the small sample size.

Note: Data have been directly age-standardised using the 2001 Australian standard population.

Source: AIHW analysis of 2004–05 NATSIHS and 2004–05 NHS.

Table 3.16.4: Source of written asthma action plan by Indigenous status and age group, 2004–05

	Doctor	Other	Total with written asthma action plan	Total persons with written asthma action plans
	Per cent			No.
Non-age-standardised				
Indigenous	91.8	8.2	100.0	14,682
Non-Indigenous	94.2	5.8	100.0	442,896
Age-standardised^(a)				
Indigenous	90.8	9.2	100.0	..
Non-Indigenous	94.9	5.1	100.0	..
Rate ratio	1.0	1.8

(a) Totals are directly age-standardised using the 2001 Australian standard population.

Source: AIHW analysis of 2004–05 NATSIHS and 2004–05 NHS.

Healthy For Life data

Chronic disease management plans (MBS item 721) General Practitioner Management Plan (GPMP)

From 1 July 2005, the Australian Government introduced chronic disease management Medicare items, including MBS 721 and 723.

MBS item 721 is for patients with a chronic or terminal medical condition who will benefit from a structured approach to management of their care needs. A rebate can be claimed once the patient's GP has prepared a General Practitioner Management Plan (GPMP). The recommended frequency of GPMPs is once every 2 years. The GP may be assisted by their practice nurse, Aboriginal health worker or other health professional in the GP's medical practice or health service. The service must include a personal attendance by the GP with the patient.

As at 30 June 2007, 19 services funded through the HFL program reported information on MBS item 721 GPMP. The number and proportion of Indigenous regular clients of these services with a chronic disease who have a current MBS item 721 GPMP, by type of chronic disease and remoteness is shown in Table 3.16.5.

- Of the 3,415 Indigenous adults with Type II diabetes who are regular clients of the HFL services, 419 (12%) had a chronic disease management plan (MBS item 721).
- Of the 1,546 Indigenous adults with coronary heart disease who are regular clients of the HFL service, 165 (11%) had a chronic disease management plan (MBS item 721).
- Of Indigenous regular clients with Type II diabetes or coronary heart disease, those living in regional areas were most likely to have a current GPMP (20% and 22%,

respectively), followed by those living in remote areas (17% and 14%, respectively), with those in urban areas the least likely (both 3%).

Table 3.16.5: Number and proportion of Indigenous regular clients of services funded through the Healthy For Life program^(a) with a chronic disease^(b) who have a current MBS item 721 General Practitioner Management Plan, by type of chronic disease and remoteness, at 30 June 2007

	Urban	Regional	Remote	Total
Number of Indigenous regular clients with a current GPMP				
Type II diabetes	47	243	129	419
Coronary heart disease	21	100	44	165
Total number of Indigenous regular clients with a chronic disease				
Type II diabetes	1,454	1,221	740	3,415
Coronary heart disease	763	465	318	1,546
Proportion of Indigenous regular clients with a chronic disease who have a current GPMP (%)				
Type II diabetes	3	20	17	12
Coronary heart disease	3	22	14	11

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

(b) Chronic diseases include Type II diabetes and coronary heart disease.

Notes

1. Data were provided by 19 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.

Chronic disease management plans (MBS item 723) Team Care Arrangement

Chronic disease management plans (MBS item 723) Team Care Arrangement (TCA) provide a rebate for a GP to coordinate the preparation of TCAs for a patient with a chronic or terminal medical condition who also requires ongoing care from a multidisciplinary team of at least three health or care providers. The recommended frequency is once every 2 years, supported by regular review services.

As at 30 June 2007, 12 services funded through the HFL program reported information on MBS 723 TCAs. The number and proportion of Indigenous regular clients of these services with a chronic disease who have a current MBS item 723 TCA, by type of chronic disease, is shown in Table 3.16.6.

- Of the 2,252 Indigenous adults with Type II diabetes who are regular clients of the HFL services, 85 (4%) had a current MBS item 723 TCA.
- Of the 956 Indigenous adults with coronary heart disease who are regular clients of the HFL services, 28 (3%) had such an arrangement.

Table 3.16.6: Number and proportion of Indigenous regular clients of services funded through the Healthy For Life program^(a) with a chronic disease^(b) who have a current MBS item 723 Team Care Arrangement, by type of chronic disease, at 30 June 2007

	Type II diabetes	Coronary heart disease
Number of Indigenous regular clients with a current TCA	85	28
Total number of Indigenous regular clients with a chronic disease	2,252	956
Proportion of Indigenous regular clients with a chronic disease who have a current TCA (%)	4%	3%

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

(b) Chronic diseases include Type II diabetes and coronary heart disease.

Note: Data were provided by 12 services.

Source: AIHW, HFL data collection.

Care planning and health service linkages

- In 2006–07, of the 59 services funded through the HFL program that provided data on care planning and health service linkages, 64% reported they had care planning for their clients with chronic disease (Table 3.16.7).
- Around two-thirds of services reported they had hospital admission communication and 68% of services reported they had hospital discharge communication for their clients with chronic disease. Just over half (54%) of services reported they provided care in residential aged care services.

Table 3.16.7: Proportion of services funded through the Healthy For Life Program that had care planning and health service linkages for their clients with chronic disease, 2006–07

Criteria assessed	Yes	No	No response
	Per cent		
Care planning	64	17	19
Health service linkages			
Hospital admission communication	66	15	19
Hospital discharge communication	68	14	19
Care provided in residential aged care services	54	27	19

Note: Data were provided by 59 services.

Source: AIHW, HFL data collection.

Data quality issues

National Aboriginal and Torres Strait Islander Health Survey (NATSIHS)

The NATSIHS uses the standard Indigenous status question. The NATSIHS sample was specifically designed to select a representative sample of Aboriginal and Torres Strait Islander Australians and thus overcomes the problem inherent in most national surveys with small and unrepresentative Indigenous samples. As with other surveys, the NATSIHS is subject to sampling and non-sampling errors. Calculations of standard errors and significance testing help to establish the accuracy of the estimates and differences.

Information recorded in this survey is essentially 'as reported' by respondents. The ABS makes every effort to collect accurate information from respondents, particularly through careful questionnaire design, pre-testing of questionnaires, use of trained interviewers and assistance from Indigenous facilitators. Nevertheless, some responses may be affected by imperfect recall or individual interpretation of survey questions.

Non-Indigenous comparisons are available through the NHS. The NHS was conducted in Major Cities, regional and Remote areas, but Very Remote areas were excluded from the sample. Time series comparisons are available through the 1995 and 2001 NHS.

In remote communities there were some modifications to the NATSIHS content in order to accommodate language and cultural appropriateness in traditional communities, and to help respondents to understand the concepts. Some questions were excluded and some reworded. Also, paper forms were used in communities in remote areas and computer-assisted interview (CAI) instruments were used in non-remote areas. The CAI process included built-in edit checks and sequencing.

Further information on NATSIHS data quality issues can be found in the 2004–05 NATSIHS publication (ABS 2006).

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.

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

ABS (Australian Bureau of Statistics) 2006. National Aboriginal and Torres Strait Islander Health Survey 2004-05. ABS cat. no. 4715.0. Canberra: ABS.