

Health care for people with intellectual disability

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TO THE EDITOR: General practitioners play an influential role in the improved health care of people with intellectual disability (ID) through assessment, diagnosis, and development and maintenance of health plans. GPs also help patients access specialist health care and community-based services.¹ Recent initiatives by the International Association for the Scientific Study of Intellectual Disabilities (IASSID) and Medicare Australia have been introduced to develop a national strategy for GPs and other health practitioners in their contribution to the promotion of health care for people with ID.

With the support of the World Health Organization, the IASSID set health targets for people with ID. These in turn contributed to a national strategy for improved health care for people with ID.^{2,3} Medicare Australia introduced Medicare rebates for people with ID on 1 July 2007 (Medicare Benefits Schedule Items 718 ["Attendance by a medical practitioner . . . at consulting rooms for a patient with an intellectual disability"] and 719 ["Attendance by a medical practitioner . . . not being an attendance at consulting rooms, a hospital or residential aged care facility for a patient with an intellectual disability"]).⁴ These rebates aim to provide a structured clinical framework, allowing more time for GPs to spend with patients with ID to assess their overall health and plan for their long-term care, thus improving the quality of service through improved decision making in the context of prescribed medication, specialist referrals and hospital admissions.¹

GPs can implement a health assessment program aimed at enhancing interactions between the adult with ID, his or her carer and the GP through the systematic gathering of a health history and review and, subsequently, development of a health action plan.² To assist GPs in their assessment of patients with ID, Lennox and colleagues have developed the Comprehensive Health Assessment Program (CHAP).² The CHAP is a 21-page booklet, split into two parts. The first part covers the medical history of the patient with ID and is filled out by the patient's carer and brought to the GP. The second part is the CHAP assessment, com-

pleted by the GP. The CHAP assessment involves a review of the medical history, a targeted examination, and assistance for the carer in completing a health action plan. A 1-year post-intervention review has shown a substantial increase in GPs' attention to the health needs of adults with ID, with concomitantly more disease detection.² Thus, these initiatives have demonstrated positive clinical outcomes for this group of patients.

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1 Lennox N, Edwards N. Lessons from the labyrinth. Views of residential care officers on barriers to comprehensive health care for adults with an intellectual disability. Brisbane: University of Queensland, 2001. http://www.som.uq.edu.au/research/qcidd/dual_diag.asp (accessed Jul 2007).

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COMMENT: The research is clear that people with intellectual disability have been receiving inadequate health care. A seminal population study clearly demonstrated that they experience high levels of unmet health need, with 42% of health conditions persistently undiagnosed and half of the conditions that are diagnosed inadequately managed.¹ Their life expectancy is much lower than the general population — about 20 years lower for people with severe disabilities.²

These unmet health needs are partially addressed by the Comprehensive Health

Assessment Program (CHAP) one-off health review. In the only randomised controlled trial of the health assessment process, we found a significant increase in health promotion and disease prevention, and greater case finding.³ We believe the CHAP enhances communication between adults with intellectual disability, their carers and their general practitioners.

The widespread use of an annual health review now afforded by Medicare Australia provides an example of best practice in the health of this neglected group of Australians. This change was achieved after sustained collaborative lobbying driven by the Australian Association of Developmental Disability Medicine and the National Council on Intellectual Disability (New South Wales branch) — an advocacy organisation — and supported by other national medical organisations.

While these changes are welcome, they are not enough, as half a million Australians⁴ (a population at least as large as the Indigenous population) with intellectual disability continue to experience poor health care while being excluded from most generic research. We call upon the Australian Government to act to regularly monitor and assist in the development of strategies to improve the health of this population. Would any other population of this size and health status receive such scant attention in the national discourse?

Competing interests: The University of Queensland owns the CHAP, on which the Medicare initiative was based, and receives a licensing fee from organisations that use the CHAP. One-third of this licensing fee is paid to Nicholas Lennox.

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