

# Chronic Conditions Policy Brief

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## Scope

Chronic conditions contribute significantly to poor health, disability, health service use, and premature death. These conditions often have a long lead time and complex causes. They frequently occur together; this is termed multimorbidity. Physical conditions often occur with mental health problems (see the separate Policy Brief on Mental Health).

The 2017 National Strategic Framework for Chronic Conditions<sup>1</sup> “..moves away from a disease-specific approach and provides national direction applicable to a broad range of chronic conditions by recognising that there are often similar underlying principles for the prevention and management of many chronic conditions ... [it] will better cater for shared health determinants, risk factors and multi-morbidities ...”.

ALSWH undertakes research on chronic conditions across women's life course to understand underlying health risks, and other factors that impact on women's well-being and health care use. A Major Report on Chronic Conditions is available on the ALSWH website. This brief highlights key findings since 2010.

## Research Findings

### Prevalence of chronic conditions

The prevalence of many, but not all, chronic conditions increased with age.

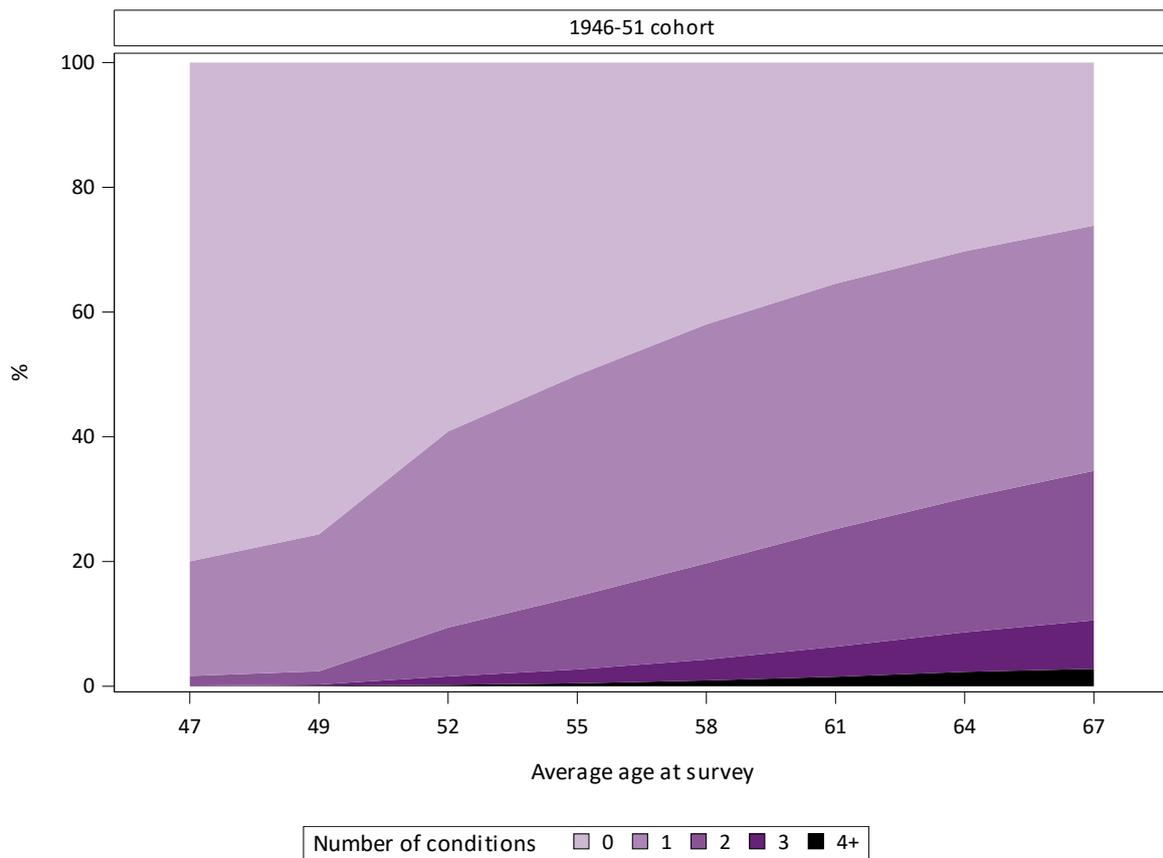
- **Depression** and **anxiety** were more common among younger women than older women and declined with age within each cohort. (More details can be found in the Policy Brief on Mental Health).
- **Asthma** was also more common in younger women than older women, but increased over time in all cohorts.
- Other conditions increased with age, but were also more common in the younger cohorts. For instance, **diabetes** and **arthritis** were more common among women in

the 1946-51 cohort at the age of 67, than among women in the 1921-26 cohort when they were aged 72.

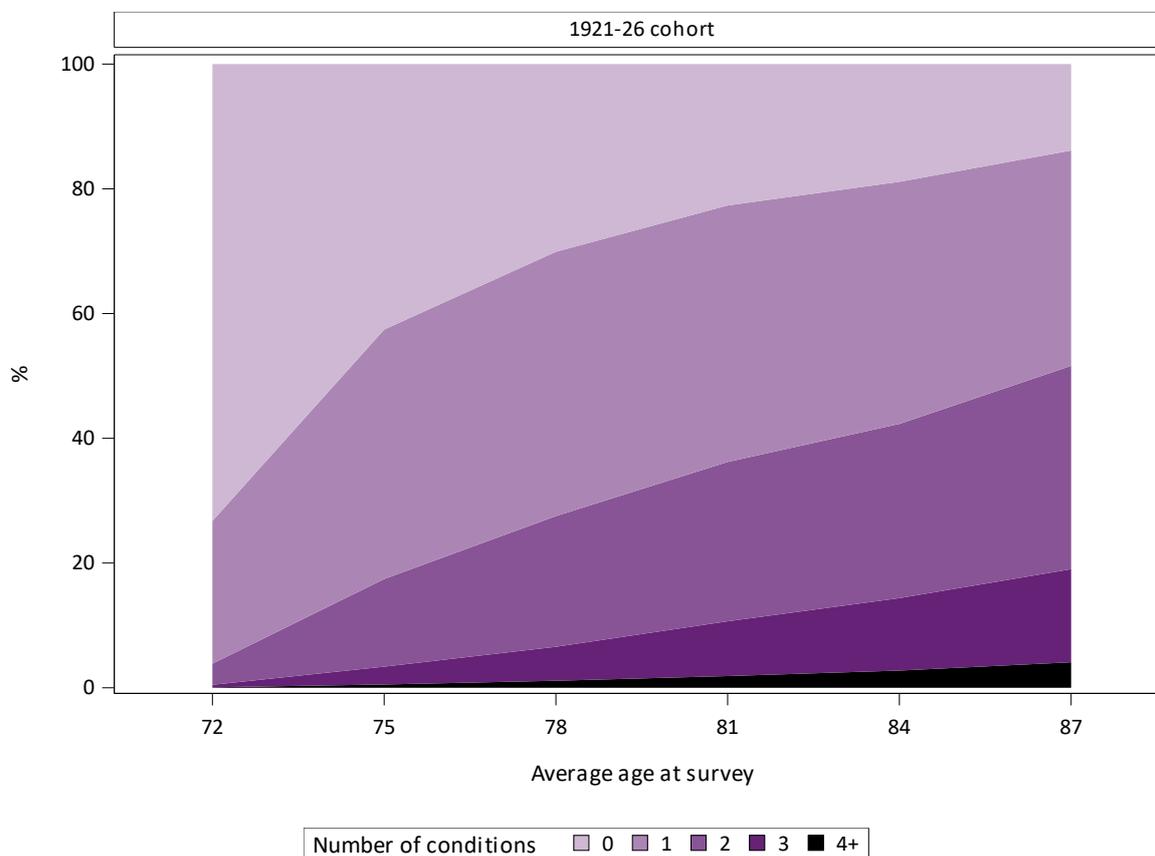
- Prevalence of **dementia** increased rapidly with age to about 25% by ages 85-90.<sup>2</sup>
- Prevalence of **frailty** increased with age, with associated increases in the risk of serious falls, fractures, disability, and death.<sup>3</sup>
- Low socio-economic status was a strong predictor of frailty, although around 20% of women in the 1921-26 cohort remained at low risk of frailty up to the ages of 85-90.<sup>4</sup>
- Between the ages of 73-78 and 85-90, 30% of women had had an **injurious fall**, and 23% had a fall without injury. Those who had had a fall had worse physical and mental health prior to the fall, and further reductions in health-related quality of life after the fall.<sup>5</sup> Other risk factors for falls included functional limitations in activities of daily living, **vision** and/or **hearing impairment**, and hazardous home environments.<sup>6,7</sup>
- **Urinary incontinence** was reported by around 1 in 10 women in their 30s, 1 in 3 women in their 50s, and 1 in 2 women in their 80s. Incontinence was associated with depression among young women;<sup>8</sup> and reduced social functioning in older women (largely due to underlying health problems).<sup>9</sup>

## Multimorbidity

With increasing age, women were more likely to have increasing numbers of chronic conditions (see Figure 1 and Figure 2 below).



**Figure 1. Number of chronic conditions reported by women in the 1946-51 cohort (asthma, heart disease, diabetes, arthritis, stroke and breast cancer) at each survey by average age at that survey.**



**Figure 2. Number of chronic conditions reported by women in the 1921-26 cohort (asthma, heart disease, diabetes, arthritis, and stroke) at each survey by average age at that survey.**

- Multimorbidity was most common among women who were overweight or obese, experienced short-term weight gain (over a 3 year period), and were socioeconomically disadvantaged.<sup>10,11</sup>
- Musculoskeletal conditions were important contributors to multimorbidity.<sup>11,12</sup>
- Having more coexistent conditions was associated with poorer quality of life, more disability and limitations to activities of daily living, higher use of health services, and earlier death.<sup>13</sup>

## Common risk factors

- Many chronic conditions share common risk factors, especially tobacco smoking, being overweight or obese, poor nutrition, inadequate physical activity and harmful alcohol use.
- Prevalence of smoking decreased among younger women, but smoking remained a significant contributor to lung cancer risk.<sup>14</sup> Women who smoked had the same risk of smoking-related deaths as men who smoked.<sup>15</sup>
- Obesity increased, especially among younger women. It was a risk factor for cardiovascular disease, diabetes and cancers<sup>16</sup>, as well as multimorbidity.<sup>10</sup> (See the separate Policy Brief on Weight and Weight Change).
- Physical activity can prevent chronic conditions and reduce their impact. It can improve quality of life and mitigate the adverse effects of overweight and obesity.<sup>17,18</sup> (See the separate Policy Brief on Physical Activity).
- Reproductive factors can affect the development of chronic conditions.<sup>19</sup> For example, menopausal symptoms were associated with increased risk of diabetes and coronary heart disease.<sup>20,21</sup>
- Alcohol use was a significant risk for breast cancer.<sup>22</sup>
- Perceived stress and mental health problems increased the risk for several chronic conditions, including diabetes, stroke and arthritis.<sup>23-25</sup>
- Risk factors for chronic conditions increased with socioeconomic disadvantage.<sup>26-28</sup>
- Living in regional and remote areas of Australia was associated with increased risk of chronic conditions and poorer access to medical care.<sup>29-33</sup>

## Effects of chronic conditions

- Women in their 50s with chronic conditions were less likely to be in paid work and had lower health-related quality of life than women without these conditions.<sup>34,35</sup>
- Women with chronic conditions could live for many years with significant disabilities and functional limitations.<sup>36</sup>
- Chronic conditions were associated with increased health care costs.<sup>28,37,38</sup>

## Prevention and management of chronic conditions

- More than 80% of women born 1946-51 reported screening for cervical cancer (Pap smears), breast cancer (mammography), and having their blood sugar, blood pressure and cholesterol levels checked. Smokers were less likely to have all screening tests. Women with who saw their GPs frequently and had good continuity of care, and those with chronic conditions were more likely to receive regular screening.<sup>39,40</sup>
- Although physical activity provides protection against chronic conditions and may help with their management, a majority of women did not improve their levels of physical activity.<sup>41</sup>
- Medicare items such as complex care plans and annual cycle of care for diabetes or for asthma appeared to be underutilized even by women with multiple comorbidities.<sup>33</sup>
- Most women did not have annual dental checks. Access to dentists, cost of consultations and poor health appeared to be significant factors influencing visits to a dentist.<sup>42</sup>

## Recommendations

- Prevention and reduction of factors, such as smoking and weight gain, that increase the risk of many different chronic conditions is very important. Public health measures to achieve these aims should receive increased attention as they are most likely to reduce the burden of chronic conditions now and in the future.
- There is a need to encourage more women to engage in cancer screening and testing for chronic disease risk factors.
- Multimorbidity requires increased emphasis on integrated person-centred health care, rather than multiple condition-specific management regimens. This is acknowledged in the National Strategic Framework for Chronic Conditions.
- Medicare items for chronic disease management need to be used more effectively.
- Women and their health care providers need to know more about the influence of reproductive factors and gender-specific issues, such as symptoms, in chronic conditions.
- Better access to health services, including dental care, could reduce the health disadvantage experienced by women living in regional and remote areas.

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