

Managing chronic disease: recent trends and implications for general practice

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Themes

- Trends in chronic disease
- Implications for health care
- Models for management
- Policy experiments in primary care
- Where next?



Trends in chronic diseases

- Increasing worldwide

- Ageing populations

 - Over 65s +82% by 2020

- CVD most common cause of disability

 - 300% increase in deaths in low & middle income countries by 2020

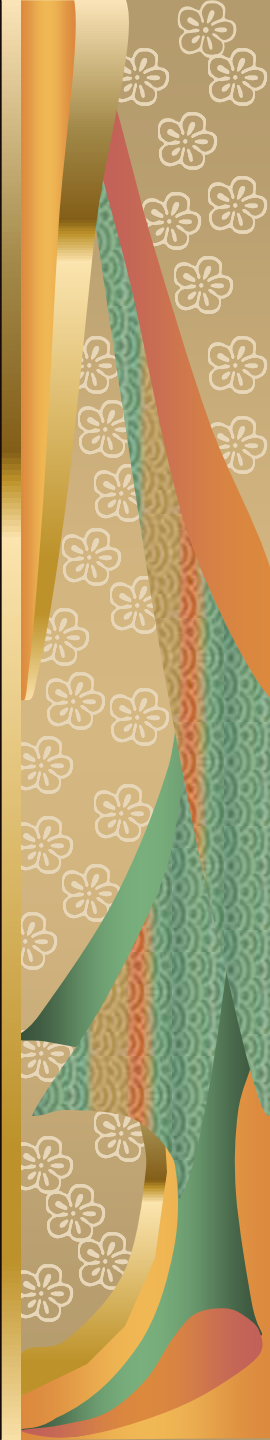
- Diabetes

 - 2.8% to 6.5% (366m) by 2030

- Arthritis



 - 3 in 10 Australians

- HIV as a chronic disease





Impact on societies

Direct costs

-  >70% health care spending in USA
-  c67% (>\$35b) in Australia 2000-01

Indirect costs

-  Employment, carers etc
-  costs set to rise exponentially in low and middle income countries



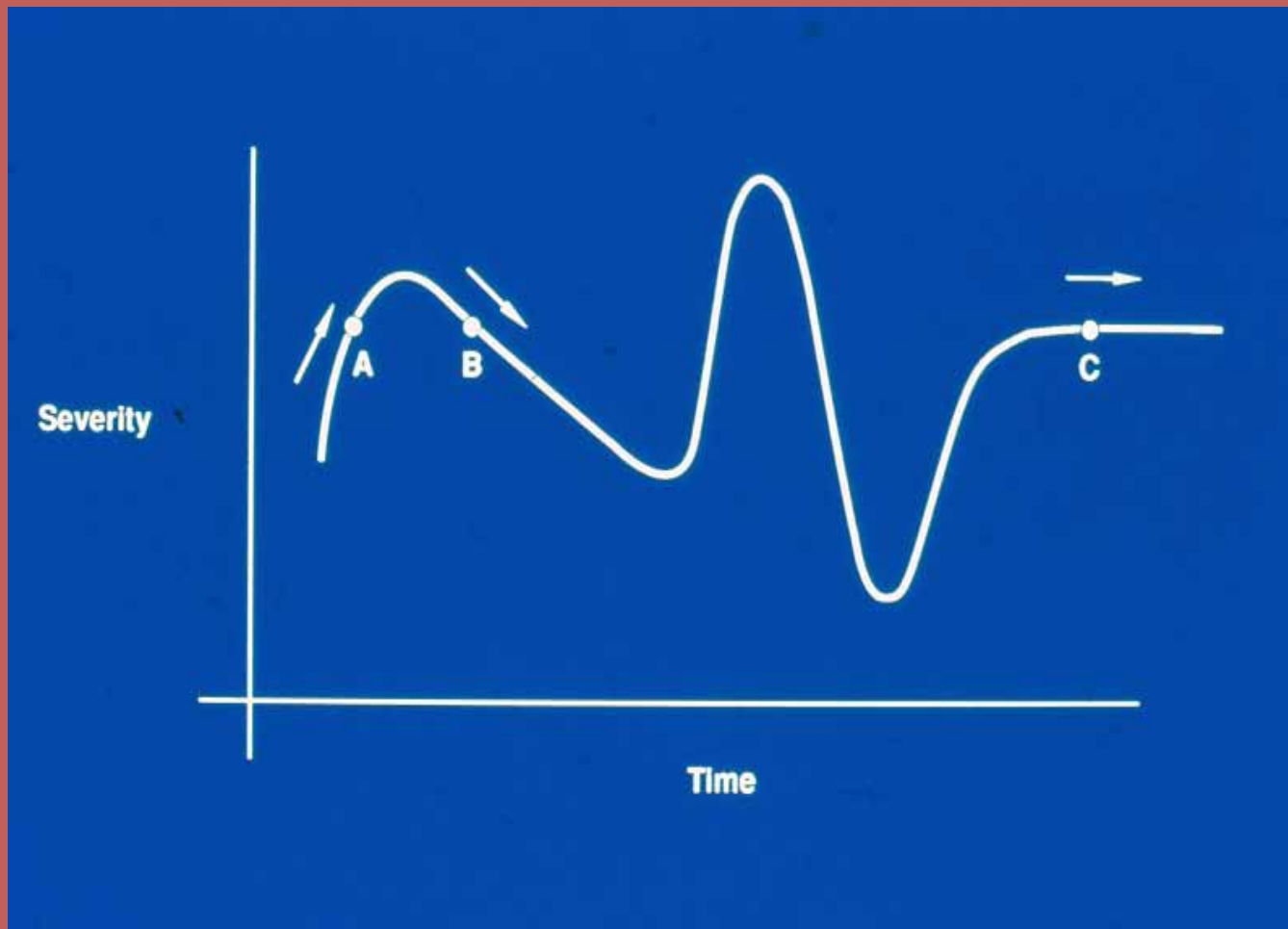
Impact on individuals

- Persistent symptoms
- Continuous medication use
- Behaviour change
- Change in social and work circumstances
- Emotional distress
- Responsibility to interpret effects of the disease and treatment
- Responsibility to participate in decisions

■ Holman, *Chronic Illness* 2005



Impact on individuals



Holman, *Chronic Illness* 2005



What do patients want?

- Access to information
- Continuity of care
- Coordinated care
- Management of symptoms
- Management of consequences



Impact on health professionals

- Education > treatment
- Site of care
- Teamwork
 - Health professionals
 - Patients and carers
- Relationships
 - Reciprocal not hierarchical
- *Ideal for primary care!*






Models for managing chronic diseases

Low and middle income countries

WHO Global strategy

-  Epping-Jordan et al, Strong et al, *Lancet* 2005

High income countries

Chronic care model

Self-management



Chronic care model

■ Key components

- register of patients
- electronic medical record
- individual management plans
- self-management education programs
- group meetings of patients and health professionals
- remote management capabilities
 - e.g. Wagner et al, *Health Aff* 2001



Chronic care model





Limitations

- ❏ applicability outside managed insurance-based systems?
- ❏ when the money runs out
 - Oregon: Solotaroff et al, *Chronic Illness*, 2005
- ❏ extension beyond evidence
 - e.g. depression
- ❏ iatrogenic potential
 - Incentives for chronicity
 - 'acting under description'






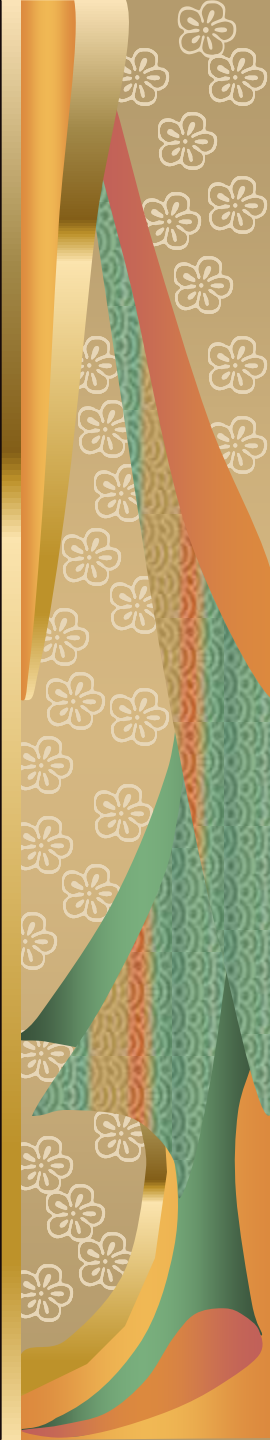
Self-management

Stanford model

-  Peer leadership
-  Shared experiences and collective problem solving
-  UK 'expert patient programme'
 -  Funding to be trebled

Flinders model

-  Clinician-led
-  Education and training for primary care
-  Tools for health practitioners to support patients

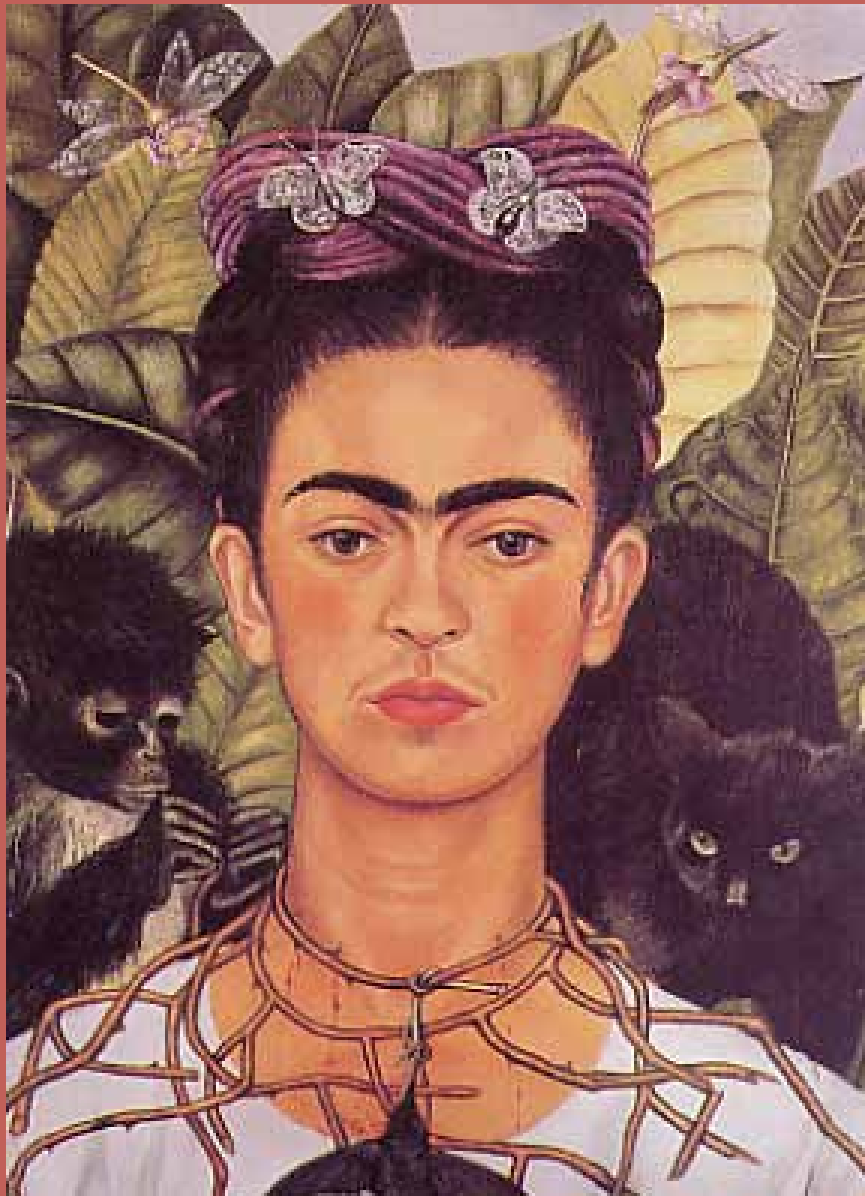


Self-management

Issues

- ❖ Most eligible people do not enrol
- ❖ Increasing inequity?
 - Foster *et al* AJPB 2003
- ❖ Does knowledge equate to self-management?
- ❖ Patient expectations of physicians
 - Heisler *et al*, *Diabetes Care* 2005
- ❖ Mutual support or mutual despair
- ❖ Empowerment, or abdication of professional responsibility?
 - Salmon & Hall, *J R Soc Med* 2004





Policy experiments in primary care


- UK Quality and Outcomes Framework (QOF)
- Australian National Chronic Disease Strategy (NCDS)



QOF

1050 quality points

-  clinical: mainly for chronic diseases

 -  10 disease areas, including CHD, stroke, hypertension, diabetes, asthma

-  organisational

-  additional services

-  patient experience

Points = finance

-  c30% of practice income



QOF hypertension

- 9 points: HT register
- 10 points: % HT patients with smoking status recorded
- 10 points: % HT smokers advised re quitting
- 20 points: % HT patients with BP recorded in last 9 months
- 56 points: % HT patients with BP <150/90



QOF issues

Quality improvements

Primary care can deliver

- High yield QOF points 2004-5
- Campbell et al, *BMJ* 2005
- McElduff et al *Qual Saf Health Care* 2004

Problems

- disincentives
- game-playing
- 'outsourcing' of chronic care
- multiple providers







NCDS

Five chronic disease groups

-  asthma
-  cancer
-  diabetes
-  CVD
-  arthritides




Multi-layered strategy

-  Prevention
-  Early intervention
-  Integration and continuity
-  Self-management



NCDS

Issues

-  Mental health integrated not specified
-  Emphasis on individual rather than structural interventions
-  Resource allocation



NCDS and primary care

- Early detection
 - Registers and recall systems
 - Public awareness
- Integration and continuity
 - EPC care planning
 - Electronic patient information systems
 - Information on local services
 - Standardised procedures
 - Links with self-management



NCDS and primary care

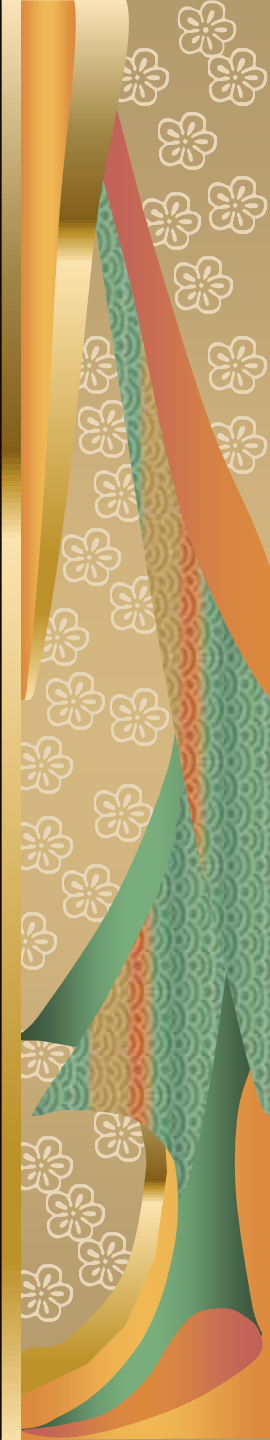
■ Mismatch evidence and policy

■ Problems with realigning a fee-for-service system

- e.g. Asthma 3+
 - \$30m 2001-5
 - but few CD registers or systematic coding
 - low practice recruitment 40/942 i.e. 4%
 - » Beilby & Holton, *Chronic Illness* 2005.






■ Increasing inequity

- Guidelines used as a tool to disengage from (socially disadvantaged) 'problematic' patients
 - Furler & Young






Where next?

Economics

-  managing inequalities
-  resource allocation
 -  state or federal
 -  private sector
 -  funding models in general practice

Organisational

-  Movement towards managed care systems
 -  Information infrastructures
 -  Multi-disciplinarity



Where next?

Education & training

For patients and carers

- reviewing self-management

For health care professionals

- chronic conditions
- pain
- psychological and social aspects
- needs of caregivers
- co-ordination and teamwork



Where next?

Research

Need for new conceptual models

Healthcare as a *complex adaptive system*

- e.g. RE-ORDER

Normalisation

- Interactional workability
- Relational integration
- Skill-set workability
- Contextual integration

May et al, in press



