ACT Health

ACT Chronic Disease Strategy 2008–2011

ACT Health

ACT Chronic Disease Strategy 2008–2011

Foreword by *Katy* Gallagher, Minister for Health

The ACT Chronic Disease Strategy 2008–2011 sets the direction for chronic disease prevention, detection and management in the ACT for the next three years.

Although the ACT enjoys good health as compared to the rest of Australia, the prevalence of chronic disease is increasing significantly. An ageing population and a variety of lifestyle factors are contributing to the burden of chronic disease on society. Addressing these needs requires close collaboration between federal, state and territory governments and the broader community, in order to create an environment that promotes quality of life for individuals and the community as a whole.

I recognise that good health is of central importance to the wellbeing and quality of life for all people. The ACT Chronic Disease Strategy will work to improve the quality of health promotion messages, early detection and appropriate support and management of chronic disease in the ACT.

The development of the Strategy involved wide consultation with the community and stakeholders. I would like to sincerely thank all those who commented on the draft Strategy. Your feedback is critical in developing a policy document that accurately reflects the views of the ACT community. I would also like to thank members of the ACT Chronic Disease Strategy Steering Committee who provided valuable expertise and guidance during the development of the Strategy.

I believe the ACT Chronic Disease Strategy will provide excellent direction for the delivery of chronic disease initiatives and services in the ACT and I am very pleased to support its implementation.

Katy Gallagher MLA
Minister for Health

Contents

Abbreviations

ABHI	Australian Better Health Initiative
ACTDGP	ACT Division of General Practice
ACTPLA	ACT Planning and Land Authority (ACT Government)
AIHW	Australian Institute of Health and Welfare
CMD	Chief Minister's Department (ACT Government)
COAG	Council of Australian Governments
COPD	Chronic Obstructive Pulmonary Disease
DALYs	Disability Adjusted Life Years
DET	Department of Education and Training (ACT Government)
DHCS	Disability, Housing and Community Services (ACT Government)
GP	General Practitioner
LDA	Land Development Agency (ACT Government)
MBS	Medicare Benefits Scheme
NCDS	National Chronic Disease Strategy
NRA	National Reform Agenda
PBS	Pharmaceutical Benefits Scheme
TAMS	Territory and Municipal Services (ACT Government)

1. Introduction

Good health underpins the wellbeing and quality of life of Australians. Preventing ill health and improving physical and mental health helps people to participate more actively in the community and increases their capacity to live full and productive lives.

The ACT Chronic Disease Strategy (the Strategy) has been developed to provide an overarching framework for the provision of appropriate programs and supports to address the increasing prevalence of people at risk of, or living with, chronic disease in our community.

The Strategy is designed to align with the National Chronic Disease Strategy (NCDS), which was endorsed by all states and territories and the Australian Government in 2005.[1]

The Council of Australian Governments (COAG), through the National Reform Agenda (NRA), agreed in February 2006 to focus on providing a national framework for health reform at both the national and local level.

Both the NCDS and the COAG NRA reflect the changing picture for health, recognising the increasing importance of health promotion and prevention of chronic disease and working in partnership across levels of government, agencies, private and public sectors and the community sector to enable people to maximise and maintain their health and wellbeing.

The Strategy provides a framework to pursue work that involves better coordination of existing chronic disease services and to develop new and innovative projects and programs that aim to reduce the incidence or complications of chronic disease.

ACT Health operates in a whole of government environment, taking opportunities to further interdepartmental cooperation and joint activities in relation to health promotion and chronic disease prevention.

The Strategy recognises that much of what is required to prevent chronic disease is reliant on collaboration with a range of policy and planning areas that are outside the traditional health system, including town planning, housing, education, sport and recreation.

From a health specific perspective, the Strategy notes the central importance of a range of health providers in delivering optimal chronic disease prevention, detection and management as part of an interprofessional team. ACT Health clinicians, general practice, community pharmacy, private allied health, private nursing and non-government organisations are all crucial in ensuring that the health and wellbeing of people living with a chronic disease is improved.

The Strategy also recognises the importance of focusing on the person when planning their care and including them as a key member of the care team. This has been developed in the context of the national Australian Better Health Initiative (ABHI), a package of Australian, state and territory government activities that focuses on health promotion, disease prevention and management of chronic disease.[2]

The impact of chronic disease on mental health is recognised as important. Mental health conditions can also be chronic diseases. Mental health services for the ACT are addressed in the draft Mental Health Services Plan, and therefore will not be considered specifically in the Strategy. Likewise, while cancer can be a chronic disease, cancer services are addressed in the draft ACT Cancer Services Plan and therefore will not be specifically addressed in this Strategy. However, there will be much within this Strategy that will be relevant for these groups.

Many parts of ACT Health, as well as a range of other providers including general practice, community pharmacy, private specialists and non-government organisations, provide care to people living with chronic disease. Building on these services, ACT Health has recently established the Chronic Disease Management Unit, located within Aged Care and Rehabilitation Services.

The Chronic Disease Management Unit, in collaboration with the *Improving Coordination in Chronic Disease Care Program* in Ambulatory Care, the *Self-Management of Chronic Conditions* program in Community Health, the health promotion activities provided by various non-government organisations funded by ACT Health, and the development of a chronic disease patient care register by the Population Health Research Centre, form the core of ACT Health's Chronic Disease Management Program. The Program aims to increase the proportion of people with chronic diseases who are receiving optimum care, including risk reduction and health promotion services.

The following documents provide context for the Strategy:

- National Chronic Disease Strategy
- COAG National Reform Agenda
- The Canberra Plan
- *access health 2007–2010*
- ACT Primary Health Care Strategy 2006–2009
- draft Diabetes Services Plan
- draft Cancer Services Plan
- draft Mental Health Services Plan
- A New Way: Aboriginal and Torres Strait Islander Health and Family Wellbeing Plan 2006–2011
- Eat Well ACT: A Public Health Nutrition Plan 2004–2010
- Public Health in the ACT 2004–2008

2. Background

The prevalence of chronic disease in the ACT is increasing significantly, as it is nationally and internationally. Factors such as the ageing population and lifestyle changes have contributed to an increase in the rate of chronic disease.

Health status indicators suggest that overall, the ACT has a high level of health as compared to the rest of Australia. In 2001, 54.1% of all ACT respondents to the National Health Survey reported their health status to be excellent or very good. The same survey measured the proportion of respondents who reported having a long-term condition (lasting more than six months). ACT residents reported similar levels of long-term conditions as respondents nationally, with 82.1% of the ACT population reporting a long-term condition, compared with 77.9% nationally.[3]

However, population projections suggest that the ACT population is ageing faster than other jurisdictions. The median age of the ACT population (34.5 years in 2005) has increased 6.4 years since 1985. By comparison, the median age of the Australian population has increased 5.9 years since 1985.[4] This changing age profile has major implications for the ACT. While people of all ages can present with a chronic disease, the ageing of the population and its longer lifespan mean that chronic diseases will place major demands on the health system for resources, both workforce and financial, in the immediate and longer-term future.

Australian Institute of Health and Welfare (AIHW) data shows that seven health conditions, most of which are long term, make up the bulk of health expenditure in Australia. They are cardiovascular disease, nervous system disorders, musculoskeletal conditions, injuries, respiratory diseases, mental disorders and poor oral health. Together these seven conditions accounted for approximately 60% of allocated health expenditure in 2000–01, or around $30 billion.[5] It is estimated that more than two-thirds of general practice consultations relate to the management of one or more chronic diseases.[6]

There are significant financial savings to be made from implementing appropriate prevention and early intervention measures. Interventions will be carefully monitored to evaluate their effectiveness and cost benefits to the community.

According to AIHW, chronic diseases:

- have complex and multiple causes;
- usually have a gradual onset, with an opportunity for early detection and secondary prevention strategies;
- occur across the life cycle, although they become more prevalent with older age;
- can compromise quality of life through physical limitations, disability and psychological consequences;

- are long term and persistent, and may lead to a gradual deterioration of health; and
- are the most common cause of premature mortality, while not usually immediately life-threatening.

Australia's Health 2006 states that chronic diseases are the primary health concerns for Australia, now and in the future.[7] For example:

- Cardiovascular disease is the leading cause of death for Australians, totalling 36% of all deaths. Cardiovascular disease is also the most expensive disease group in terms of direct health care expenditure, at $5.5 billion or 11% of total allocated health care expenditure in 2000–01.
- The self-reported prevalence of diabetes in Australia has more than doubled over the past 25 years. Information from the 1999–2000 Australian Diabetes, Obesity and Lifestyle (AusDiab) study, the most recent national survey in which blood glucose levels were measured, estimated that more than 850,000 Australians aged 25 years and over had Type 2 diabetes in 1999–2000. That constitutes 7.2% of the population, or more than 1 in 14 people. Around half of the people in the AusDiab study who tested positive for diabetes were not aware that they had it.
- The prevalence of end stage kidney disease has almost tripled over the past 25 years, from 24 per 100,000 people in 1881 to 71 per 100,000 in 2004. Kidney disease shares several risk factors with other diseases, including cardiovascular disease and respiratory disease. A person with chronic kidney disease therefore may also have one or more other chronic conditions.

The top ten leading causes of disease burden in terms of Disability Adjusted Life Years (DALYs) are chronic diseases. They account for nearly 43% of the total disease burden in Australia. They are: chronic heart disease; anxiety and depression; type 2 diabetes; stroke; chronic obstructive pulmonary disorder (COPD); lung cancer; Alzheimer's and other dementias; colorectoral cancer; asthma; and breast cancer.[8]

Additionally, people living with chronic diseases such as HIV/AIDS, Hepatitis B and C and mental illness experience stigma, labeling and discrimination in addition to the personal, social and economic impact of their condition.

AIHW has identified a number of risk factors that contribute to the onset, maintenance and prognosis of many chronic diseases:

Behavioural risk factors:

- Tobacco smoking
- Alcohol misuse
- Poor nutrition
- Physical inactivity

Biomedical risk factors:

- High blood pressure
- High blood lipids
- Excess weight

Other factors:

- Socio-environmental determinents
- Psychosocial factors
- Early life factors

Results from the 2001 National Drug Strategy Household Survey showed around 20% of Australians aged 14 years and over are daily smokers and 10% consume alcohol at risky levels. The 1999–2000 Australian Diabetes, Obesity and Lifestyle Study suggests that 30% of Australians aged 25 years and over had high blood pressure, 50% had high blood cholesterol levels, and 60% carried excess weight.[9]

Many of these risk factors are underpinned by a range of social determinants, such as income, employment, education, housing and cultural background. This is supported by the fact that chronic diseases are most prevalent in more disadvantaged sectors of the population. There is an essential connection between the individual and their social circumstances that can fundamentally impact on health outcomes and quality of life. It is therefore important when designing measures to address risk that consideration is also given to addressing the social factors that are linked to these risk factors.

Of particular note is the higher prevalence of chronic disease for people of Aboriginal and Torres Strait Islander background. Between 1999–2003, diseases of the circulatory and respiratory systems, and endocrine, nutritional and metabolic diseases were all among the leading causes of death for people of Aboriginal and Torres Strait Islander background. Self- reported diabetes was almost four times as high as for non-indigenous Australians.[10]

Prevention and management of chronic disease in people of Aboriginal and Torres Strait Islander background is the responsibility of all sections of health, and therefore cultural accessibility and competence is a priority. The Strategy contains specific activities to address the needs of Aboriginal and Torres Strait Islander people in chronic disease prevention, detection and care.

2.1 The Need for Reform

There is increasing recognition of the fact that the current range of health services does not meet the needs of people at risk of, or living with, a chronic disease. The current system has developed primarily to respond to acute and communicable disease with acute care hospitals as the centrepiece of the system. This is increasingly out of step with the needs of a population that requires more primary care and a more coordinated system to provide chronic care, community-based care, health promotion, disease prevention, and greater self-sufficiency for personal health.

The changing picture of health requires a shift away from the acute sector and a move towards more community-based care. Chronic diseases are often better managed in a community setting. Greater flexibility in the way the health system provides for changing population needs will ensure an appropriate level of care for people with a chronic disease, their families and carers.

Changes to the health system are only one component of the approach needed to address the health needs of our community. Influence over people's lives and their health does not begin and end with public health initiatives and primary health care. Communities need to be planned to provide safe public places for movement, recreation and socialisation, and to encourage wellbeing and social interaction. People need to have access to safe, affordable and appropriate accommodation, education and employment.

Addressing these needs will require a closer collaboration and working partnership between government agencies and the broader community, including the corporate sector, to work towards a community and work environment that supports quality of life for individuals and the community as a whole.

2.2 National Chronic Disease Strategy

In Australia, after three years of work coordinated by the National Health Priority Action Council, Australian Health Ministers Council endorsed the NCDS in late 2005, together with national service improvement frameworks for each of the five nationally agreed priority areas: asthma; cancer; diabetes; heart, stroke and vascular disease; and osteoarthritis, rheumatoid arthritis and osteoporosis.

The NCDS notes AIHW data that 70 per cent of health expenditure in Australia is attributable to chronic disease. Nine in ten adult Australians have at least one of the common risk factors associated with chronic disease, with 54% of adult males and 45% of adult females having two or more. Common risk factors include tobacco smoking; physical inactivity; poor diet and nutrition; harmful alcohol use; high blood pressure; excess weight; and high blood lipids. Together they account for one-third of the chronic disease burden.

The NCDS highlights that chronic diseases are most prevalent in more disadvantaged sectors of the population, making prevention and treatment more complex. People of Aboriginal and Torres Strait Islander background also have much higher rates of chronic diseases and mortality, and greater exposure to risk factors, particularly in infancy and childhood, than non-indigenous Australians.

The NCDS identifies four key action areas:

- Prevention across the continuum;
- Early detection and early treatment;
- Integration and continuity of prevention and care; and
- Self-management.

These require four specific implementation actions:

- Building workforce capacity;
- Developing strategic partnerships;
- Enhancing investment and funding opportunities; and
- Developing infrastructure and information technology support.

2.3 Council of Australian Governments' Initiatives

The NRA, agreed to by COAG in February 2006, is a key platform to improving the health system and is expected to underpin Australia's future prosperity. The NRA is based on an overarching theme of enhancing productivity and participation, with human capital as a key component.

The priority areas of reform in the human capital component of the NRA are health, education and training, and work incentives. A healthy, skilled and motivated population is critical to workforce participation and productivity, and hence Australia's future living standards. By focusing on the outcomes needed to enhance participation and productivity, the human capital stream of reform aims to provide Australians with the opportunities and choices they need to lead active and productive lives.

States and territories, including the ACT, have traditionally encouraged healthier life styles through their health promotion and disease prevention projects aimed at reducing the prevalence of key risk factors that contribute to chronic diseases. Some examples of these initiatives include Quit programs, responsible drinking campaigns, drug awareness activities and healthy eating projects.

More recently there have been some successful partnership initiatives with the Australian Government via a shared and collaborative approach to investments and reform for health systems. The COAG ABHI is an initial step in this direction.

The ABHI is in the third of its four years, while the NRA is a ten-year program. At the COAG meeting of 13 April 2007, the long-term NRA was advanced with a number if actions, including agreeing to have a new cost-shared package of $200 million to address the significant growth in Diabetes Mellitus Type 2.

COAG has recently developed a nationally agreed risk assessment tool, program standards and accreditation arrangements for programs and/or providers to reduce the risk of developing Diabetes Mellitus Type 2 and for people either at risk of or newly diagnosed with Diabetes Mellitus Type 1.

It is important for ACT actions to be closely aligned with the national agenda and initiatives.

2.4 Benefits of Integration

Efficient program integration actions should enable time and dollars to be used wisely, avoiding duplication of effort, and building on common program interests and objectives. Integration of chronic disease programs and the linking of resources can result in efficiency and improved communication and coordination among people living with a chronic disease, service providers, and government funding agencies, and efficient use of staff, funds, surveillance and intervention efforts.[11]

A comprehensive chronic disease prevention and management strategy will be most effective through a partnership and collaborative effort with the Australian Government, recognising the roles and responsibilities of the different levels of government in achieving a satisfactory outcome. Overarching principles to be considered include:

- An integrated approach aimed at the general population targeting behaviour that is common across chronic diseases; e.g. reducing salt levels in the food supply system (to reduce hypertension and thus act on cardiovascular disease; the biggest single killer) requires coordinated national activity (e.g. with the food industry, but also social marketing, establishment of standards, etc).
- Agreement to national and jurisdictional outcomes that match the priority areas identified.
- Agreement to the dual goal of improving chronic disease outcomes and reducing inequalities in the distribution of the burden of chronic diseases.
- An inter-sectoral approach that involves a partnership at all levels, linking the preventive action of various components of the health system including health promotion, public health services, primary care, and hospital care.

These policies can no longer be isolated from policies in other sectors such as employment, income maintenance, social welfare, housing, education, and the mass media, including television.

The Strategy has been developed in the context of this changing environment and under the strategic framework of *access health*, launched by the Minister for Health in August 2007. Chronic disease management is one of the priority action areas of *access health*, which provides the vision and direction for ACT Health services until 2010.

3. The Strategy

3.1 Aims

The Strategy aims to improve the health of the ACT community through improved prevention, detection and management of chronic disease across the population.

3.2 Principles

The Strategy recognises that an effective response to chronic disease requires a focus at three major levels:

- Whole of person;
- Whole of community; and
- Whole of government.

The following key principles for chronic disease prevention, detection and management underpin the overarching direction of the Strategy:

- Person-centred care — people are consulted on all aspects of their care and care is focused on the whole person;
- Care is planned in partnership with the person, their carer(s) and family, as agreed with the person or their advocate;
- Collaboration — across government, both ACT and Australian Government and with non-government organisations;
- Interprofessional care — care is delivered by a range of health professionals and health consumer organisations, working with each other and in partnership with the person;
- Addressing the needs of disadvantaged and high-risk groups; and
- A life-course approach — focusing activities on specific age groups, particularly children, youth and older people.

3.3 Areas of focus

The Strategy includes the four areas of action identified in the NCDS as well as an additional area of action focused on research and surveillance:

- Action Area 1 — prevention and risk reduction across the continuum;
- Action Area 2 — early detection and early treatment;
- Action Area 3 — integration and continuity of prevention and care;
- Action Area 4 — self-management; and
- Action Area 5 — research and surveillance.

The Strategy focuses on activities that are relevant across the spectrum of chronic disease in a whole of person response, rather than disease specific initiatives. Therefore, issues such as health promotion and early intervention, integration of care, self-management and research and surveillance are key areas of focus. The Strategy focuses upon developing actions that better coordinate existing services, including the full range of programs funded by the Australian Government such as new item numbers under the Medicare Benefits Scheme (MBS), the Pharmaceutical Benefits Scheme (PBS), ABHI and the national diabetes initiative and look to develop new and innovative responses to chronic disease prevention, detection and management.

3.3.1 Action Area 1 — Prevention and risk reduction across the continuum

Health promotion and risk reduction are applicable across the entire continuum of chronic disease prevention and care — to prevent the condition itself, where possible, and to prevent and reduce progression of the condition and its associated complications and co-morbidities.

The Strategy includes a strong focus on health promotion and early intervention. Many risk factors are consistent across a number of chronic diseases, allowing for a coordinated approach to chronic disease prevention. Risk factors such as physical inactivity, poor nutrition, excessive alcohol consumption and smoking are common across a range of chronic diseases and strategies will be developed to address these risk factors.

A population based approach to health promotion and chronic disease prevention will be utilised. Health promotion activities will focus on the key issues of nutrition, physical activity, alcohol and smoking and will target populations at particularly crucial points in their lifespan, such as children. There will be a focus on particular population groups that experience high rates of chronic disease, such as Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse backgrounds, and acknowledgement of the links between risk factors for chronic disease and underlying social determinants.

The Strategy recognises the importance of child and maternal health in preventing chronic diseases in adulthood. There is strong evidence that a child's early health, growth and development have a significant effect on health and wellbeing in later years. Prevention initiatives for mothers and young children are a highly effective and cost efficient method of reducing the rate of chronic disease in the community. The Strategy aims to encourage maternal health, support healthy pregnancies and improve the health of children aged 0–3 years.

Developing healthy eating and physical activity habits in school age children is crucial. Good nutrition and exercise are integral to a young people's physical, social and mental development and wellbeing. A physically active lifestyle in childhood brings numerous health benefits and healthy behaviour patterns that continue into adulthood, as well as gains in social and emotional development. Similarly, good nutrition in childhood is necessary for optimum development and encourages healthy eating in adulthood.

Caregivers have an important role to play in the health of children, and strategies will be enacted to deliver health promotion messages to caregivers and children. The Strategy will work with relevant partners such as the Department of Education and Training (DET), Territory and Municipal Services (TAMS), Sport and Recreation Services and the Department of Disability, Housing and Community Services (DHCS) to encourage the development of healthy habits in children.

ACT Health will continue to implement the Health Promotion Grants Program, which aims to work jointly with other organisations to strengthen the capacity of people to make healthy choices. The Program provides funding for projects that address the promotion of health across the ACT population, founded on consistent health messages of healthy lifestyle choices and behaviours.

In order to further the Strategy, ACT Health will continue to work collaboratively across government departments, maintaining and extending their partnerships with, for example, TAMS, DHCS, Chief Minister's Department (CMD), ACT Planning and Land Authority (ACTPLA), Land Development Agency (LDA) and DET.

3.3.2 Action Area 2 — Early detection and early treatment

Early detection supports early treatment, which can improve health outcomes by reducing premature mortality, delaying the progression and complications of disease and improving quality of life and the ability to self-manage. Early detection and treatment may reduce or avoid unnecessary hospital admissions and the high cost of complex treatments.

People who are at risk of chronic disease should be encouraged to access health care as early as possible. Promotion of MBS item numbers such as the 45–49 year old Health Check will assist in the early identification and treatment of conditions, therefore improving long-term health outcomes.

Oral hygiene and dental health from early childhood is critical and is recognised as an important preventative measure for chronic disease, promoting good nutrition and prevention of heart disease and other chronic diseases. ACT Health provides universal school dental checks and a dental service for eligible adults.

3.3.3 Action Area 3 — Integration and continuity of prevention and care

A challenge for chronic disease prevention and care is to provide integrated and continuous care across time, at different stages of the condition, with co-morbid conditions, and between different services and service providers.

Integration of care will involve coordinated interprofessional collaboration with a range of service providers contributing to a person's care, including specialists, general practitioners (GPs), non-government organisations, allied health professionals, pharmacists and nurses. It will also consider the person as the most important member of the care planning team and work in partnership with them and their carers.

General practice is centrally placed in the management of chronic disease. There is a range of MBS item numbers that general practice can access to assist with the management of a chronic disease. The use of these should be encouraged and facilitated, with appropriate consideration of the capacity and willingness of general practice to undertake the tasks associated with these item numbers.

There is an emerging role for community pharmacy being supported by the Australian Government through the Guild Government Community Pharmacy Agreements.[12] Under this funding, the research and development program explores an enhanced role for pharmacy in the treatment of a range of chronic diseases including diabetes, asthma, cardiovascular disease and osteoarthritis. Where appropriate, an interprofessional approach, acknowledging the role of community pharmacy, will be adopted.

This action area will ensure that a person-centred approach is taken to the provision of chronic disease management and care, and that integrated care is provided and coordinated across service boundaries.

3.3.4 Action Area 4 — Self-management

Self-management is the active participation by people in their own health care. Self-management involves ensuring the person is the focal point of their care, working in partnership with the person and acknowledging the important role that families and carers can play in self-management, if the person wishes.

ACT Health currently delivers a chronic disease self-management education program, *Self-Management of Chronic Conditions*, through Community Health. A number of other chronic disease detection and self-management initiatives are currently under development, including online self-management support and support for GPs to access lifestyle modification programs for their clients.

The following principles of self-management have been taken from the NCDS. Embedding the principles of self-management in the health system means that a person is supported by the system to:

- Understand the nature of their condition including risk factors and co-morbidities;
- Have knowledge of their treatment options and be able to make informed choices regarding treatments;
- Actively participate in decision making with health professionals, family and carers, and other supports in terms of continuing care;
- Follow a treatment or care plan that has been negotiated and agreed with their health care providers, family and carers, and other agencies including non-government and consumer organisations;
- Monitor signs and symptoms of change in their health condition and have an action plan to respond to identified changes;

- Manage the impact of the condition on their physical, emotional and social life and have better mental health and wellbeing as a result;
- Adopt a lifestyle that reduces risk and promotes health through prevention and early intervention;
- Have confidence in their ability to use support services and make decisions regarding their health and quality of life; and
- Remotely monitor and record their condition.

3.3.5 Action Area 5 — Research and surveillance

Recent chronic disease prevention frameworks at both the national and state level in Australia have emphasised a transition from vertical, single-issue public health efforts to a more coordinated approach that targets clustered risk factors for chronic diseases. There is a need to establish a nationwide system to monitor the incidence of chronic disease and associated behavioural risk factors.

A chronic disease surveillance strategy will combine monitoring of specific condition states in addition to modifiable risk factors for conditions that align with national surveillance strategies. The development of suitable performance measures will be used to monitor the progress and effectiveness of combined efforts as well as to identify trends.

The chronic disease surveillance system would draw together a range of data from existing administrative databases and survey collections in addition to establishing new data collection mechanisms. It is important for the ACT to contribute to this national work.

Research is a key element of a chronic disease strategy. The ACT framework includes collaborative epidemiological and health research with universities and other organisations on chronic disease prevention and intervention at a population level. The Strategy highlights local areas of priority for research initiatives.

4. Action Plan

Recommended Actions	Lead Agency	Partners
Action Area 1 — Prevention and risk reduction across the continuum		
1.1. Promote and support the development of: • Affordable housing initiatives; • Well-planned, safe recreational and social spaces in local communities; • Accessible transport options; and • Early Childhood Schools and services.	CMD DHCS ACTPLA TAMS DET	ACT Health, CMD, DHCS, ACTPLA, LDA, TAMS and DET
1.2. Explore options for raising awareness of breastfeeding to increase the proportion of babies that are breastfed to the age of six months.	ACT Health	ACT Division of General Practice (ACTDGP) and relevant non-government organisations.
1.3. Develop and implement processes to ensure that current services provided through Maternal and Child Health (MACH) and Midwifery programs provide health promotion messages and support to take up those messages, particularly around the benefits of breastfeeding; and nutrition, smoking and alcohol use in pregnancy and whilst breastfeeding.	ACT Health	ACTDGP, DHCS and Pharmacy Guild of Australia ACT.
1.4. Work with the community, general practice, community pharmacies and non-government organisations to consolidate and coordinate current health promotion messages and to ensure that messages are reaching a broad target audience, including people with a disability, their families and carers.	ACT Health	ACTDGP, DHCS, Pharmacy Guild of Australia ACT and relevant non-government organisations.
1.5. In collaboration with relevant partners: • Review existing nutrition programs and initiatives such as the *Kids at Play*, *ACT Early Childhood Active Play and Eating Well* project for their effectiveness in promoting and encouraging healthy eating habits in children, young people and their caregivers; and • Identify ways of enhancing existing programs and developing new programs that effectively promote and encourage healthy eating for everyone.	ACT Health	DET, TAMS (Sport and Recreation Services), DHCS, ACTDGP and relevant non-government organisations.

Recommended Actions	Lead Agency	Partners
1.6. In collaboration with relevant partners: • Evaluate the range of physical activity programs and initiatives available in the ACT to increase physical activity levels for school-age children and young people; • Produce a service directory; • Identify gaps and access issues, e.g. population groups not participating in programs; and • Identify options for enhancing existing programs and initiatives, such as *Kids at Play, ACT Early Childhood Active Play and Eating Well*, and providing new programs where required.	TAMS (Sport and Recreation Services)	ACT Health, DET, DHCS, ACTDGP and relevant non-government organisations.
1.7. Develop and implement smoking cessation programs for people of Aboriginal and Torres Strait Islander background, including pregnant women.	ACT Health	Winnunga Nimmityjah Aboriginal Health Service, Gugan Gulwan Aboriginal Youth Corporation and relevant non-government organisations.
1.8. Promote anti-smoking messages for the community generally and for pregnant women in particular.	ACT Health	Perinatal maternity services, ACTDGP, Pharmacy Guild ACT and relevant non-government organisations.

Recommended Actions	Lead Agency	Partners
1.9. In collaboration with ACT Health's Injury Prevention and Management Unit, develop and provide access to anti-smoking messages and smoking cessation programs for health care workers.	ACT Health	
Action Area 2 — Early detection and early treatment		
2.1. In collaboration with relevant partners: • Develop a program to encourage the use of the MBS Aboriginal and Torres Strait Islander Child and Adult Health Check in the ACT; • Support and encourage general practice to identify clients of Aboriginal and Torres Strait Islander background and offer health checks; • Develop a program to encourage the use of the MBS 45–49 year old Health Check in the ACT. This will include promoting the health check to 45–49 year olds with at least one risk factor; • Work to ensure that demand for the health check can be met by the general practice sector; and • Work to ensure access to MBS health checks is appropriate and equitable, particularly for disadvantaged people and for people of Aboriginal and Torres Strait Islander background.	ACT Health	ACTDGP and Winnunga Nimmityjah Aboriginal Health Service.
2.2. Develop health promotion materials and/or training for GPs and allied health professionals working with people with a disability.	ACT Health	DHCS, ACTDGP, relevant non-government organisations.
Action Area 3. — Integration and continuity of prevention and care		
3.1. Continue to support the *Improving Coordination in Chronic Disease Care Program*, being implemented by Ambulatory Care at the Canberra Hospital, to provide care coordination to people living with selected chronic diseases.	ACT Health	ACTDGP

Recommended Actions	Lead Agency	Partners
3.2. Develop and promote the use of shared care guidelines and protocols for the management of people living with a chronic disease or with a number of chronic diseases so that: • The person is included in the development of an individual care plan; • The person's individual circumstances are taken into account; • The coexistence of different conditions is recognised; • Services are provided in an integrated manner; • Services are accessible, affordable and appropriate for people of Aboriginal and Torres Strait Islander background; and • Chronic diseases are identified and appropriately managed in people with a disability, using individual care plans and planning for the future.	ACT Health	ACTDGP, DHCS and Winnunga Nimmityjah Aboriginal Health Service.
3.3. Implement the patient care register being developed by the Population Health Research Centre to monitor key care indicators for people known to be living with congestive heart failure, type 2 diabetes and chronic obstructive pulmonary disorder, in order to improve service delivery and health outcomes.	ACT Health	ACTDGP
3.4. Monitor the implementation of the ACT Diabetes Services Plan to determine its appropriateness as a model for a range of other chronic diseases/ co-morbidities.	ACT Health	
3.5. Develop and implement strategies to ensure that older people living in the community with a chronic disease are proactively managed and monitored to prevent, wherever possible, progression or complications. This action will link to the ACT Aged Care and Rehabilitation Services Plan.	ACT Health	ACTDGP
3.6. Develop and implement appropriate discharge planning and protocols, in line with the ACT Health Discharge Planning Policy, for people living with a chronic disease to ensure that: • Care is integrated between acute and community settings; and • Transfer to palliative care services is timely and coordinated.	ACT Health	ACT palliative care service providers and ACTDGP.

Recommended Actions	Lead Agency	Partners
3.7. Design and implement an Information Management and Information Technology system(s) to support information sharing for chronic disease management.	ACT Health	
Action Area 4 — Self-management		
4.1. Review education, self-help, self-management and rehabilitation programs for people living with a chronic disease or at risk of developing a chronic disease in order to: • Produce a services directory; • Identify gaps, access and coordination issues, including issues around cultural accessibility; and • Identify options to enhance existing programs and to implement new ones.	ACT Health	ACTDGP and relevant non-government organisations
4.2. Identify training options for community services and health workers in line with the Incorporating Chronic Disease Self Management Principles in Training Packages for CHC02 Community Services and HLT07 Health — Report, September 2007 (Community Services and Health Industry Skills Council).	ACT Health	Relevant non-government organisations
4.3. Implement the web-based tool being developed by Health Improvement Branch to provide self-management support to appropriate groups within the ACT community. This tool could also provide information and referral assistance to health professionals.	ACT Health	ACTDGP
Action Area 5 — Research and surveillance		
5.1. Develop priorities for chronic diseases research projects in the ACT and work with relevant organisations to undertake research.	ACT Health	Australian National University, University of Canberra and the Australian Catholic University.
5.2. Contribute to national work on a chronic diseases surveillance system.	ACT Health	Australian Government Department of Health and Ageing

5. Implementation Phase

The principles and actions detailed in this Strategy provide planning direction for chronic disease prevention, detection and management in the ACT.

Implementation will be overseen by a Steering Committee, with representatives from the Pharmacy Guild ACT, ACT Division of General Practice, consumers, Winnunga Nimmityjah Aboriginal Health Service, ANU Medical School and all operational areas of ACT Health.

It is proposed that for each 12-month period of the Strategy, a list of priority actions be developed by the Steering Committee and agreed for implementation within that time. Progress against the priority actions will be reviewed six-monthly, and an updated list of priority actions will be agreed annually.

The Steering Committee will also oversee the implementation of the ACT Primary Health Care Strategy 2006-2009, the ACT Chronic Disease Management Program and the ACT component of ABHI.

The Steering Committee will report to ACT Health's Portfolio Executive and will provide six-monthly reports on progress in implementation to ACT Health Portfolio Executive and ACT Health Council.

Endnotes

1 National Chronic Disease Strategy http://www.health.gov.au/internet/wcms/publishing.nsf/Content/pq-ncds.

2 Australian Better Health Initiative (ABHI) http://www.health.gov.au/internet/wcms/publishing.nsf/Content/feb2006coag03.htm

3 *ACT Health, ACT Chief Health Officer's Report 2006* http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1155002538&sid=

4 Chief Minister's Department, *The Canberra Social Plan progress report June 2007* http://www.cmd.act.gov.au/__data/assets/pdf_file/0018/1494/social_plan_progress_report2007.pdf

5 Australian Institute of Health and Welfare, *Health System Expenditure on Disease and Injury in Australia, 2000–01* http://www.aihw.gov.au/publications/hwe/hsedia00-01-2/hsedia00-01-2.pdf

6 Australian Institute of Health and Welfare, *Older Patients Attending General Practice in Australia 2000–2002.* http://www.aihw.gov.au/publications/gep/opagpa/opagpa00-02-c01.pdf

7 Australian Institute of Health and Welfare, *Australia's Health 2006* http://www.aihw.gov.au/publications/aus/ah06/ah06-c04.pdf

8 Australian Institute of Health and Welfare, *Australia's Health 2006* http://www.aihw.gov.au/publications/aus/ah06/ah06-c05.pdf

9 Australian Institute of Health and Welfare www.aihw.gov.au/cdarf/risk_fact/index.cfm

10 The Australian Bureau of Statistics, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2005* http://www.abs.gov.au/ausstats/abs@.nsf/1020492cfcd63696ca2568a1002477b5/3919938725ca0e1fca256d90001ca9b8!OpenDocument

11 U.S. Department of Health and Human Services, the Public Health Service, *the Centers for Disease Control and Prevention 6/4/07*

12 The Pharmacy Guild of Australia, *Research and Development* http://beta.guild.org.au/research/