Chronic illness: policies and paradoxes

It is almost a truism to state that Australia has experienced a health transition from infectious and acute diseases to chronic disease, impairment and disability in the last century (Murray & Lopez, 1996; Beaglehole & Bonita, 1997; Australian Institute of Health and Welfare, 1998) notwithstanding the forecasts of a new era of infectious disease (Garrett, 1994). The effects of the reduction in infectious diseases over the last century have not been confined to improvements in survival. The unintended corollary has been the growth of chronic and degenerative disorders as the main cause of both morbidity and mortality.

Technologies for treating chronic and degenerative disorders are becoming more sophisticated, complex, and expensive. Partly as a result of new technologies, partly because community attitudes have changed, and partly because governments are concerned about cost, treatment and support are increasingly provided at home and in the community. At the same time the changing role of women, reductions in family size and greater geographic mobility among family members have reduced the availability of informal care and support. In response there has been a dramatic expansion of community-based services for people with disabilities and chronic disorders. Population ageing associated with the "baby boomer" cohort will place significant additional pressure on health services in the coming three decades.

These shifts are seen as a major factors driving the demand for health resources for the foreseeable future both in Australia and internationally. The challenge for health policy is to sustain or improve health and well- being for people with chronic illness and at the same time halt or reduce the associated rising health care costs. Policy development is beginning to address the complex implications of this shift.

There is an understanding evident in the research literature that chronic diseases and their consequences interact to produce patterns of illness that require continuous and often complex partnerships and management between health care professionals, the individuals with chronic disorders, and the family, friends and neighbours who provide care and support. However, how this knowledge can best be used to effect good health outcomes is a question that has not yet been definitively answered, notwithstanding the different approaches that have been adopted in response. Most of these approaches have incorporated either an implicit or explicit concept of partnership between the person living with chronic illness and their health professional/s. Sometimes the partnership also includes carers. The Commonwealth Government has acknowledged this with its development of the Sharing Health Care Initiative, elements of which are reported in this issue.

What is of interest is the concomitant appearance of the terms "chronic disease self-management" and/ or "chronic illness management" almost as a mantra. In this issue, Siegloff and Aroni explore what is meant by the term "self-management", raising the concern that we may not all be using the same meanings and the potential this has for producing misunderstandings between clinicians and people living with chronic illness. Weeks et al. suggest a number of options for health professionals that move to clarify their role in supporting self-management. Our understanding of self-management and its implications remains a fertile area for further research.

In Australia, self-management is not a new phenomenon. Historically, apart from the practice of individual self-care, it was the province of self-help groups. However, given that these groups were created and controlled by the laity, they did not achieve widespread legitimacy in the formal health care structure, often remaining, instead, at the margins of professional services. The model that was dominant in acute care was, and often still is, ineffectively used to provide care for those living with chronic illness.

In order for self-management to have a place in the health care system there needs to be appropriate interaction between a self-managing person and their clinician/s. These relationships are slow in developing, as is made evident by Joanna Ng's paper. More recently, Lorig and Holman (2000) have argued that the patient must become a partner in the process, "not just because patients deserve to be partners in

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important way of establishing a legitimate place for self-care in the institution of health care. In many ways, the model of self-management as program bridges the space between self-help and traditional health service delivery.

This issue of the *Australian Journal of Primary Health* provides a broad overview of the development of chronic disease self-management in Australia and many of the questions it has given rise to. The issue is divided into five sections, examining self-management, identity and self-management, system change, sharing health care demonstration projects, and, finally, resources for consumer empowerment. The final section includes a bibliography that will assist individuals who are new to the area of self-management.

Some key aspects of self-management are missing from this issue but will be addressed in subsequent issues. They include papers exploring questions of self-management and ethnicity, gender, disability, and policy.

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