

# A Strategy for Translating Evidence Into Policy and Practice to Close the Gap - Developing Essential Service Standards for Aboriginal and Torres Strait Islander Cardiovascular Care



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Essential Service Standards for Equitable National Cardiovascular Care for  
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The development and application of essential standards for cardiovascular care for Aboriginal and Torres Strait Islander people creates a strategic platform on which to systematically close the gap in the health outcomes and life expectancy between Aboriginal and Torres Strait Islander and non-Indigenous people in Australia. We outline six developmental stages that can be used to enhance the effective translation of evidence into practice that reduces life expectancy differentials. Focussing efforts where the biggest gain can be made; considering how to make a policy-relevant difference with an emphasis on translation into policy and practice; establishing a foundation for action by engaging with stakeholders throughout the process; developing a framework to guide action; drafting policy-relevant and framework-appropriate essential service standards; and defining standards that help policy decision makers achieve current priority policy targets.

## Keywords

Indigenous • Standard of Care • Cardiovascular diseases • Healthcare disparities • Australia  
• Knowledge translation

## Introduction

Much has been written outlining the poor state of health of Australia's first peoples. On almost any social or health indicator, Aboriginal and Torres Strait Islander people remain within the most disadvantaged sector of

contemporary Australian society [1,2]. Despite national policy support and significant investment over recent years, the disparity remains resistant to change. In several areas these gaps have continued to grow, such as is seen with mortality from chronic diseases [3]. Unfortunately, recent approaches to policy development and the implementation of health

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system reform in Indigenous affairs have lacked a sense of context specific evidence and conceptual coherence.

This paper outlines a policy-targeted approach to reducing life expectancy differentials between Aboriginal and Torres Strait Islander people and their non-Indigenous counterparts, as developed through the ESSENCE project (Essential Service Standards for Equitable National Cardiovascular CarE for Aboriginal and Torres Strait Islander People). We propose this staged and developmental process as an exemplar approach to improved policy development and priority setting with the ultimate aim of reducing life expectancy differentials for vulnerable communities. We purposefully chose cardiovascular disease (CVD) as a focus, firstly because of the strength of evidence that exists to guide preventative and therapeutic interventions, but also because of the significant impact cardiovascular conditions have in driving life expectancy differentials between Aboriginal and Torres Strait Islander people and non-Indigenous Australians [4].

## Background

In 2007 the Council of Australian Governments (COAG) committed to closing the 17 year life expectancy gap experienced by Aboriginal and Torres Strait Islander peoples within a generation [5]. This commitment created a partnership between all levels of government in Australia and Aboriginal and Torres Strait Islander communities and was heralded as a defining point in Aboriginal and Torres Strait Islander health, placing a focus on Aboriginal and Torres Strait Islander people expecting the same health and life expectancy as other Australians [5]. Few commentators, policy makers or health system operatives have openly opposed such an objective. Yet despite widespread support, change has been difficult to achieve and commitment hard to sustain.

As has been frequently noted, the recent (and not so recent) history of Aboriginal and Torres Strait Islander health and social policy can be traced through its failures with much greater clarity than any notable successes. Issues of inadequate and inefficient resourcing of specific policy have resulted in ineffective implementation. Ineffective mechanisms for implementation has also impacted policy, limiting its full potential and fuelling criticism for a lack of tangible outcomes [6,7]. The federal government's "Closing the Gap" commitment has been decried for its heavy focus on health service throughput rather than meaningful health outcomes. These failures have meant that Aboriginal health policy has lacked a systematic approach to addressing the key factors which contribute to the significant gap in life expectancy [8].

As a proposed departure from evidence and context-free efforts to Close the Gap, the ESSENCE project was established to develop a systematic approach to addressing inequities in cardiovascular health care based on sound evidence and consensus. This could be used to guide policy decisions, priority settings and effective and sustainable implementation by building upon existing capabilities and resources.

## A Strategy for Closing the Gap

### Focus the Effort

A focus on addressing disparities in cardiovascular care for Aboriginal and Torres Strait Islander people can contribute to closing the gap and be an exemplar for work in other leading causes of illness, mortality and disparate outcomes.

Aboriginal and Torres Strait Islander people experience significantly higher rates of morbidity and mortality from chronic disease [4]. These significantly higher rates result in the substantial health gap experienced by this population. CVD is the main contributor of the health gap, accounting for 17% of the burden of disease, 26% of mortality, and 27% of the mortality gap [4,9]. The incidence and mortality pattern of CVD experienced by Aboriginal and Torres Strait Islander people is characterised by early onset and significant differentials, most notably at young ages [3,4]. Aboriginal and Torres Strait Islander people are more likely to have multiple risk factors than non-Indigenous Australians [10] and disparities in the delivery of health care are evident across the continuum of risk, from prevention, through early detection and treatment, to long-term management [3].

Epidemiological evidence suggests that the gap in life expectancy could be reduced by 37% if Aboriginal and Torres Strait Islander people shared the same CVD mortality profile as non-Indigenous Australians [11]. As such, a focussed effort on reducing disparities in CVD and care can have a significant impact on life expectancy differentials.

### Focus on Translation - Make a Policy-relevant Difference

If we expect the evidence developed within clinical and epidemiological research and health system experience to guide, inform or dictate health policy responses, a focus and commitment to knowledge translation and exchange is essential [12–15]. Increasingly, funders of research and health service delivery are requiring evidence that research can transcend scientific discovery to be implementable in everyday policy and practice, and can ultimately be delivered to those in need with a subsequent impact on population levels of health and wellbeing [15]. Expansion in the fields of translation and implementation science have proffered many frameworks to guide policy translation [12,15,16], yet pragmatic realities of enhancing the transition of evidence to policy would dictate both the involvement of key policy and service partners at the table to guide the development of evidence in its own right, and alignment of existing evidence with the political and policy realities of existing systems.

The Cardiac Society of Australia and New Zealand (CSANZ) convened two critical meetings focused on CVD in Indigenous peoples in 2009 and 2011 [17,18]. In order to augment the translation of existing evidence to policy and practice, CSANZ proposed the development of a set of health system standards to ensure evidence based care across the continuum of risk and disease, that should be accessible and appropriate to all Australians [17]. It was proposed that such

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