



Chronic Conditions Program Industry Roundtable Report

Melbourne
Tuesday, 7 February 2006

Introduction

The Chronic Conditions Program held an Industry Roundtable in Melbourne on Tuesday February 7, 2006 with the aim to examine current activities within the Program and then produce a list of further research questions and/or other activities that are priorities for the Community Controlled Health Sector and other organisations servicing Aboriginal and Torres Strait Islander peoples. The meeting was attended by twenty six people and included representatives for the following organisations:

NACCHO
VACCHO
Danila Dilba Health Service
Central Australian Aboriginal Congress
Katherine West Health Board
Wurli Wurlinjang Aboriginal Health Service (Katherine)
Rumbalara Aboriginal Co-operative
National Heart Foundation
Diabetes Australia
QAIHC / CCRE in Circulatory & associated conditions
NATSINSAP
QIMR
MSHR
University of Melbourne
Commonwealth Department of Health & Ageing
OATSIH

The Discussion:

The discussion produced clear and consistent messages about what further research activities are needed around chronic illness in Aboriginal and Torres Strait Islander peoples. The following is an edited version of the discussions around suggested project concepts. The boxed text are comments added by the Program Manager.

Defining and operationalising the Aboriginal Health Construct:

Aboriginal health is not just the physical well being of an individual but is the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential thereby bringing about the total well being of their community. It is a whole-of –life view and includes the cyclical concept of life-death-life. (NAHS 1989)

There was a lot of discussion around the definition of Aboriginal health as defined by the National Aboriginal Health Strategy 1989.

Questions and comments included:

- *How do we define the Aboriginal health construct and is it still valid? And how do we operationalise the Aboriginal health construct?*

- *AMSs are practicing it but not resourced for it, funding is based on clinical model, we are not measuring or funded for the extended stuff. What is valued by Aboriginal people? What do Aboriginal people value as a health gain?*
- *What indicators are appropriate for use in evaluating Aboriginal health?*
- *What are the current indicators that AMSs have to report against, how do we prioritise these, and what are the economic implications of these? Are we measuring and recording the right things within our model of health and what the processes we are using to deliver the message and are we using our resources appropriately? What is it that we need to measure to capture Aboriginal health indicators?*
- *Measuring – need to avoid throughput measures, thinking about Indigenous defined measures of evaluation? Need a measure of quality of life that is Indigenous specific.*
- *We need an instrument to capture the other things that are included eg Aboriginal space, staff, leadership etc*
- *How do we capture and measure and report of these sorts of things?*
- *Problem with health outcome measures is that we only measure the results of health services – not what happens, say with the store. Health Services trying to influence a whole lot of things that aren't really within scope – ie diets, food supply etc*

This lead on to discussions around the use of the data collected within AMSs nationally and how to make the best use of this data. NACCHO has a plan for aggregating and using that data and using it to influence policy but is not resourced to carry out the research. There is potential here for the CRC to work with NACCHO on this.

Health Economics of Chronic Conditions:

Questions raised included:

- *Do we really know the cost of the burden of chronic disease as experienced by Aboriginal people? What would it cost to do something, what the benefits would be?*
- *What does it really cost for an AMS to run services and what are the best buys around chronic conditions? - particularly for urban vs remote services*

Service Mix:

Integrated and coordinated care is a key action area for improving outcomes for people with chronic conditions under the national chronic disease strategy.

Questions suggested by the group included:

- *What sort of service mix models work the best?*
- *PHC interaction – GP's vs AMSs*
- *What component should be provided by AMSs and what by mainstream? We need to be able to make mainstream services and government accountable.*

Work in this area could be linked in with the "Dropping through the holes" project being developed within the PHC Program.

Research Transfer into Policy and Practice:

The general consensus was that we know we are sick but how do we better enact what we already know?

Questions included:

- *How do we really make research in CC work for us, how do we get policy support, how do we influence the integration of research into actual practice.*
- *Where has transfer into policy been successful? What are the pathways to policy change?*
- *How can we use available evidence when lobbying governments?*

Chronic Disease self-management:

Understanding the barriers to effective uptake of health promotion and self-management messages:

Self-management is widely recognised as an important strategy for managing chronic illness and was identified as an area of significance for improved health outcomes. The National Chronic Disease Strategy (Consultation Draft May-June 2005) identifies self management as one of the key action areas and defines it as "people being actively involved in their own health".

There was agreement that, within an Aboriginal context, this definition needs to be extended beyond the individual to their family and community units, and self-management strategies need to incorporate Aboriginal value structures. This ties in with defining the Aboriginal health construct and providing health care that encompasses what Aboriginal people value as a health gain.

Comments & Questions included:

- *We found that what actually works is you have to involve the rest of the family; target families and communities – not just individuals. We need to be able to demonstrate the value of this?*
- *How can we better incorporate Aboriginal value structures into how we deliver information and health messages to people? We need to target training of health service providers and what goes into what goes into materials?*
- *Investigate health seeking behaviour – how do people value and understand health benefit etc?*
- *How do we fit health promotion to people's values, meanings, ideas about lifestyle change?*
- *Provision of information and subsequent behaviour change we'd hope to see through health promotion –*
- *Communication to clients – possibly complacency where if you're in a community with 50% of people have diabetes it might be sort of normal. Things need to be looked at in context.*
- *National frameworks around Chronic Disease Self Management have narrow focus. It needs to encompass individuals within their family units and community context – self management and community management*
- *What are the successful models around self-management eg Indigenous family program in Perth.*
- *There has been a lot of work done around Health literacy internationally but none done in Australia. This is an important area to investigate.*

Current CRC work to link into: (list incomplete)

A number of Flinders University Projects including

The self management component of the National Chronic Diseases Self Management Strategies

Evaluation of the Flinders Model of Chronic care. (Flinders Model is a *clinician led* model of self management).

Chronic Condition self management education and training for Aboriginal Health Workers

Plus more – see Program project list)

Sharing Health Care Initiative – based at Danila Dilba Health Service

(The Commonwealth SHCI uses the Stanford Model of chronic disease self-management which focuses on *peer leadership*. – Has this been evaluated?)

Sharing True Stories (PHC Program)

This project demonstrated the extent of miscommunication and provided evidence of the importance of interpreters

Cardiovascular Disease:

In Aboriginal and Torres Strait Islander peoples cardiovascular disease is the single largest contributor to the higher death rate, and is one of the seven National Health Priority Areas.

It was suggested that there is an opportunity for the CRCAH to form linkages with the National Heart Foundation and the CCRE for Circulatory and Associated conditions.

The following research concepts were suggested:

- *Why aren't tertiary cardiac services being accessed and fully utilised by Aboriginal & Torres Strait Islander people?*
- *The evidence around cardiovascular disease is there, but now it's about the application of that evidence in an environment that works for Aboriginal people. The CRC could be utilised as a conduit to link in with organisations that might be interested in developing some models.*

The issue of heart disease and depression was also raised with some work currently being done in Alice Springs which could link into the model development work.

Smoking:

Tobacco smoking is recognised as a major risk factor in chronic conditions and has been the focus of much effort within the mainstream population. It was strongly agreed that it is a significant health problem within Aboriginal communities and that current mainstream strategies do not work.

Specific questions included:

- *What are the successful interventions? How do you change people's behaviour?*
- *How do interventions work for individuals in communities where there are a majority of people smoking?*
- *Why aren't anti smoking campaigns working for Aboriginal communities?*

The Centre for Excellence in Indigenous Tobacco Control is an in-kind project with the CRCAH – discuss with them how best the CRCAH could support their work.

Men's Health:

The issue of specific services for Aboriginal men was raised and the desperate need for such services emphasised. There is an overwhelming demand but it is difficult to sustain services because of shortfalls in funding and particularly in male staff. There is very little support available for men's health. It was suggested we need to investigate what are the barriers to male recruitment into health, and that there is a need to document the potential outcomes from men's health interventions.

[OATSIH suggested that we have an existing Aboriginal & Torres Strait Islander workforce national strategy and don't want to create separate strategy but could aim to incorporate specific men's health issues within existing policy]

Nutrition:

Poor nutrition is widely recognised as a major risk factor for chronic illness and was raised as an important area that requires more research within the Aboriginal context, particularly in urban areas.

Suggested focus of research included:

- *Need to look at services in communities beyond the AMS - stores, food supply/transport; Consider value of treating store staff etc as part of health service.*
- *Need multi-sectoral approach to looking at nutrition work in communities.*
- *Turnover of staff in stores and health services and difficulty of getting continuity of programs.*
- *Look at work being done by NATSINSAP, Arnhemland Progress Association (ALPA) re cross subsidising and had good results, involving a number of other agencies.*
- *We need systematic change based on contemporary eating practices, eg how much food eaten through takeaway. Dependence on takeaway is also an opportunity to provide healthy food and we know that when healthy food is provided it is taken up very enthusiastically.*

Other considerations for the Chronic Conditions program included:

- There is a need to link/integrate the existing projects within Chronic Conditions Program.
- The CRC could support the dissemination of outcomes of various projects, and look at assistance with dissemination of research results generally.
- More work needs to be done around understandings of research and its processes and how it can interact with service delivery. This could incorporate engagement in research by service delivery staff and researchers developing a better understanding of how AMSs work.

Next Steps:

All participants from the meeting will be given the opportunity to provide feedback on this report and on the list of more clearly defined research concepts extracted from the discussion. Feedback will also be sought from Program Leaders and members of the RDG.

A final list of project concepts/outlines will be taken to the CRC Board meeting in March for discussion and prioritisation.