

## **CHO SEMINAR #1 – May 2007**

### **Population Health Aspects of Chronic Disease Management**

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As the Chief Health Officer, everybody expects me to open with some numbers about the population, talk about a few critical diseases and carry on about prevention. But the message today will be on the logic of secondary prevention, of quality of care for chronic disease. Most of this gets managed in the community and the importance of self-help and self-management will be mentioned as well.

What is happening to Canberra's demography in relation to chronic disease? Life expectancy has increased quite markedly over the last 20 years. This is not something that I expected when I was an intern 20 years ago. It is going to continue to increase for the next 20 years. We understand why life expectancy is increasing. A key driver is the better management of chronic diseases and a number of those drivers are on a trend which will continue to play out.

These drivers are not just playing out on any old population. They are playing out on that big bulge of the Post World War II baby boomers; there are a lot of people that this is going to apply to. For Canberra in particular there are some other factors driving the older population.

Increasingly people stay in Canberra upon retirement. 54/11, the specific phenomena in Canberra where people go: "It is two weeks to my 55th birthday, I have to retire or my pay will drop, my net wealth will drop." That is over. Any of you in the Commonwealth Superannuation Scheme will have seen the material from the scheme on the 54/11 matter, or it's successor the PSS, and it doesn't apply any more. We will not be seeing people continuing to retire and leave town at the age of 54 years 11 months.

Even now Canberra has a net inward migration of 75 year olds and over. In the next ten years we expect 50,000 more 65+ year olds and over the next ten years the population of people 85 years old or older will increase from 3000 to 15,000. People in these age groups are not all that well. Fifty two per cent of this age group have a disease of the circulatory system which accounts for about 10.5 per cent of our total hospital admissions. A third of them have a disease of the respiratory system, accounting for 4.6 per cent of admissions, and 10 per cent have diagnosed diabetes. On top of that, there will be another 5 to 10 per cent who have diabetes and have not yet been diagnosed.

This is quite a significant emerging or increasing morbidity load within the ACT. I would like to mention three diseases of particular interest – diabetes, heart failure and chronic obstructive lung disease. These are interesting because their management makes a big difference to the quality and to the quantity of life. Treatments for these conditions are improving and there is research going on around the world, and significant research going on in this town in all three of them, but treatments are

already pretty good. They significantly improve quality and quantity of life. Unfortunately people with these three conditions do not have optimum management – less than half. Some people would say less than 20 per cent have optimum management. We know what to do but we are not doing it.

Now let us talk about the concept of secondary prevention. Primary prevention prevents disease. Secondary prevention prevents disability in people who have disease. That is the technical definition. What we mean is that for people who have a chronic disease, effective management will prevent disease progression. It will slow the natural history of the disease and prevent or delay the development of complications. So, that is the concept. And I'd like to mention that we have the health promotion crew in ACT Health here today. We have been looking at the population numbers and strategies and it is clear that we need to do more in secondary prevention for people with chronic disease.

The approach that many of you will be familiar with in health promotion is that you address the risk factors and try and push down people's risks of developing disease, or in this case, of developing complications or having more rapid disease progression. There are common risk factors across these three diseases, specifically smoking, nutrition and physical activity. When we want to put the secondary prevention activities into operation for the target groups, the messages we use and the support we offer all need to be specially tailored to achieve secondary prevention in people who have chronic diseases. We have got to recognise them as having different needs, as being a different group, as needing different messages and different support for us to promote their health.

And the other important thing is, and I do not have enough time to emphasise this as much as I would like, but it is that secondary prevention for this group needs to be combined with effective one on one clinical care, whatever that may be for their particular disease. It has got to be a combination of good health promotion that they can participate in and effective clinical care. So if we can achieve that, it would add up to quality care for people with chronic disease. It is not rocket science and as Bruce Barraclough keeps saying: "It is harder than that." (Among his many duties Professor Bruce Barraclough is Chair of the Board of the NSW Clinical Excellence Commission and is President elect of the International Society for Quality in Health Care). We put a man on the moon in 1969, I remember watching it on telly. So that was 1969. Medical science has come a long way since then yet we are really at the beginning of the journey where we are trying to get best practice care even for just three-quarters of people with these three diseases. That is a long term stretch target and even over the next ten years it is unlikely we will achieve it. But we have got to give it a really strong shot and we have got to understand it is really hard. We also have to realise that part of the problem is with chronic disease management versus acute care transference - fixing people smashed up in motor cars. We look at them and say: "That is so hard, so high tech and so clever." That said, one of the key points I want to discuss in more detail now is that monitoring and surveillance of the population with these diseases is going to be crucial to any major improvement that we try and make. To get better quality of care for patients with chronic diseases we have to take some population approaches and throw them into the mix with the best one-on-one clinical care available. Regional chronic disease registers are a key part of this. They do not need to be comprehensive, nor do they have to be intrusive. We

already have the technology and we are starting to look within ACT Health at who are our patients with these diseases. The strategy of using registers to track care does work and has pumped the vaccination rate in Australia up from 66 per cent in the early 1990s to 92 per cent now.

It has worked for cancer care and for many decades we have had a register of everybody with cancer. It works for transplants and it is a key to achieving the incredible outcomes we get for transplants in this country. It also works for rare diseases. It is proven technology. It is necessary for chronic disease management and we have got to move into it.

How would the registers work? They facilitate care coordination with or without a specific coordinator. Many of you will have watched or perhaps been involved with the coordinated care trials of a few years ago. There was a lot of investment in posing the question: “Does everybody need a care coordinator?” The answer was: “Some people do, some people don’t.” Sometimes it makes a difference, sometimes it doesn’t. But registers are able to facilitate care coordination with any strategy, with or without a specific coordinator. They support one-on-one clinical care. They support health promotion, they support community activity and the activities of non-government groups and they support self-help. They make population-based improvements in chronic disease management visible and they also make our failures visible so we can see what we are doing.

Talking about community care, self-help and self-management, the majority of clinical care for people with chronic diseases occurs in the community. That is not to downplay the importance of what happens in hospitals and we need to understand the very important interplay there. Even within the community much of what impacts on chronic disease progression is not the one-on-one care, it is the community-based activities, the mutual self-help that people work out themselves and the self-management of those common risk factors. I am not advocating here that people move to self-help or self-management instead of seeing their GP or an appropriate specialist. I am making the point that it is these sorts of activities that affect the risk factors on the secondary prevention strategy.

Having introduced the field of the problem that we are dealing with, talked about a technology coming from population health with the registers, I now want to talk about how we can promote secondary prevention. Are you familiar with the concept of the University of the Third Age? Lots of nods. Well, the University of the Third Age started in France in 1973. It identified a need for older people who wanted to educate themselves, for retired university lecturers who wanted to participate in continuing education and had the skills to either provide it for others or learn themselves. These people found they had the time to pursue the education that they were interested in, time they often did not have in their working lives or when they had kids at home. The U3A concept works on community mindedness. You do not have to pay people for this. If you organise things people will contribute and participate.

It is an activity that has emerged from the cooperative movement of the early 20th century and the self-help movements, particularly in the sixties and seventies. These movements have had a big impact on education, they have had a huge impact on health and of course they are continuing. The ACT is particularly blessed in this

respect with a major investment by our community over the last 40 years reinforced by a very strong NGO scene.

I do not think that ACT Health or the medical profession - or anybody else - can improve chronic disease management without the people of the third age. Harnessing the wisdom of our older citizens has been a long term aim of ACT Health's strategy as well as the strategy of ACT Governments of all persuasions. Large funded non-government organisations, local community and self-help groups - which may start as small as three people and grow as family, carers, friends and, of course, people with chronic diseases themselves become involved - can all coordinate their activities. Together they will take us toward that figure of three-quarters, or even more, of people with chronic diseases who get optimum management.

So, let's move on to coordinating improved clinical care with secondary prevention and self-management. I have not talked as much as I would like to about self-management, but that is a key issue requiring a partnership approach with the community. It can be driven, indeed, I think it needs to be driven by central intelligence using population health methods. In some ways this is really population health's contribution to the issue; marshalling all available facts and understanding who needs what, how we are doing, what our failures are and what are our successes is crucial.

We also need to use innovative communication channels for micro-segmented mass communication. This is one of the differences with primary prevention. With primary prevention and mass communication you are trying to reach the whole community, and that's just too big to try and tailor bespoke messages for.

With chronic disease management I think we need to try and select specific targets and create micro messages just for them. For example, who are the fifteen blokes in Tuggeranong who are living on their own and who would like to get together once a week to work out how to cook? Who are the fifteen women in Gungahlin who have become sedentary and want to get out into the pool for the aquarobics class on their own without the intimidation of the AIS athletes training in the next lane? How do we connect those people up? We have a clever city, we have clever people. We have lots of communication channels and we have to be innovative about how we use them to connect people to care for themselves, for each other and, as professionals, for their patients. So we connect people to care and we connect people into community activity.

To conclude, I want to mention the key performance indicators that ACT Health is using to approach chronic disease management. Some of these need to be published not just support at the end of the year or every three years, but month by month, quarter by quarter. How else do we know how we are tracking and what the tasks are ahead?

As I said at the beginning, this is not a plan that we are presenting. This is not an off the shelf strategy. This is a set of challenges that I think we need to work out and go forward with over the next five years and I hope that everybody in the room can see how they might be able to participate in.

