

Self-management of long term condition



The NHS was created out of the ideal that good healthcare should be available to all, regardless of wealth. The values associated with universal health care rank high in the public regard (Appleby and Alvarez-Rosette 2005). Throughout the period covered by the British Social Attitudes Survey (1983-2005), large majorities throughout the UK have put it as the highest-priority area of government expenditure for extra spending (Park et al. 2005). This societal attitude may be at risk due to the looming crisis that long term conditions pose the country.

Long-term conditions, by definition, are often not immediately life threatening and place substantial burdens on the health, economic status and quality of life of individuals, families and communities (Centre for disease control and prevention, 1997). Living with illness usually results in a disturbance of normal existence. It creates a level of uncertainty as a result of possible illness progression or recurrence, difficult treatment side effects and complications (Ledeboer et al., 2005). Healthcare systems were initially designed to respond to acute, episodic illness. However, healthcare systems are increasingly being called upon to care for patients with ongoing conditions, where the goals include preventing complications or deterioration rather than cure (Zuvekas and J. W. Cohen, 2007).

Chronic diseases are those that can only be controlled and not, at present, cured. They include diabetes, asthma, arthritis, heart failure, chronic obstructive pulmonary disease, dementia and a range of disabling neurological conditions. The care of people with chronic conditions also consumes a large proportion of health and social care resources. People with chronic conditions are significantly more likely to see their GP (accounting for

about 80% of GP consultations), to be admitted as inpatients, and to use more inpatient days than those without such conditions (QUOTE). The World Health Organisation has identified that such conditions will be the leading cause of disability by 2020 and that, if not successfully managed, will become the most expensive problem for health care systems.(QUOTE). The emergence of chronic disease as the largest threat to health status and the largest cause of health expenditure has caused a dramatic rethink in the way that the NHS views patients suffering from chronic conditions (Wanless Report, 2002). The obvious flaws of a paternalistic approach to managing long term conditions has resulted in self-management programmes becoming an increasingly popular solution for people suffering from long term conditions. The solution appears to present obvious benefits to patients and health care providers (Better health for patients, lowering the number of acute episodes, reducing health care use and long term savings to name but a few) (Lorig et Al, 1999; Jordan & Osborne, 2006). Self-management programmes are commonly used to help patients learn the skills to manage their own conditions better. Health care providers have directed considerable resources to support and run such programmes. This embracing of self-management has occurred despite a still considerable debate as to the effectiveness of these programmes.

This paper will make the case that self-management is both possible and desirable and that even if self-management is not currently delivering the cost savings envisaged, the benefits to patients outweigh any lingering concerns about value for money. To achieve this aim, this paper will examine the reasons behind the promotion of self-management as a tool, its ability to

empower and increase participation, its importance in developing self-efficacy and the consequent role that self-efficacy plays in ensuring patient satisfaction and ethical treatment. This paper will argue that the literature presents a clear and compelling case that, self-management interventions make it possible to improve patient self-efficacy, promote patients' involvement in the decision making process and provide greater patient satisfaction, and that these results are desirable for healthcare organisations.

Background

The UK government has regularly attempted to tackle the so called 'democratic deficiency' of the NHS and create a more patient-centred NHS (QUOTE). This move away from a paternalistic system of care to a more consumer based model underpins the notion that the " patient, and not the provider, will be king" (QUOTE). This change reflects the growing acceptance that the NHS must meet the needs of patients, carers and the public, whilst also involving patients, carers and the public in its development. " create a generation of patients empowered to take action to improve their health"(QUOTE). There have been numerous attempts to engage people (patients included) in the decision making process ever since the creation of Community Health Councils (CHCs) in the 1970s (Lupton et al., 1998). The Wanless report (2002) called for a new focus on moderating demand by investing in effective health promotion and disease management with the active involvement of individual patients and local communities. This drive for involvement and empowerment is also reflected in the Expert Patient

Programme (EPP), which was first announced in Saving Lives: Our Healthier Nation (DoH 1999).

The Expert Patient Programme (EPP) is an NHS initiative that was launched in 2002 to help patients with chronic conditions to take control of their lives. These have subsequently been superseded by (NEED INFO) The programme is a training course that teaches people how to manage their conditions by using five core skills (problem solving, decision making, making the best use of resources, developing effective partnerships with healthcare providers, taking appropriate action). The majority of Expert Patients Programme courses are delivered by trained tutors who have personal experience of living with a long-term health problem. Courses usually run over six weekly sessions and include topics such as dealing with pain, extreme tiredness, coping with feelings of depression, relaxation techniques, exercise, healthy eating, communicating with family, friends and health care professionals and planning for the future (QUOTE). There is a common core of self-management tasks that cuts across specific illness categories. These include, but are not limited to, recognizing and responding to symptoms, using medications, managing acute episodes, maintaining diet and physical activity, smoking cessation, managing relations with significant others, and managing the psychological responses to illness (Clark et Al 1991).

Is self-management possible?

Corbin and Strauss (1988 Unending work and care) identified three tasks that people living with chronic conditions face on a daily basis over the course of a lifetime. These are:

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Medical: management of the condition (taking medication, changing diet, or self-monitoring blood sugar)

Social: Creating and maintaining new meaningful life roles regarding jobs, family and friends

Emotional: Coping with the anger, fear, frustration and sadness of having a chronic condition.

Courses in self-management are attempting to provide the tools for patients living with chronic conditions to tackle these issues. Self management has been defined as: “ the individual’s ability to manage the symptoms, treatments, physical and psychological consequences and life styles changes inherent in living with a chronic condition” (Barlow et al 2002). It is therefore impossible to disassociate self-management from behavioural change theories as patients are expected to change their behavioural patterns in order to maximise positive outcomes. Indeed, it is accepted that health-compromising behaviours can be eliminated by self-regulatory efforts, and health-enhancing behaviours can be adopted instead, such as physical exercise, weight control, preventive nutrition, dental hygiene, condom use, or accident prevention. (Schwarzer & Luszczynska, 2008). Self-Management programmes are attempting to develop a change in participant’s behaviours in order to allow them to take control of the management of their condition.

Self-management programmes have incorporated social learning theories and social norm theories. Social Cognitive Theory (formerly Social Learning Theory) postulates that behaviors can be predicted and explained using expectancies and incentives. Individuals who value the perceived effects of

changed lifestyles (incentives) will attempt to change if they believe that (a) their current lifestyles pose threats to any personally valued outcomes, such as health or appearance (environmental cues); (b) that particular behavioural changes will reduce the threats (outcome expectations); and (c) that they are personally capable of adopting the new behaviours (efficacy expectations) (Bandura, 1977; 1982; 1986; 1997). The social norms theory is also important to the success of self-management programmes in changing behaviours. The approach provides a theory of human behaviour that has important implications for health promotion and prevention. The theory predicts that overestimations of problem behaviour will increase these problem behaviours while underestimations of healthy behaviours will discourage individuals from engaging in them (Perkins and Berkowitz, 1986). In essence, this theory claims that interventions based on social norms theory focus on the healthy attitudes and behaviour of the majority and try to increase it, while also using information about healthy norms to guide interventions with abusers. Self-management groups led by tutors who have experience of living with a long term condition also allows patients to challenge the belief that 'being unable to self-manage is the norm'. Research has clearly established that social norms not only spur but also guide action in direct and meaningful ways (Terry & Hogg, 2001).

The place of the 'expert patient', which acknowledges that patients assume an active role in the management of their conditions and the importance of assisting and empowering patients to take more responsibility for their health care and outcomes, has also been emphasised as an important component of self-management programmes. Kaplan and Brennan argue

that when patient and clinician work in partnership to develop a common understanding of the patient's values, preferences and needs, and work towards the common goals of optimum healing and recovery, the result is an increase in quality of healthcare (QUOTE). This role requires patients to engage and actively participate with healthcare professionals. As already noted above, the teaching of self-management skills is not enough to bring about change in behaviour, and to truly engage, patients are required to achieve a level of self-efficacy. People develop a sense of self-efficacy which plays a part in determining which activities or situations a person will perform or avoid. Self-efficacy has been defined as: " people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives." (Bandura, 1994: 71). Self-efficacy (or the self-perception of having skills to perform a behaviour) is a well recognised and powerful predictor of health-related behaviour changes (Bandura 1978). Self-efficacy is therefore the key to ensuring that self-management is possible.

Is Self-management desirable?

A common aim of all models of self-management programmes is to increase patients' involvement in care by teaching them to develop and articulate their personal care goals, thereby fostering greater adherence to complex self-care regimens. As noted above, this common aim is possible to achieve and requires developing self-efficacy within patients. This section will now focus on why this aim of involvement is desirable from a ethical and practical point of view.

The ethical principle of 'respect for autonomy' requires that the patient with decisional autonomy be accorded authority over what will or will not be done regarding his or her medical care (Beauchamp and Childress 2001). This principle of autonomy is of heightened significance when patients, suffering from chronic conditions, have to make choices that affect their condition(s) outside of a health professionals office. In England alone, there are now nearly 10 million people with a chronic disease (QUOTE). If all 10 million were patients were unable or unwilling to make health decisions without consulting a health professional, then it would be a safe assumption that this would place an unbearable strain on resources, crippling or even killing the system.

Redman argues that to ethically deal with chronic conditions, patients and families must undergo a process of learning to manage it and its symptoms, to deal with it emotionally, and to regain a life of coherence and integrity (Redman 2005). Indeed, it has become increasingly recognised that the knowledge and expertise gained by patients living with conditions is redefining the health professional / patient relationship (Holma & Lorig 2000). However, health professionals have taken an ambivalent view as to the value of self-management programmes for patients. The ethical debate of autonomy has been found to clash with professional responsibility and accountability. Concerns have been raised by GP's which suggest that GPs themselves need to feel in control to fulfil their professional responsibilities (Blakeman et Al 2006).

With the introduction of consumerism-like ideas in the NHS, patient satisfaction has gained widespread recognition as a measure of quality.

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Patient satisfaction has become a key principle of the National Health Service (NHS) and most recently has been emphasised in the NHS Constitution. It has often been argued that by increasing the role of patients, health care providers should become more responsive to patients' needs and preferences and deliver better quality care (Wensing 2000). A patient-centred approach should be responsive to the values, needs and preferences of patients (Hibbard, 2003); respect for and incorporation of patient values may be used to inform both the provision of care and evaluation of patient experience, providing a basis for improving service delivery.

Discussion

Research conducted into the effectiveness of self-management has so far produced mixed results. On the one hand, there have been consistent positive findings into the value that self-management courses provide over information/education only events (Bodenheimer et Al, 2002) and Lorig et al (1999) found that self-management interventions were feasible and could be beneficial “ beyond the usual care in terms of improved health status, and can decrease hospitalisation with a potential of substantial savings in health care costs”. On the other, a number of trials have not provided conclusive evidence that self-management programmes are effective for all patients suffering from chronic conditions (Jordan & Osbourne, 2006) and only limited findings as to the validity of claims made as to the physiological benefits of self-management programmes (Chodosh et Al, 2005). It is also worth noting that in studies where positive results for self-management have been found, potential publication bias has been regularly reported. The difficulty in

identifying which components of self management programmes are effective, have added to the confusion surrounding its effectiveness.

Comparing results on the effect of self-management in asthma patients exemplifies this dilemma. A Cochrane review reported that although self-management interventions had little effect on lung function overall, this outcome was better in those who adjusted their medication using a written plan than in those whose medication was adjusted by a doctor (Cochrane QUOTE). In another review, some improvement in lung function was noted, although the self-management intervention varied (five of eight used a combination of education with an action plan, one used a writing intervention for emotional expression and one a stress management intervention) (QUOTE).

In the case of diabetes, for which glucose control is a key component of self management , reviews of studies into the effect of self-management programmes have shown that 11 (61%) of 18 of the studies that measured glucose control showed some evidence of effectiveness at some point. Long-term positive results were found to have used different self-management techniques. Two used problem-solving amongst other components, whereas a third used an approach that emphasised stress management (QUOTE). Seven of 13 diabetes studies that measured the effect of SMIs on self-management behaviours indicated some change compared with a control group, and four further studies showed changes in behaviour over time. Alterations in diet and exercise were the most frequently measured behaviours. The findings suggest that changes in behaviour do happen after SMIs for diabetes, and are similar to those reported in the review by Norris <https://assignbuster.com/self-management-of-long-term-condition/>

and others, who found a positive effect of self-management training on self-care and lifestyle behaviours. (QUOTE)

The most commonly reported clinical outcome in arthritis was physician's assessment of the number of painful and swollen joints. The studies that found improvements used a diverse range of techniques cognitive behavioural therapy, expressive writing, and a programme delivered by mail (QUOTE). Of 12 studies that assessed changes in behaviour for arthritis, ten reported some evidence of change. Seven showed increases in exercise, joint protection, or both, compared with controls, and two showed changes over time in these behaviours. Most of these interventions were based on a social-learning approach (QUOTE).

Superficially, this pattern suggests that different self-management techniques can lead to similar outcomes. This reflects the range of theories about what will help people achieve self-management and a diverse population for whom different individual goals and processes may be appropriate. This diversity has implications for the selection of evaluation approaches and tools. Unfortunately, the research is currently solely focused on measurable quantitative data,

Conclusion

This paper has presented the case that self-management is both possible and desirable. The evidence suggests that self-management is a key component to the future direction of the NHS. It offers an effective solution to multiple problems. From a patients perspective, self-management offers

an opportunity to learn effective tools to help them overcome the difficulties associated with living with chronic conditions.

More research is needed concerning the long-term interaction between disease-management programs and healthcare costs. There is at present little significant data to back up the intrinsic belief that self-management does lead to better health and lower costs.