

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) of data collection.

The SAR collects data from approximately 140 Australian Government funded Aboriginal and Torres Strait Islander primary health care services and is held at the Australian Government Department of Health and Ageing (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 were between 97% and 99% during the period 2002–03 to 2004–05.

It should be noted 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 2 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 once it is established, that is, once it has been diagnosed.

Analyses

Aboriginal and Torres Strait Islander primary health care services

Chronic disease management

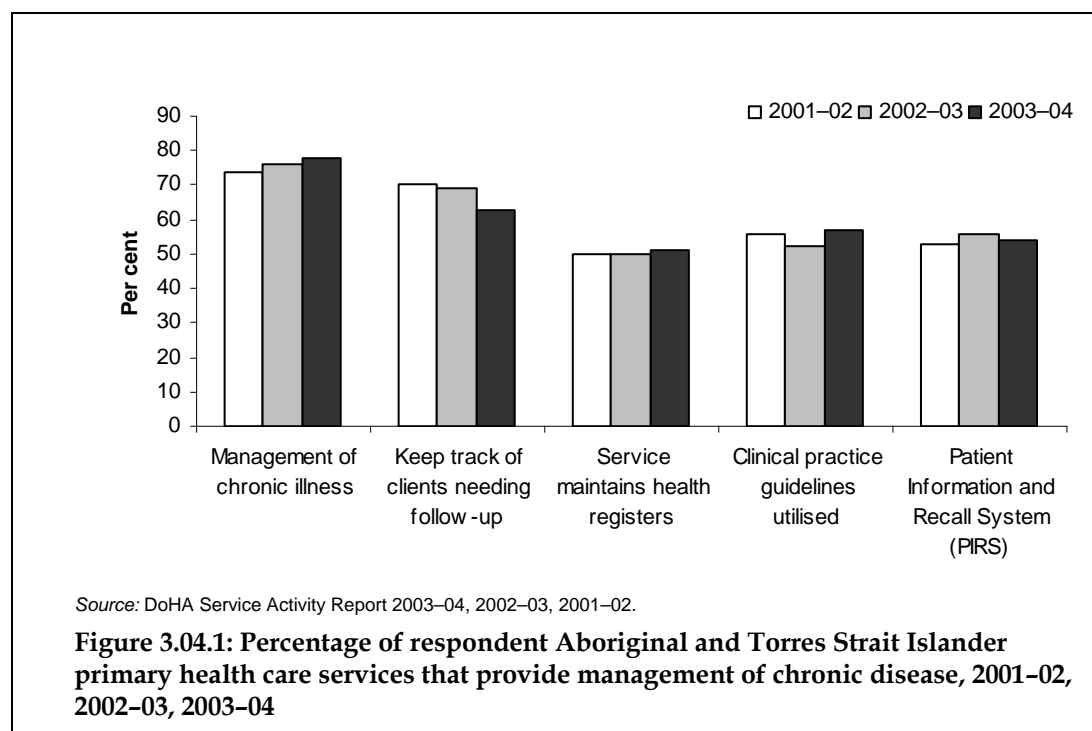
- In 2003–04, there were 138 respondent Aboriginal and Torres Strait Islander primary health care services. Not all services provide clinical care. Approximately 77% of these services had a doctor working at the service.
- Approximately 78% of Aboriginal and Torres Strait Islander primary health care services provided management of chronic illness, 63% reported keeping track of clients needing follow-up (for example, through monitoring sheets/follow-up files), 54% used patient information recall systems which automatically provide reminders for follow-up and routine health checks, 51% reported they maintained health registers (for example, chronic disease register) and 57% utilised clinical practice guidelines. Approximately 54% of Aboriginal and Torres Strait Islander 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 3.04.1).

- There was little change in the proportion of Aboriginal and Torres Strait Islander primary health care services providing management of chronic illness, maintaining health registers and utilising clinical practice guidelines between 2001–02 and 2003–04 (Figure 3.04.1). There was a slight decline in the proportion of Aboriginal and Torres Strait Islander primary health care services keeping track of clients needing follow-up, for example, through monitoring sheets/follow-up files (from 70% to 63%) and a slight increase in those utilising patient information recall systems for follow-up (from 53% to 54%) between 2001–02 and 2003–04.

Table 3.04.1: Percentage of respondent Aboriginal and Torres Strait Islander primary health care services providing chronic disease management activities and use of Patient Information and Recall Systems, 2003–04

	per cent
Chronic disease management activities	
Management of chronic illness	78
Keep track of clients needing follow-up (e.g. through monitoring sheets/follow-up files)	63
Service maintains health registers (e.g. Chronic Disease Register)	51
Clinical practice guidelines utilised (e.g. Central Australian Remote Practitioners Association, diabetes guidelines)	57
Patient Information and Recall Systems (PIRS)	
PIRS which automatically provides reminders for follow-up and routine health checks	54

Source: DoHA Service Activity Report 2003–04.



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 during 2004. All registrations in Central Australia were for Indigenous Australians and all but two in the Top End were Indigenous. 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 Aboriginal and Torres Strait Islander 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 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 three-weekly administration is recommended. Pharmacokinetic data suggest that prolonging the dosing interval beyond four weeks may increase the risk of breakthrough ARF, therefore 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, while 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 Aboriginal and Torres Strait Islander 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

Service Activity Reporting (SAR) data collection

Response rates to the SAR by Aboriginal and Torres Strait Islander primary health care services were between 97% and 99% during the period 2002–03 to 2004–05. The SAR collects service-level data on health care and health-related activities by survey questionnaire over a 12-month period. While 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 while 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

NHFA (National Heart Foundation of Australia) and CSANZ (Cardiac Society of Australia and New Zealand) 2006. Diagnosis and management of acute rheumatic fever and rheumatic heart disease in Australia: an evidence-based review. National Heart Foundation of Australia (RF/RHD Guideline Development Working Group).