Managing chronic disease: recent trends and implications for general practice

Australian Primary Health Care Research Institute
Canberra
6 February 2006
Christopher Dowrick

Professor of Primary Medical Care
University of Liverpool, UK

Editor, *Chronic Illness*

cfd@liv.ac.uk
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 AJPH 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, JR 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

<table>
<thead>
<tr>
<th>Points</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>HT register</td>
</tr>
<tr>
<td>10</td>
<td>% HT patients with smoking status recorded</td>
</tr>
<tr>
<td>10</td>
<td>% HT smokers advised to quit smoking</td>
</tr>
<tr>
<td>20</td>
<td>% HT patients with BP recorded in last 9 months</td>
</tr>
<tr>
<td>56</td>
<td>% HT patients with BP &lt; 150/90</td>
</tr>
</tbody>
</table>
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%

- 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