

Chronic disease self-management approaches within the complex organisational structure of a health care system

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Self-management has the potential to reduce the burden of chronic disease — but it needs to be integrated into the health system

The interesting collection of articles in this supplement focuses principally on issues in Australian health care. However, this does not limit its generalisability — the points addressed cover a variety of issues that health care systems around the world are facing, and will face, as they attempt to promote and incorporate self-management approaches within the complex organisational structure of a health care system.

Making the case for a need to ensure adequate resources to support those with chronic conditions, Jordan and colleagues argue that although preventive health is important, it needs to be balanced with support for people who have a chronic condition (page S9).¹ To strengthen this point, they provide estimates of the large numbers of people with long-term conditions. Such estimates are subject to a range of methodological issues, such as the validity of self-report compared with doctor diagnosis,² and varying definitions of chronic disease. Jordan et al define a condition as “chronic” if it lasts 6 months or more, and consequently estimate that 77% of Australians have a long-term condition.¹ Regardless of the definition used, it is accepted that a large proportion of the population have at least one long-term condition, and the rate is likely to increase as the population ages, with a consequent increase in cost pressures.³

The organisational issues confronting attempts to mainstream self-management are discussed in a number of the articles in this supplement. Jordan et al emphasise that policymakers need to appreciate that support is not only required at a patient level, but also must be directed towards health care professionals, particularly primary care physicians.¹

The importance of primary care is considered in detail by Harris and colleagues, who rightly stress the difficulty of integrating self-management support with primary health care (page S17).⁴ They highlight that many self-management programs are conducted by services separate to primary care. As a result, these programs have different organisational responsibilities, financial structures and management lines. These factors all militate against the easy integration of self-management into mainstream care. Achieving integration requires new models of practice, which in turn will require new ways of working for health care professionals, who will need specific training in the skills to deliver self-management interventions. The importance of obtaining health care professional “buy-in” to self-management and acceptance of changing roles and practice constitutes possibly the largest impediment to integrating self-management into routine health care.⁵

Acceptance of self-management revolves around the accumulation of robust evidence to persuade policymakers and health care professionals of its value. Rogers and colleagues examine the evidence for the effectiveness of the Expert Patients Programme in the United Kingdom (page S21),⁶ which used an adapted version of the Chronic Disease Self-Management Program.⁷ Rogers et al demonstrate that this program had only limited effectiveness.

These data raise the important issue of a program's ability to transfer from one culture to another and to adapt to differing structures and organisational demands in health services around the world.

The limited effectiveness of the Expert Patients Programme on outcomes other than psychological measures is emphasised in an exploration of self-management for osteoarthritis (see Brand, page S25).⁸

One important detail that self-management programs often fail to adequately address is the link between the outcome being assessed and the specifics of the program. Psychosocial outcomes are appropriate if the program is directed to improve psychological wellbeing or increase patient confidence; if the aim is to reduce symptoms, this should constitute the primary outcome. There has been a tendency to look to self-management programs to improve all types of outcomes, regardless of the aim and content of the program.⁹

The utility of any self-management program is also influenced by its acceptability and perceived potential value to patients. One limiting factor, discussed in a number of articles in this supplement, is health literacy. Glasgow and colleagues see health literacy as necessary for patients to benefit from self-management programs and to seek, access, comprehend and use health information (page S14).¹⁰ If this important issue is not addressed, a potential unexpected consequence of some programs is the possibility that they will increase health inequalities. The Expert Patients Programme attracted mainly middle-class participants, which emphasises the importance of health literacy and the need for programs to be attractive and accessible to all members of the community.

Buchbinder makes the case for the use of population-based media campaigns using the example of a back pain program, Back Pain: Don't Take It Lying Down, in Victoria (page S29).¹¹ This and other mass media interventions directed at back pain have generally shown evidence of positive results. The particular characteristics of back pain and the tendency to avoid behaviours (fear avoidance) make it particularly amenable to mass media campaigns. The extent to which other conditions such as rheumatoid arthritis or diabetes will respond to such campaigns remains to be examined, as each condition appears to create different demands on self-management interventions.⁹ There is, however, great value in utilising the mass media as a tool to influence the context of chronic disease by changing public and employers' attitudes. A mass media campaign in combination with the widespread introduction of self-management interventions is a route that needs to be developed in the future.

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