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Are we there yet? Closing the gap in indigenous health in Australia: Monitoring clinical performance in Aboriginal and Islander community control health services in Queensland

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Abstract
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largest for BW-WM (51), followed by BW-BM and WW-BM (each with 25 CR events) and lowest for WW-WM (1).

Image/graph I:

**Conclusion:** In an increasing number of counties, HD mortality rates in women are becoming similar to or higher than rates for men. This finding suggests that environmental factors can override female biological protectiveness for HD. The actual causes of these trends are uncertain and deserve definitive examination.

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**Introduction:** Aboriginal people in Australia continue to experience a high burden of chronic disease, including cardiovascular disease. Aboriginal Medical Services (AMSs) are a significant component of the effort to reduce this burden and must be supported to deliver the highest quality care. **Objectives:** To evaluate clinical health care performance in Queensland Aboriginal and Islander Health Council (QAHC) member Aboriginal Medical Services (AMSs) in Australia. **Methods:** In October 2009, AMSs in Queensland began to use a standard indicator set, the QAHC Core Indicators, to monitor recorded prevalence and management performance on a number of key risk factors, clinical care activities and chronic diseases. Data is extracted monthly from clinic electronic medical record systems (EMRs) and submitted to a web based portal for services to review their performance over time and benchmarked. A copy of the data is also sent to the OAHC data repository to allow agreed secondary analysis to occur. In July 2011 longitudinal data was analysed to examine trends in the number of participating services, proportion of patients with current recording of key health care activities and the prevalence of risk factors and cardiovascular disease. **Results:** From October 2009 to July 2011, AMSs sending data for the QAHC Core indicators increased from 6 to 15 participants; the number of patients for whom data was captured increased from 10,800 to 26,004 of whom 19,634 (75.5%) were regular Indigenous patients in July 2011. The aggregated performance of participating services captured increased from 6 to 15 participants; the number of patients for whom data was increased from 6 to 15 participants; the number of patients for whom data was.

**Conclusion:** These data provide objective evidence that cardiovascular research output has substantially increased in Argentina, India, and South Africa over the past decade. Potential reasons for these increases, as well as reasons for differences in ACI across the three countries, merit further investigation.

The level of HDL in patients with CAD comparing to patients with normal coronary in the Arab and eastern population comparing to the western population

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**Introduction:** It is well known that elevated LDL has a significant risk factor for developing CAD. There is a large number of studies to confirm that association, however, low HDL has been proposed as a risk factor for CAD but there is only limited number of data in that regard, especially in the Middle East. **Objectives:** To evaluate the prevalence of low HDL in patients with CAD by angiogram comparing to the level of HDL of patients with normal coronary. The analysis includes the ethnicity and sex of the subject. **Methods:** Chart review and angiogram review of all patients who underwent coronary angiogram at a single center in Dubai. Every patient who underwent angiogram will retrieve his/her lipid profile which was done just before or after angiogram. Also included in the study are the demographic data of the patients. The patients were divided into Easterners and Westerners. The Eastern group includes people from the Middle and Far East. The Western includes Europeans and Americans. **Results:** The total number of patients in the study was 635. 473 were males, and 162 were females. 444 were Easterners, 191 were Westerners. Mean age for males was 54, and 61.7 for females. Mean age for Easterners was 56.7, and 54 for Westerners. For subjects with normal coronary the mean LDL,HDL values for Easterners: 2.95,1.25, Westerners: 3.18,0.9 (p = 0.4,0.067). For subjects with abnormal coronary the mean LDL,HDL values for Easterners: 2.82,1.10, Westerners: