Preface
The concept of ‘person-centred’ or ‘patient-centred’ health care is increasingly acknowledged by health professionals as an important focus, particularly in the care of people with long-term conditions. Some will now be familiar with the use of this term as short-hand for a set of principles to guide the planning and delivery of health care, while others may be unfamiliar with the language but nevertheless agree with the longstanding move towards health care that aligns with both medical evidence and what is appropriate for the individual.

This discussion paper deals with some of the practical ways in which primary care services including general practice, allied health services and community pharmacy can incorporate principles of patient-centred care. It has been produced following the National Asthma Council Australia’s Patient-Centred Health Care Workshop, held 25–27 November 2005 and funded by Pfizer Australia and the Australian Government Department of Health and Ageing. It draws on the workshop report: Patient-Centred Health Care Workshop November 2005 – Report of Proceedings, available on the National Asthma Council Australia website.

As well as exploring how the health system might be adapted to better suit the needs of patients at the levels of policy, funding and infrastructure, participants recognised that all health professionals can and should ensure that their own practices are responsive to patients’ needs. The workshop acknowledged that many GPs, practice nurses and other primary care health professionals are already working in accordance with these principles.

Background
It is now widely accepted that health care systems should be designed in a way that responds to individuals’ preferences, values and needs,1,2 particularly in the area of chronic disease. Realising these aims doesn’t just involve health professionals empathising with their patients – it demands re-organisation of health care systems to maximise partnerships between patients and health providers.3

In the context of chronic disease care, the reasons for this shift are both ethical and pragmatic, and include these arguments:

- **Human behaviour influences health outcomes.** Patients and health professionals don’t always agree on what is best. Doctors tend to focus on disease processes, while people focus on their lives – of which disease management is one aspect. People will be influenced by many factors other than their doctor’s advice, including socioeconomic circumstances, ethno-cultural values and beliefs. Unless these are taken into account, the patient and health professional cannot work together effectively. Productive interaction occurs when health professionals see one of their roles as helping people to understand the significance of their conditions within their lives, and to get on with life.

- **Complex conditions require individualised management.** Health professionals working in primary care well understand that disease management guidelines are not necessarily applicable to clinical situations, and that evidence from randomised controlled trials may not be relevant to patients whose situation does not match inclusion criteria. When the patient’s health problems don’t fit the guidelines, health professionals must use all

> It is more important to know what sort of person this disease has than to know what sort of disease this person has.  
> attributed to William Osler, Physician (1849–1919)

> Doctors try to make young people comply with treatment while young people try to make the disease comply with their lifestyle.  
> Ron Neville, GP8
When it only makes sense to start with the individual

Caring for an elderly woman with osteoarthritis, diabetes and asthma is an example of an everyday general practice clinical situation in which guidelines offer limited assistance. Guidelines for each condition make conflicting recommendations, and there is no strong evidence to inform management decisions. Skilled interpretation is needed to tailor treatments to deal with the health problems as she experiences them, and to suit her life priorities.

their skills to offer care that is tailored to the person, not a particular condition. Long-term conditions with complex management require more complex ways of interacting with the patient to ensure adherence to agreed treatment plans and improve quality of life and clinical outcomes.3

• Our health system increasingly relies on patient involvement. It is well recognised that, consistent with global experience, Australian health care is in transition from a system set up to manage acute disease to a system organised for effective prevention and control of chronic conditions.4 Around the world, health systems are under pressure and can no longer afford to be structured around diseases rather than patients.5 In order to cope with the demands of a growing population of people with chronic disease conditions, health systems require active involvement of individuals in understanding and effectively managing their conditions and lifestyles. Patient organisations consider that this may be the most cost-effective way to improve health outcomes for patients.5

• Clinical outcomes data support patient-centred approaches. Increasing evidence from around the world shows that clinical and cost outcomes are improved when health care is organised around patients’ needs, rather than around specific disease conditions, the convenience of separate services or the traditions of specific medical disciplines. A system that is designed to integrate various health services and funding mechanisms can achieve more comprehensive and convenient primary care services, significantly shorter waiting times for specialist and hospital services, and a lower requirement for acute hospital services, at a similar per-capita cost as older-style systems with lesser outcomes.6 Self-management approaches for managing long-term conditions, based on person-centred principles, are gaining popularity in Australia and internationally and a substantial body of evidence demonstrates that they can improve both health and quality of life.7

• Australian health policy has shifted towards a patient-centred approach. The promotion of person-centred care is a central aim of the improvement in health service delivery outlined in the National Chronic Disease Strategy (NCDS) and the National Service Improvement Frameworks (NSIF) for asthma; cancer; diabetes; heart, stroke and vascular disease; and osteoarthritis, rheumatoid arthritis and osteoporosis. These are intended to guide the activities of all involved in health care system from health service planners and managers to health sector policy makers, funders and providers.

What we mean by ‘person-centred’ health care

Proposed definitions vary and there is no universally accepted definition.1 For the purpose of this discussion paper, person-centred health care is most simply understood as a system that is designed to respect the patient’s preferences, values and/or needs.1 This approach involves partnership between health professional and patient, with shared aspirations for treatment and acknowledgement of people’s life goals. For those with long-term conditions, it means giving them the understanding and skills to optimise their investment of time in their condition to keep themselves well. This idea is not new, but is increasingly supported by clinical evidence, particularly in the areas of diabetes, asthma and arthritis.

Health professionals working in primary care, particularly GPs, are already recognised for their person-centred approach, compared with some specialist disciplines or hospital settings.

Central principles

Although the priorities of patients, their families and carers will differ according to culture and medical condition, all these elements are fundamental to person-centred health care.2,5,9

• Respect for the individual’s values, expressed needs and preferences.

• Choice – patients have the right and responsibility to participate in health care decisions including treatment and management. To do this responsibly they need the options and probable outcomes carefully explained. Patient-centred care doesn’t mean the subjugation of science to patients’ uniformed demands. Clearly, it is counterproductive to provide health care that simply reflects patient demands without first offering choices that are well informed by available evidence.

Patient-based evidence

Patient organisations are urging people to take responsibility to ensure that their health care is based on evidence by asking the following questions at every management decision point.10

1. What are my treatment options?
2. What are the possible outcomes of those options?
3. How likely is each of the outcomes to occur?
• **Access** to services required by the person’s medical condition, including preventive care.

• **Support** – acknowledging and addressing the person’s emotional and social needs. This means involving the person’s family and friends (as the patient desires) and considering educational, cultural and personal factors affecting the person’s ability to manage their condition.

• **Education and information** that is accurate, relevant and answers the person’s concerns. Information must be given in a mode appropriate to the person’s level of understanding of their condition, educational status, language, age and culture.

### Related and enabling principles

Putting these principles into practice requires a focus on health promotion and healthy lifestyles, rather than just on specific medical conditions, and effective communication between provider and patient.

Health professionals’ ability to deliver person-centred health care depends on factors that link these approaches at the level of health policy and government (Figure 1). These enabling principles include:

- coordination and integration of care across boundaries of the health care system
- supportive community-based services and programs
- planned and systematic involvement of patients in health policy – both individually and through patient organisations.

### How do we enhance our person-centred focus in primary care?

The following approaches are practical examples of how health professionals in primary care can make a difference. Many health professionals are already doing these.

**Organise the delivery of services around patient preferences**

A large Australian survey found that people’s expectations of general practice included choice of GP, open discussion with the GP and the opportunity to get more information about diagnosis, treatment options, referral options and community-based support services. The core list of attributes of patient-centred general practice identified in this survey (Table 1) were similar to those proposed and promoted in the USA.

Similar findings have been reported elsewhere. A UK study found that people with asthma want access to a clinic near home, a doctor who listens to them, to be treated as a whole person, to see the same doctor on each visit, to receive information about the prescribed treatment, to be confident in the doctor’s skills and ability, to be in control of treatment decisions, and for care to be financially affordable.

Improved attendance at consultations might be achieved by providing services outside normal working hours, group support and regular follow up.

**Figure 1. The foundations of person-centred health care in primary care**

Person-centred primary health care involves practices being organised around the principles of informed choice, respect, partnership, a holistic approach and good communication. Primary care providers’ capacity to offer this type of care is supported by a health system designed to ensure access, patient involvement in policy making, and coordination between levels and types of health services.
Hearing and answering patients’ concerns

Information about medical conditions, treatment options and medications rank high among patients’ most common concerns. Limited time during the consultation is often cited as a reason GPs cannot provide all the information people want. Strategies for making the best use of the time available include the following:

- Organising the practice so that an appropriately trained nurse can provide the disease-specific information that patients want.
- Making sure patients know that pharmacists can provide expert advice on medications and side effects. For those with complex medication regimens, a home medicines review may enable people to discuss their concerns in full. Allowing a person to discuss their fears about medications, and gain reassurance on what to expect, can lead to better adherence.
- Giving patients information before the consultation, e.g. disease-specific information or a leaflet inviting them to list all their questions to bring to the consultation.
- Collecting medical history in advance, e.g. by the practice nurse.

Doctors are often concerned that allowing patients to talk freely at the beginning of the consultation will waste time. However, a UK study found that, if uninterrupted, patients’ initial explanation of the reason for the visit takes 1.5 minutes on average, and that 78% of people will stop talking within 2 minutes of the beginning of the consultation.13 Health professionals often underestimate the psychological impact of disease by focusing on the physical side, yet this medical focus might differ from patient’s own concerns.
Case studies: ask about the person’s own concerns

Case 1. An elderly man with a cardiovascular condition is referred by his cardiologist to a cardiopulmonary rehabilitation program. At the initial assessment, he is asked, “If you could fix one thing, what, if anything, would that be?” The man replies, “My walking. I can’t walk as far as I would like to.” When asked what is limiting his ability to walk, he replies without hesitation that it is pain from osteoarthritis in his knees.

On further discussion, it emerges that arthritic pain as a reason for his limited ability to walk was not noted by the specialist cardiovascular services he has been attending. He explains that, “They never asked... And I was there for my heart”.

This man’s options for managing his arthritis might include:

- medications for pain relief (subject to precautions and contraindications)
- referral to a community-based physiotherapist or exercise physiologist (or working with those at the cardiopulmonary rehabilitation program)
- attendance at a chronic disease self-management program.

His GP, pharmacist, physiotherapist and cardiologist would all be involved in tailoring his care to help him become more mobile.

Case 2. A 60-year-old man with chronic heart failure and severe symptoms visits his GP after discharge from hospital. He brings the instructions provided by the hospital, which include weighing himself daily, restricting fluid intake, restricting salt and walking each day. He expresses bewilderment with the number of new obligations and says he has not done any of these so far.

Rather than merely telling him to follow the instructions, the GP explains that these are important for staying healthy, and asks, “Which of these activities, if anything, do you think you could start doing?” He opts for weighing himself as the easiest instruction to follow, and decides to measure his current fluid intake to learn whether it will be easy to meet the suggested daily maximum.

At his next visit the GP asks how he is managing, and discusses various support services, such as a self-management program, on offer in the local region. Eventually the man finds he is able to adhere reasonably well to all the instructions, and explains he had initially felt it was “all too much”.

Provide information in a manner appropriate for the person

General practices are increasingly adapting to people’s needs and commitments by offering alternative modes of communication such as email, the Internet and text messaging. Email could provide a convenient way for patients to reschedule appointments or request repeat prescriptions, and has been suggested as a low-cost alternative to postal or phone reminders.15,16

The Internet is a major source of information, yet most health professionals have given little consideration to how patients access information and the strengths of those information sources to patients. In many cases, the Internet may provide better information than a doctor or health educator.

Mobile phone text messaging has been reported to be an effective and welcome mode of reminding teenagers to take their asthma medication and providing tips on inhaler use and asthma self-care.8

Because people often can’t retain all the information if it is given at once, education may need to be tailored over several consultations, particularly where behaviour change is the goal.3 Chronic disease self-management programs are increasingly being adopted as a structured approach to meeting people’s information needs.

Tailor management through shared decision-making

Key features of effective doctor–patient interaction to manage long-term conditions are shared goal setting, written management plans and regular follow-up.3

Health professionals can help ensure their recommendations are suited to the patients’ needs by asking them how confident they are about managing their condition, their expectations for management, what they understand about the condition, and what factors that will affect their ability and willingness to carry out aspects of self-management such as readiness to monitor glucose in diabetes, barriers to losing weight or increasing physical activity, or problems adhering to preventer asthma medication.

Routine attention to the following aspects of the person’s situation has been suggested as a way of ensuring that the visit results in shared decision-making and individualised management plans:3

- Explore people’s social supports and physical environment, which may influence their health (e.g. smokers in the person’s household, access to healthy food choices and physical activity, family attitudes to the behaviour changes needed to stay well).
- Negotiate an agreed individualised written disease management plan, including specific strategies for dealing with acute symptomatic episodes.
• Find common ground for planning ongoing management so that you and the patient can agree on what should be done.

• Find out whether and to what extent the person wants to participate in decision-making. This might depend on age, cultural background and education.

Patients with moderate-to-severe asthma benefit from a combination of self-management education, GP review and an individualised written asthma action plan.\(^7,17\) Participation in self-management education programs that include preparation of a written asthma action plan helps people understand their condition and take responsibility for day-to-day monitoring and medication adjustment, and has been shown to reduce hospitalisation rates, emergency department visits, other unplanned urgent asthma care, days missed from work or school, night-time symptoms and effects on quality of life.\(^17\) There is also strong evidence for benefits of self-management approaches in diabetes and hypertension, and some evidence for arthritis and chronic obstructive pulmonary disease.\(^18\) (See Offer referral to self-management programs.)

**Case study: acknowledge the person’s perspective**

**Case 3.** A 55-year-old woman with longstanding adult attention-deficit hyperactivity disorder, obesity and recently diagnosed type 2 diabetes attends her local public hospital diabetes clinic, where she is advised to join a group session on healthy eating run by a hospital dietician. Despite this, she feels dissatisfied and helpless to manage her weight, so her GP refers her to a diettian in private practice for dietary management of diabetes and obesity.

At the first session, she discloses that she had only recently learned that her medication causes weight gain and would have contributed significantly to her diabetes. She explains that this had made her feel very frustrated during the group education session at the outpatient clinic, where general statements were made about diabetes and weight gain and she felt that she was being blamed. She tells the diettian that she felt so “left out and guilty” that she had not taken in any of the information on dietary choices. In contrast to the group session, the one-to-one private consultation allows her to explain her own circumstances and she feels satisfied that someone understands her difficulties and that she is receiving tailored advice.

When complex or difficult self-management is needed (e.g. blood glucose self-monitoring in diabetes or cessation of smoking), it is helpful to set specific and achievable goals for the interval between each visit, aiming towards long-term achievement and maintenance of the changes adopted.\(^3\)

**Patient-centred health outcome measures**

Ongoing monitoring of the condition should also be based on the person’s own concerns and goals for health care. Support programs and clinical trials now often assess quality of life, functional health status and patient satisfaction to gain a measure of effects that is meaningful to patients.

In asthma treatment, traditional end-points (symptoms, reliever use, forced expiratory volume in one second per cent predicted, morning peak expiratory flow, airway hyperresponsiveness) do not fully capture treatment benefits from the patient’s point of view.\(^19\) More important measures for patients might include days missed from work due to asthma or ability to exercise without symptoms.

**Develop teamwork with other services**

Teamwork is recognised as an aspect of patient-centred care.\(^20\) One service provider, e.g. GP, cannot feasibly undertake all aspects of a person’s care such as comprehensive motivational interviewing, patient education for self-management, dietary assessment or coaching to achieve behavioural change. General practice can better ensure that a wide range of patients’ needs are met by working with other providers such as local asthma educators, local diabetes centres, allied health professionals, community agencies (e.g. ancillary community services) and support groups (e.g. Diabetes Australia, Asthma Foundations Australia, arthritis foundations).\(^3\)

**Offer referral to self-management programs**

Patients need support to successfully manage the impact of long-term conditions on their lives. Self-management programs specifically developed for people with complex care needs generally involve these guiding principles:

• Allow and encourage the patient to define health problems.

• Explore options for dealing with these problems.

• Offer choice and respect the person’s choice – rather than directing and prescribing.

• Collaboratively set goals and action plans to address problems or adopt/maintain health-related behaviours.

Approaches that recognise and act in partnership to manage patient-defined problems are the most successful, regardless of the mode of delivery.\(^21\) Well-defined approaches such as the Stanford Chronic Disease Self-Management Program and the Flinders Model of chronic disease self-management are based on these principles.

Health coaching in chronic disease is an emerging approach based on person-centred care principles. These models focus on action plans set by the person with the condition. Coaching generally involves a health professional, other than the main prescriber or clinician, who provides individualised support for self-management. This approach has been
applied mainly in areas of diabetes and cardiovascular conditions including coronary heart disease.

Conclusion

In all disciplines and health services, patients benefit where health professionals pay attention to the principles of collaborative partnerships with patients, offering patients an opportunity to make informed decisions about their health care based on effectively communicated medical evidence and setting mutually agreed goals for care. Many primary care health professionals are already practising within such a person-centred framework, which acknowledges that the proper focus of health care is the person, not the condition.

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