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APHCRI LINKAGE & EXCHANGE TRAVELLING FELLOWSHIP REPORT

Stream Four Report: A systematic review of chronic disease management

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CHRONIC DISEASE MANAGEMENT - THE UNITED KINGDOM CONTEXT

Health policy makers in Australia and the United Kingdom have focused on the increasing role of primary health care in the management of people with chronic disease. The approaches taken by the two countries have varied mainly because of the differences in the way primary health care is organised and funded. Many of the Australian policy options arising from the key findings of the chronic disease management review focused on support to improve practice level data and payment systems to facilitate greater multidisciplinary team care to support self-management. This is in contrast to the UK where high quality practice level data are used to monitor and reward chronic disease management through the Quality and Outcomes Framework [1]. In addition to this, the payment system for UK primary health care favours a multi-disciplinary approach to chronic disease management.

SELF-MANAGEMENT SUPPORT

There is still a need to more firmly embed self-management support in primary health care in the UK as there is in Australia. Programs such as the Expert Patients Programme (EPP) have been successful at recruiting patients and recent evaluations suggest that it is a useful addition to the services on offer for people with chronic disease [2,3]. However, the EPP is run by the Primary Care Trust (PCT) and may not involve the General Practitioner or have the full support of the GP. In addition to this there has been poor recruitment of people from ethnic minority groups or low socio-economic class, missing many of those most in need of self-management support [3].

In discussions with PCT Long Term Conditions Commissioning Leads in the West Midlands it was felt that patients were still being given mixed messages and inconsistent advice about the self-management of their condition. One of the PCT members described an ideal patient pathway from diagnosis and then referral to self-management support and multidisciplinary team care with every member of the multidisciplinary team providing consistent information and advice. There is clearly a role for Government and non-government organisations in working together to ensure consistent information is provided for use by health professionals and patients both in the UK and Australia.

DECISION SUPPORT

Practice level data in the UK have improved since the 1990s and are used extensively in quality improvement for chronic disease management. The Quality and Outcomes Framework (QOF) uses practice level data to assess GP performance in terms of achieving benchmarks for the management of a variety of chronic conditions. GPs have been successful at achieving the benchmarks and as a result payments to GPs have increased [4]. The program has been criticised for emphasising process outcomes and not patient level outcomes [5] and also for promoting a mechanistic "box ticking" approach to patient care. In spite of the criticism of the QOF the experience in the UK highlights how practice level data might be used to support chronic disease management and encourage or reward guideline-based care. It would be useful to explore what impact the QOF has had on patient level health outcomes and how to ensure that patients with highly complex conditions or combinations of co-morbidities might be included.

Practice nurses play an important role in the management of chronic disease in the UK. In general they are well trained, however, a recent survey of practice nurses providing respiratory care found that 20% of nurses providing advanced level asthma care had not undertaken accredited training and this rose to 52% of those providing advanced Chronic Obstructive Pulmonary Disease care [6]. In spite of the increased role of the practice nurse in the UK compared to Australia, improving nurse education in the management of chronic disease and self-management is still an important policy option for the UK as it is here.

CLINICAL INFORMATION SYSTEMS

In addition to the QOF, data are used to enable practices and PCTs to plan their chronic disease management services at a local level. The Patient At Risk of Re-hospitalisation (PARR) software was developed by the University of York and Health Dialog and is available free for PCTs to download from the Kings Fund website [7]. This program uses hospital and community data to predict which patients are likely to be at risk of readmission so that interventions can be targeted and hospital admission prevented. An example of an intervention to prevent hospital admission is the development of a "virtual ward" where high risk patients are intensively managed in their own home by a multidisciplinary team of health professionals [8].

DELIVERY SYSTEM DESIGN

Practice nurses play an important role in the management of chronic disease in the UK and the funding system for UK primary care supports the delegation of some chronic disease management roles from GPs to practice nurses. The multidisciplinary team care approach to chronic disease management has also extended to special health centres that exist as a "halfway house" between primary and secondary care, an example is the Partners in Health Centre in North East Birmingham [9]. The program has not been evaluated to assess the impact on health outcomes and service use. The model has drawn heavily from the Kaiser Permanente model of care for people with long-term conditions and is linked closely with practice-based commissioning. The challenge for both Australia and the UK is to ensure that health professionals are well trained to provide multidisciplinary care and have access to high quality and consistent information. If services are not developed with the support of general practice they may duplicate practice services and may not have the buy-in of the patient's GP.

SIGNIFICANCE OF THE FINDINGS FOR AUSTRALIA

Chronic disease management in the UK has drawn heavily from the United States managed care organisations, such as Kaiser Permanente, and has taken a multidisciplinary team approach to patient care, which has been successful. The QOF has established that benchmarks can be met using a variety of primary health professionals. The challenge for Australia will be to embrace the increasing use of multidisciplinary team care with a funding structure to facilitate this. A key feature of many of the programs and achievements in the UK has been the existence and use of high quality and comprehensive practice level data. Practice data of this quality and scope

are not widespread in Australia. Support for practices to improve their practice level data will enable policy makers and health professionals to monitor the process and outcomes of care. In both Australia and the UK it is important that programs to support the management of chronic disease are developed with the full support of general practitioners and that the members of the multidisciplinary team compliment, rather than duplicate, one another.

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