Looking after yourself: Clinical understandings of chronic-care self-management strategies in rural and urban contexts of the United Kingdom and Australia

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Abstract

Objectives: This article reports on the outcomes of two similar projects undertaken during 2011–2012 in Australia (Rural Northern New South Wales) and the United Kingdom (Urban Northern United Kingdom) that sought to identify the strategies that health professionals employ to actively involve patients with chronic conditions in the planning and delivery of their care. In particular, this study explored understandings and contexts of care that impacted on the participants' practices. This study was informed by the global shift to partnership approaches in health policy and the growing imperative to deliver patient or client-centred care.

Methods: An ethnomethodological design was used, as ethnomethodology does not dictate a set of research methods or procedures, but rather is congruent with any method that seeks to explore what people do in their routine everyday lives. Focus groups and interviews were employed to explore the strategies used by a range of primary health-care providers, such as general practitioners, nurses, social workers, diabetes educators, dieticians and occupational therapists, to support clients to effectively manage their own chronic conditions.

Results: Data from both studies were synthesised and analysed thematically, with the themes reflecting the context, similarities and differences of the two studies that the participants felt had either facilitated or blocked their efforts to support their clients to adopt self-care strategies.

Conclusion: Supporting patients/clients to engage in actively self-managing their health-care needs requires changes to clients' and clinicians' traditional perspectives on their roles. The barriers and enablers to supporting clients to manage their own health needs were similar across both locations and included tensions in role identity and functions, the discourse of health-care professionals as 'experts' who deliver care and their level of confidence in being facilitators who 'educate' clients to effectively manage their health-care needs, rather than only the 'providers' of care.

Keywords

Chronic conditions, self-management support, shared care planning, partnership approaches, comorbidities

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Introduction

A global shift in policy to partnership approaches to health care has seen a movement towards greater involvement of people in the management of their health.[1] This shift has been viewed as of particular importance in the context of health-care environments that are challenged to meet the needs of an ageing population and clients with increasing multi-morbidities. Self-management refers to 'being actively involved in managing one's own illness and not simply receiving information from a health educator who is considered an expert in

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the area'.[2] Support for self-management refers to the role that clinicians play in assessing and building client knowledge, skill and confidence to effectively manage their own health-care concerns and treatments. This study explores how health-care professionals engage with and operationalise self-management strategies to support clients with chronic conditions. There are a plethora of studies defining self-management and recommending the greater involvement of clients in their care. However, the experiences of health professionals who implement strategies to support these clients are less understood.

In the United Kingdom, Department of Health (DoH)[3] calls for improved coordination of care to support patient involvement and self-management have recently been consolidated with the launch of National Health Service (NHS) England's guidance for clinical commissioning groups and commissioners around patient and public participation. This strategy aims to ensure that patients can be active in their own health care, to

> Ensure that every person with a long-term condition or disability has a personalised care plan supporting them to develop the knowledge, skills and confidence to manage their own health.[4]

Similarly, in Australia, a national health reform agenda, launched in 2009, has redesigned primary health care to meet a number of objectives including a greater focus on being 'Patient-centred and supportive of health literacy, self-management and individual preference'.[5]

Despite these international policy initiatives, the proliferation of competing and overlapping approaches to support for self-management have created ambiguity in both policy and practice around how best to support self-management strategies for those with chronic diseases.[6–9] A self-management programme that has been widely reported and evaluated in the literature is the *Chronic Disease Self-Management Program* (CDSMP) developed at Stanford University in the 1990s.[10] This programme is premised on the assumptions that

> people with different chronic diseases have similar self-management problems and disease related tasks, they can learn to take responsibility for the self-management of their disease(s), and that confident, knowledgeable people practicing self-management will experience improved health status.[11]

An example of a strategy to assist health professionals to operationalise self-management is care planning, for which evidence of effectiveness is beginning to emerge.[12,13] Care planning is a systematic way of managing long-term conditions and involving people in decision-making about their care.[9] This is achieved by proactively reviewing a patient's current situation and priorities and planning their forthcoming care as a collaborative activity.[14,15] The Year of Care[15] approach to care planning, which focused initially on diabetes before being applied to other long-term conditions, has

demonstrated positive impact on patient satisfaction, clinical outcomes and practitioner skills. Service redesign, which is at the core of health-care reform in both countries, significantly and positively impacts on team-work and practice-based systems.[14,16] In the United Kingdom, this was deemed so promising that this approach is now advocated in recent guidance from the Royal College of General Practitioners and within the National Institute for Health and Clinical Excellence (NICE) Quality Standards for diabetes,[17,18] while in Australia, context evidence regarding the success of recently implemented redesign of health-care delivery models is starting to emerge.[5] In both the United Kingdom and Australia, health departments have embarked on reform agendas[6,7] supporting self-management for those with chronic conditions. Clinician understandings and implementation of these policy initiatives is the focus of this article which is based on two very similar studies, conducted simultaneously in both countries following discussions between the two research teams.

It became clear that across both countries, there is a strong desire to involve patients/clients more in the planning and management of their chronic conditions; however, as the literature indicates, policies introduced to help clinicians to support people to effectively self-manage their own health needs do not always reflect how patients and practitioners are positioned, as discussed in many of the discourses around self-management.[7]

The assumption that people need to be taught how to care for themselves underpin most programmes and policies that relate to the self-management for those with chronic diseases.[7,19] However, as suggested by Kendall et al.,[7] while self-management is widely represented as a learning process for clients, there is limited acknowledgement of the complex sociocultural contexts that influence clients' willingness and ability to self-manage and clinicians' understandings of how to support client choices in managing their own health needs. The risk is that clients who do not take responsibility for their health, within the parameters expected by the clinicians, may be blamed and assumed to be 'non-compliant' and even 'wasters' of health-care dollars.[7] For example, older people may resist a move away from traditional models of care, while those who are younger may make lifestyle choices that are not always in their health interests. There is acknowledgement in the literature that moving towards an effective model of self-management is a learning process for clinicians as well as patients.[8,20] Clearly, there is a culture shift required for clinicians to effectively support and empower their clients to make choices as self-managers of their own health-care needs.[21] Blakeman et al.[22] studied the social processes underpinning support for self-management in the United Kingdom and found a tension between the practitioners' professional identity and the expectation that they act as facilitators to support and educate patients to self-manage their health-care needs. There has been a significant lack of attention paid to the paradox that this creates for

health professionals, who traditionally have assumed the role of 'experts' with the knowledge and skills to manage others health needs. So, while this paradox is fairly well established in the literature, what this article contributes is a clearer understanding of how this plays out when practitioners try to implement this shift in roles and what facilitates and enables change.

Contextual influences may also impinge on the ability of practitioners to implement support for self-management. For example, one consideration, particularly in relation to the Australian context, is the impact of rurality on the operationalisation of new models of care, which are often developed in metropolitan settings and not always a good fit in rural locations, where resources are more limited and distances between colleagues and specialist care services are vast.[23,24]

This article reports on two related studies with the lead author a member of both research teams. The UK study was commissioned by the North East Strategic Health Authority with the specific intent of evaluating the pathways to implementation of care planning for patients with multiple conditions among primary care practices participating in a learning collaborative facilitating its adoption. The Australian study was funded by an internal university grant, with the aim of exploring how a range of health-care clinicians supported client to self-manage in a rural context. The policy shift experiences in both countries provided an incentive to research. The issues and reports from both studies will be published individually. Secondary analysis of the congruent data sets provided an opportunity to compare the data about the participants' experiences and the role of their practice context. This both constitutes an original contribution to knowledge in the field and has the potential to enhance transferability of findings to readers in a diversity of contexts

This article explores how groups of clinicians working in different countries and contexts have implemented new policy directives by exploring impacts on their role identity and practices. Enablers and barriers in providing support for self-management were also explored as recent literature suggests that there are tensions between the clients' rights to make health choices that may not be considered the 'right' ones from the perspective of the health provider.[7]

The two projects discussed in this article sought to build on Kendall et al.[7] and Blakeman et al.'s[22] work by exploring clinician understandings of their experiences of operationalising a range of reforms in primary health-care delivery models, using new policy frameworks and models of self-management. By uncovering how these clinicians managed the complexity of supporting their clients to self-manage, the authors considered competing discourses that relate to professional identity, government policy reform agendas, health funding models and the advocacy roles of health professionals. The dual location of the research affords a particular opportunity to explore the participants' experiences of supporting self-management in clients with chronic conditions, exploring the contextual impacts on support for self-management, and identifies synergies and differences in the participants' experiences across the two locations.

Methods

These qualitative studies drew on an ethnomethodological design,[25] which means a study of 'a member's knowledge of his (sic) ordinary affairs'.[26] Ethnomethodology does not dictate a set of research methods or procedures, but rather is congruent with any method that seeks to explore what people do in their routine everyday lives.[27] In this case, clinicians were asked to examine their everyday practice and comment on their understandings of self-management and how they support clients to self-manage their chronic conditions. The study was conducted in northern New South Wales, Australia, across a wide rural area, and an urban area of Northern Britain. The authors acknowledge the significant differences in these settings in terms of culture, distance and access to health professionals, as well as differing health service funding models, policy initiatives and patient demographics. However, this was not perceived to be a limitation, rather it focused an investigative lens on the influence of health reform agendas and clinical context of each location as the participants were all asked to comment on their everyday practice, whatever that may be. Methodologically congruent data collection strategies were selected largely informed by strategies that were most convenient and minimised time commitment for the respondents. Focus groups of 10–15 people were conducted in Australia with 21 nurses, 2 medical staff, 4 social workers, 2 dieticians and 3 community health managers who work with clients with chronic conditions. The three focus groups were conducted following quarterly team meetings of these clinicians from across vast rural areas of New South Wales, as within the scope of the project it was not possible for the researchers to travel to remote and rural location to interview each participant. Two members of the research team acted as facilitators at each focus group to ensure that all participants were heard. In the United Kingdom, individual interviews were conducted with 13 practitioners from all 10 general practices taking part in the learning collaborative to implement care planning, including 7 general practitioners (GPs), 5 nurses and 1 practice manager at various stages of the collaborative process.

A shared interview guide informed both data collection activities, with data from each project analysed individually before the two research teams engaged in secondary analysis of both data sets.

Ethical approval for these studies was granted by two universities and two health-care services, and participants were provided with the relevant information sheet about the study and asked to sign a consent form.

Questions were posed to participants based on some of the issues discussed in the literature and presented in the background to this study. For example, focus group members and interviewees were asked 'Could you explain

your understanding of patient or client self-management as a concept and how you implement it?', participants were also asked to 'discuss what drives the way you enable people with chronic conditions to self-manage their own health-care needs'. Focus group discussions and interviews were tape-recorded and transcribed with the permission of the participants. In addition, in the United Kingdom, a training day for 18 additional participants on the operationalisation of self-management was observed, and notes were taken by the researchers. Both sets of data were analysed thematically, first by the individual research team and then collectively across both teams. The preliminary results of each study were sent to the relevant participants for checking, and further comments were included into the joint analysis undertaken by the research teams.

Results

The results discussed in this section are a synthesis of the findings of both studies, and where relevant, synergies and differences are highlighted. The themes that emerged resulted from an analysis of both data sets by the authors, to understand how the participants supported their clients to self-manage their chronic conditions. Despite the obvious contextual differences, there were some striking similarities in the results. Participants in both studies identified a range of factors that they felt impacted on their ability to support their clients to self-manage their health issues. Some of these related to policy frameworks, models of care, professional roles and identity, funding models and perceptions about the readiness of clients to take responsibility for their health needs. Other factors had a clear root in each local context. For example, respondents based in rural Australia discussed the lack of specialist health care available for those with chronic conditions, making it imperative that clients developed a clear understanding of their conditions, treatment choices and how to 'troubleshoot' any issues. While in the United Kingdom, the implementation of disease-specific approaches combined with health-care professionals' systems-based approaches to disease was considered an influence on effective patient-centred care. However, most of the findings had congruence across both locations, with commonality regarding the challenges of implementing new models of care, the difficulty of managing comorbidities in systems that are designed to meet disease-specific needs, the health professionals' role as 'experts' and the importance of understanding client motivation and readiness to participate in self-managed care. The findings are organised under three key themes which emerged from the participants' experiences: The first theme is 'Models of care', which identifies the policies and frameworks that clinicians feel underpinned their implementation of self-management strategies. The second theme, 'Barriers and enablers to supporting

self-management', has four sub-themes – 'disease-specific factors', 'rural context', 'perceptions of client readiness' and 'identity, roles and skill sets of practitioners' – each of which was identified by the participants as important factors that impact on their implementation of strategies to support clients to self-manage. The third key theme is titled 'Political contexts', and it captures the participants' concerns about the broader health reform agendas of each country and how these influence their implementation self-management strategies.

Theme 1: models of care

Participants in both locations discussed issues relating to patient-centred or client-centred approaches to care, which underpins their support for self-management strategies. They acknowledged that this demanded a rebalancing of patient/ professional relationships and some reflection on service aims. Some concerns were raised, particularly in the Australian context, that economic pragmatics were a key driver of this change, at least as much as patient-centred care aspirations:

> We just can't physically fit any more patients into our centre [rural outreach dialysis centre], so they have to go home and manage their disease, whether they like it or not … (Renal outreach nurse, Australia)

> The health system has always been about the need to 'fix' peoples' health problems, with little acknowledgement that patients could play a bigger part in understanding and managing their own health. (Social worker, Australia)

> [for patients with multiple conditions] it does mean longer appointments, but hopefully with better planning in them knowing how to cope with exacerbations then it might reduce further events in the future and reduce appointments as well hopefully. (Nurse, United Kingdom)

> It's all about bangs for bucks, I think that if we intervene early we're more likely to make a difference … once you've gone beyond those first few years or couple of years of diagnosis, patients have quite fixed beliefs about their condition which are more difficult to shift, whereas if you can get in there at the beginning and just do it better then you reap the rewards. (GP, United Kingdom)

This first theme demonstrates that the participants clearly understood the need for them to support clients to better manage their own health needs. However, they were also mindful of the culture shift required to achieve the cost benefits associated with clients managing their conditions more effectively.

The participants went on to discuss a number of specific barriers and enablers to implementing models of self-management within the constraints of existing health-care contexts, which is the focus of the second theme.

Theme 2: barriers and enablers to supporting self-management

Across both locations, the participants discussed implementing policies, frameworks and models of care concerned with supporting self-management in their clients. They identified a number of barriers and enablers that they felt impacted on their efforts.

These have been organised into sub-themes titled (a) disease-specific factors; (b) rural context; (c) perceptions of patient readiness; (d) identity, roles and skill set of practitioners. These will now be discussed in more detail.

Disease-specific factors. Disease-specific frameworks used in health-care contexts to manage the care of people with long-term conditions across both countries were a key factor discussed by the participants in both studies. Although the principles of self-managed care planning were widely accepted by all participants to be relevant to people with specific chronic conditions and in some cases facilitated care for those with particular conditions, they did not always make holistic care easy. It was suggested by some participants that different disease processes demanded different modes of operationalisation. In Australia, the participants discussed the complex funding arrangements that are linked to specific chronic conditions as a barrier to holistic approaches to self-managed care. While the need to develop a more tailored approach was suggested as the way forward by UK participants.

In Australia, when asked about the models of care that support self-management, one clinician replied, 'I go to see a client and they do open up about so many other things that impact on you know, all their chronic diseases, but inflexible models don't allow you to challenge the disease-specific sort of approach'.

In the United Kingdom, the provision of test results to clients prior to an appointment to enable sufficient time for them to digest the results and generate questions or discussion points for the consultation was considered problematic. Initially, this approach was felt to be difficult to adopt for conditions such as Chronic Obstructive Pulmonary Disease, where patient behaviour has little influence over biological results, as opposed to conditions for which improved interaction, goal setting and exploration of lifestyle factors might lead to improvements. A key tension, therefore, arose around how best to tailor care planning according to individuals' conditions, within systems that require a degree of standardization:

> combining … long term conditions is really a challenge … the patient may have really complex medical conditions and they might not actually group quite nicely, so for example there are certain things group easily like diabetes and heart disease, then you will have something to do with respiratory they're slightly different the approaches, when you add on mental health and musculoskeletal conditions or neurological conditions then it is very difficult. (GP, United Kingdom)

These concerns illustrate the ways in which disease-specific systems of thought, while designed to enable care, actually created barriers to the implementation of holistic models in some instances. However, as the participants endeavoured to implement self-managed care models, all described how they moved from identifying barriers to being proactive and innovative in developing solutions. In doing so, they began to align self-management models within the complex reality of practice with people who experience multiple chronic conditions. These enabling strategies were evident across both study locations.

In Australia, the participants described amending the disease-specific approaches by re-focusing their efforts on the issues that were of most importance to the client. A diabetes outreach educator explained it like this:

> See, now I ask them [the clients] what they want to work on, because they're not going to hear what you pick as the most important thing for them. You've got to tap into what they think's the most important, regardless of whether it fits with the care plan for diabetes. (Diabetes outreach educator, Australia)

The next sub-theme is the rural context, which while more relevant to the Australian context may also resonate with those who practice in non-metropolitan settings.

Rural context. As well as being described as a barrier, in terms of access to resources, a majority of the Australian participants also described the rural context as an enabler of patient-centred models of care, with a nurse describing this perspective:

> The other thing that poses opportunity for us rurally is that while we do have limited resources in some places and, you know, limited capacities because workforce might be very, very thin on the ground. So we have to work together for the whole of community to be able to maximise what they can get within the community. You know, metropolitan, urban areas, they don't have to do that. (Community nurse, Australia)

A social worker in Australia also commented on the rural context as an enabler:

> Like if we know they've[health department] got money for this and we've got money for that we just pool our resources and all work together, your outcome is going to be better … and that doesn't happen everywhere, but it does happen here in rural Australia … which is really good. (Social worker, Australia)

So, while rurality created numerous challenges for the Australian participants, such as access to professional development, peer support and specialist care for clients, the participants also described how the rural context enabled them to support clients to self-manage their care. Another factor, client readiness to self-manage their care, was also viewed as both an enabler and barriers by the participants in both studies.

Perceptions of client readiness. Health professionals' perceptions of patient readiness were identified as a key influencer on the implementation of self-management across both locations. This involved the participants discussing their skill and confidence in assessing the patients/clients ability to engage with healthy lifestyle plans and managing their health in ways that allow them to adopt a workable self-managed model of care. Many clinicians identified the tensions between what they consider to be effective self-management and the level of compliance of their clients. For example, one community health manager in Australia said,

> As health professionals we tend to go in and hit them with the knowledge and expect that if we give them all this information that they'll do what you tell them to do. Then you wonder why you get so frustrated when they don't do as you say and they come in year after year and their condition get worse.

Another Australian participant added, 'we've got to really change our mindset actually … the way that we deliver patient-centred care. Education has to be client driven, particularly with chronic disease where they've got to do it every day'.

In the United Kingdom, it was noted that self-management challenges patient attitudes of 'not bothering the doctor' by encouraging clients to adopt more active roles in directing discussion about their health needs. The participants described how older people or those who had long experienced living with a chronic condition, and who had become patterned into a particular model of care, were perceived as less likely to be responsive to care planning:

> I think what I've found in general is that the … older generation they're so used to the system as it is, they come along and we tell them and that's it and they follow instruction almost, whereas the younger people are much more open I think now to this sort of care where they're taking responsibility as well. (Nurse, United Kingdom)

> Everybody slips into a particular pattern of behaviour … once you've gone beyond those first few years or couple of years of diagnosis, patients have quite fixed beliefs about their condition which are more difficult to shift. (GP, United Kingdom)

Interestingly, in Australia, it was also mentioned that younger people, while engaging in greater involvement in their care, were also more likely to make 'poor' lifestyle choices that impacted on their health. One clinician said,

> Younger people sometimes make poor choices then expect the healthcare system to 'fix' their mistakes. This leads to a climate of blaming non-compliant clients.

Some participants in both locations noted a concern that those who are already managing their condition effectively might view new requirements, such as shared care planning

as an added burden. It was also suggested by a number of participants that a greater emphasis on self-management may widen inequalities as those who have greater levels of health literacy are the ones more likely to engage with it:

> It might widen inequalities … we have to be careful because for people with really poor control, they have chaotic lifestyles or … disadvantaged groups in society, they are less likely to pick up these because they never plan anything. (GP, United Kingdom)

> If people are really resistant, there's, there's no magic wand, is there, that will actually motivate people to change, because I think that people to have a tendency, especially if they're ill, to come up with all sorts of creative ways to deny that illness. (Social worker, Australia)

In Australia, the clinicians also discussed how long it takes to change people's attitudes to self-management models of care. One community health manager explains it like this:

> My perspective is that no matter how much we put into them and how much resources – whether it's physical or financial or human – we seem to be not achieving great things whereas, you know, we say, 'Look, if you change your lifestyle, if you stop eating sweets or something if you're a diabetic', it doesn't seem to be working. So, you know, I suppose for me it's wondering; well what else can we do to, to have some effect on the outcomes for these people?

Client readiness to engage with clinicians who are attempting to support them to self-manage their chronic conditions was discussed by all participants, as both an enabler and barrier to implementing health-care policy reforms. The final sub-theme in relation to barriers and enablers concerns the participants' role, identity and skill set in relation to the strategies they use to support their clients to self-manage chronic conditions.

Identity, roles and skill sets of practitioners. The participants in both studies supported self-management and described changes in their practice with respect to employing better listening skills and developing more egalitarian relationships with patients. The involvement of all practice staff was felt to be hugely important for the successful implementation of this patient-centred approach, and education was thought to be a key facilitator to encouraging the adoption of shared care planning:

> The great help is really getting the practice on board, getting the practice manager on board; people doing it on their own will never succeed. (GP, United Kingdom)

> There's certain people in the practice who I can imagine will find that new way of working quite difficult to take on board, I

think those of us who've attended the training are more receptive to change. (Practice nurse, United Kingdom)

Participants varied in the extent to which they felt their approach to consultations were client-centred. In Australia, the participants believed that traditionally clinical staff saw themselves as responsible for 'providing' health care, and if clients made 'poor' choices, they felt responsible. One nurse explained it like this:

We take responsibility as workers to ensure that people stay as healthy as possible. Rather than kind of blaming people because they're smoking or whatever is, we need to find a way to encourage people to take responsibility, to me it's very complex … I kind of feel responsible if they don't listen and act on my advice. (Community nurse, Australia)

There were discussions about the professional identity and roles of health professionals, and about 'allowing' clients to make choices about their care, which suggested some tension between the roles and identity of the clinician as health-care professionals and the choices of the client, whom they want to engage in effectively managing their own conditions:

I think as health professionals we're really … we're not happy unless we're doing lots of assessment, we're doing multiple treatments. But we've got to reverse that thinking back to … you know, we're just guiding them. We've got to stop telling them and doing it for them. (Community health nurse, Australia)

In both studies, participants acknowledged that a change in their approach was required away from a focus on 'fixing' patients, to supporting them to play a more active role in decisions about the management of their conditions:

I think already it's [training on care planning] had an influence on us listening more and asking open questions rather than just giving information which is what we've done in the past. Now we're maybe stepping back a little bit more than we were, and listening more. (Practice Nurse, United Kingdom)

Before we learnt how to do [care planning], it was very much doctor agenda, in such a way that we thought that is the best for the patient so we went on and discussed areas which we feel important, where care planning involves sharing information, sharing data and then engaging the patient and then we come together with the priorities, so the priorities could be slightly different, but there will be a lot of negotiation between the doctor and the patient. (GP, United Kingdom)

There was a clear desire to acknowledge and support patient choices, as described below, although the tensions in this approach were obvious:

Before we even get to dialysis, it's important to have those motivational interviewing type things and say, you know, 'What's important to you?' if it's like I want the end stage dialysis or I'd prefer conservative management, we have to help

the patient to work out what's going to be right for them … which is not always what we would recommend as a nurse … So this is an inner argument with myself … and more and more I'm convinced that the patient's choices need to be supported. (Renal outreach nurse, Australia)

Supporting people to self-manage their condition involved a rethinking of the roles of practitioners in that it entailed a focus on broader spheres of patient concerns than those traditionally considered in the clinical encounter:

I suppose all things may be related but it is difficult if they're talking about something that's not related that you think isn't related but it's important to them so you have to go down that line. (Nurse, United Kingdom)

So it's important to know that some patients are choosing things, and some nurses don't understand, so it's important to get your clients to make choices, but to also be aware of the consequences. The nurses need to be accepting of the clients' choices as well. We need to understand that that is what our client needs to do, and not judge. (Community nurse, Australia)

Shared care planning to support self-management was noted to demand a wider skill including counselling approaches than previous forms of consultation. A tension was noted across both studies between supporting patients' informed choices and practitioners' specialist knowledge of particular conditions. In the Australian study, one participant commented,

I think it's about encouraging clients to take an active role in their health care … It's about enabling them to perform that role and us as the expert guides to inform them.

Participants in both studies expressed the need for robust data on the effectiveness of care planning for self-management in terms of reducing exacerbations and numbers of appointments, in order to demonstrate the value of the approach to practitioners and policymakers. Practices in the United Kingdom that have implemented care planning for diabetes for a number of years suggested that there had seen some improvements in diabetes control and a reduction in frequency of appointments. In Australia, the participants talked about the importance of embedding in policy greater acknowledgement of the clinicians' changing roles as facilitators and brokers of client health choices, rather than just as providers of care.

The third and final theme reflects the participants' understandings of the context in which health reform agendas occur, with a degree of cynicism evident regarding the political motivations that drive the need for change.

Theme 3: political contexts

All the participants described uncertainty over political commitment to supporting self-management. In the United

Kingdom, this related to recent changes in government and the current financial climate making them cautious about implementing large-scale changes to practice:

> I suppose because of the political climate, we've got to be careful, I know this is a pilot and we're being paid to be part of the pilot and we need to feed into that but what's the landscape going to look like, are we going to be able to do this in the near future and because everything in general practice and commissioning and everything is so much up in the air I think it just makes one apprehensive about making whole system changes when everything is so uncertain. (GP, United Kingdom)

This theme captures the participants' uncertainty about whether significant changes to practice, such as those required to implement greater support for clients to self-manage their chronic conditions, are sustainable. The concern was that the current priority on implementing self-managed care strategies may well be buried under newer rafts of initiatives, designed to meet short-term political agendas, rather than facilitate real changes to meet the needs of ageing populations with complex and chronic conditions.

In Australia, the concerns about the political context of health care focused on the complex and sometimes competing funding models for primary care and community health initiatives. One participant described the impact of short-term, pilot funding, where there was little opportunity to influence how the funding could become more sustainable:

> So many different levels of service that are funded to provide different things. I hate to think how much resources and billions of dollars going into renal and diabetic and cardiac, you know? It would be good if it was pooled together and translated into healthier patients … cos it's not sustainable. (Nurse Manager, Australia)

Discussion

The findings clearly support those of earlier studies, such as Blakeman et al.[22] and Kendall et al.,[7] identifying that supporting patients/clients to engage in actively managing their health-care needs requires changes to both client and clinicians' traditional perspectives on their role. The participants discussed their practice and educational preparation, as well as the need to develop more integrated, sustainable health policies to better support clients with comorbidities, who want to adopt self-management practices. In Australia, the key challenges to supporting patient self-care from the perspective of the clinicians were rigid models of care, their professional roles and identity as 'experts' in the delivery of health care as well as the complex state/federal funding models. The barriers and enablers to supporting clients to manage their own health needs were similar across both locations and included disease-specific models of care, the practice setting, particularly the rural context in Australia, perceptions of patient readiness to engage with managing their own

care and the role identity and functions of health-care professionals. The traditional discourse of health-care professionals as those who 'deliver' care was evident in the participants' experiences. Their concerns about their ability to re-shape their roles to being facilitators who support and 'educate' clients to effectively manage their health-care needs were common across both locations. The contextual challenges, such as the prominence of disease-specific, rather than client-centred, care practices was also reflected across both countries. In Australia, the rural location was considered a challenge in terms of distances and lack of access to resources, but also described as an enabler; as funding could be 'pooled', participants worked more closely with each other, which meant that patients with multiple chronic conditions were seen by the same local clinicians, which differed from service delivery models seen in urban areas. In terms of the findings of earlier studies by Kendall et al.[7] and Blakeman et al.,[22] the assumption that patients need educating to 'comply' with expert advice was embedded in the discussions in relation to client readiness to manage their own conditions. An obvious tension was the participants' concerns about trying to support clients to make informed choices. Changing the focus of practice to patient choices was clearly challenging for some of the clinicians and even some patients, such as older clients who expected a more traditional approach to care, and young clients who were sometimes perceived as making 'poor' lifestyle choices. These findings reflect those of Baumann and Dang,[6] who also suggest that more attention is needed to address these barriers to supporting self-care strategies for those with chronic conditions.

Despite the challenges identified in both studies, there was a clear desire from all the participants to move towards empowering and enabling patients to take charge of their health-care needs, with the health-care professionals as coaches, facilitators and supporters of their efforts. It was interesting to note that across both locations, the participants clearly acknowledged that in order for self-managed care planning to be effective, clinicians need to reflect on their role as 'experts'.[19] There was an awareness that while self-management is widely represented as a learning process for clients, in reality, it is just as much a learning process for clinicians, who need to work with patient choices, even if they don't 'fit' their ideas of optimal care. This is certainly consistent with some of the challenges of supporting self-managed care, discussed in the literature.[6,7,22] In conclusion, this article has reported on the outcomes of two studies of the implementation of self-managed care planning, and how it is operationalised by participants in an urban setting in the United Kingdom and in rural Australia.

We need to acknowledge the methodological limitations of these studies and stress that we are not claiming national commentaries but are drawing on two linked studies that were conducted simultaneously, using the same methodology and similar methods. We consider that this article provides insight into 'typical' practices in relation to strategies

used by clinicians to support self-managed care in both countries and highlights the factors that impact on the implementation of new policies to support these changes.

While the results are not generalisable to other settings or populations, they provide a sense of some of the common issues from clinicians' perspectives that may have resonance internationally and inform policy and practice discussions in relation to the strategies clinicians use to implement self-management strategies. Further research is planned to build on these findings, which may offer greater insights into how best to educate and support clinicians to facilitate self-managed care and acknowledge patient choices.

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