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## Self-management In Diabetes Prevention And Care

The term 'self-management' is a misnomer in diabetes prevention and care. Although patients are identified as the pivotal determinant of diabetes outcomes, one's ability to acquire proficiency in self-management is complex and multifaceted. Literature argues that the term self-management is 'problematically oxymoronic in that chronic diseases are not individualistic but embedded in family, community and societal conditions that shape and influence - and may constrain - the choices people make or can make' (Thirsk & Clark 2014).

The National Chronic Disease Strategy defines self-management as "active participation by people in their own health care" (Australian Health Minister s' Advisory Council 2017), this inevitably assumes most disease management responsibilities upon patients. However, it is known that extrinsic factors such as effective clinical relationships and adequate family support contribute considerably to one's motivation and ability to engage in self-management behaviours. For example, although shared decision-making between health professionals and patients has been continuously promoted as one of the key features in supporting patients' autonomy to gain control over their disease management, health professionals who do not take careful considerations when applying this concept in clinical practice by reflecting the meaning of 'self-management' from the patient's perspectives may negatively impact on the patients' capacity to self-manage. Shared decision-making for patients who do not wish to or cannot exercise the same degree of control over their care, such as those with pre-existing physical disabilities or mental illnesses, can increase their burden on disease management (Lawn, McMillan & Pulvirenti 2011). In addition, literature suggests that the role of significant others has one of the most notable influences on patients' motivation to self-manage as they are embedded within the patients' daily environments and therefore can markedly impact on patients' day to day diabetes self-management behaviours (Lee et al. 2019). It is recognised that this can either help or hinder patient outcomes depending on the level of support provided both mentally and physically. A study found that patients with greater autonomy support from families and friends were associated with lower diabetes distress, greater self-efficacy, more frequent self-monitoring of blood glucose and better glycemic control (Lee et al. 2019). It is thought that positive diabetes-related attitudes via better formal and informal health supporters are associated with improved diabetes outcomes in patients, and vice versa.

Despite the undeniable importance of extrinsic factors in facilitating patients' motivation to engage in self-management behaviours, intrinsic factors such as one's attitudes, health literacy, and self-efficacy are also essential elements in determining positive diabetes outcomes (Rodriguez 2013). The concept of self-efficacy is important in the context of diabetes self-management due to the following. Self-efficacy is 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). Self-efficacy beliefs determine how people feel, think, motivate themselves, and behave over time. Bandura (1994) also suggests that people with a strong sense of self-efficacy are more likely to approach difficult tasks and recover their sense of efficacy quickly after encountering failures. To translate this into diabetes self-management, patients with an adequate sense of self-efficacy will be more capable in engaging in positive self-management behaviours such as adhering to medication regimes, glucose monitoring or adopting lifestyle changes as prescribed. Sources of such efficacy are influenced by the clinical

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support from health professionals and autonomy support from families.

It is evident that the term 'self-management' extends beyond its literal meaning. While it is agreed that diabetes outcomes are predominantly affected by a patient's self-management behaviours, intrinsic and extrinsic factors that promote or limit one's ability to self-manage must also be considered.

Is self-management beneficial to positive health outcomes in diabetes prevention or management? Critically discuss in relation to outcome research, the Chronic Care Model and role of the Diabetes Educator.

According to the Australian Institute of Health and Welfare (AIHW), the prevalence of diabetes has tripled between 1989–90 and 2014–15, the proportion of people with diabetes has also increased from 1.5% to 4.7% (AIHW, 2018). Although hereditary factors contribute somewhat to the development of diabetes, lifestyle risk factors remain to be the biggest cause of type2 diabetes worldwide. Evidence shows type 2 diabetes can be prevented in up to 58% of people at high risk through modifying lifestyle risk factors such as poor diet, physical inactivity, obesity and tobacco use (Johnson, Martin & Timoshanko 2015). It is apparent that the prevention and management of diabetes require individuals to be at the centre of managing their own health.

Current Australian guidelines place a great emphasis on facilitating structured diabetes self-management education as a part of a complex intervention based on the Chronic Care Model (Royal Australian College of General Practitioners (RACGP), 2016). It is widely agreed that people with diabetes need to develop the capacity to manage lifestyle behaviours, monitor glucose levels, make effective use of medications and healthcare services and minimise risk factors to prevent complications. Structured patient education can optimise glycemic control, improve patient's quality of life and subsequently reduce national health expenditures (Primary Health Care Advisory Group 2015). Hence health professionals, particularly those working in primary health, play a critical role in empowering patients to develop the confidence, skills, and knowledge to effectively manage their diabetes. According to the General Practice Management of type2 Diabetes guidelines, it is recommended that 'all people with type 2 diabetes should be referred for structured diabetes patient education' (RACGP, 2016). Yet literature argues that most people with diabetes in Australia are not offered the opportunity to participate in diabetes education possibly due to GP work capacity constraints and the few incentives to encourage them to refer people to such programs (Primary Health Care Advisory Group 2015). Poor integration of diabetes specialty services, such as the diabetes educator, is a potential barrier for patients to acquire the necessary skills to self-manage.

It is understood that the clinical care requirements of people with diabetes is complex and is best achieved through a multidisciplinary team approach, particularly by integrating the diabetes educator due to their specialty in providing structured self-management education (Australian Diabetes Educators Association (ADEA) 2019). The ADEA suggests that the education provided by a diabetes educator differs from generalised diabetes education in that it 'moves beyond traditional discipline boundaries and encompasses the full spectrum of diabetes self-management and self-care behaviours' (ADEA 2019). Successful application of such interventions requires a patient-centered care approach where potential barriers such as patients' health literacy, priorities, family support, socioeconomic constraints, cultural beliefs, physical disability, and mental health are explored (Lee et al. 2019, O'Neil et al. 2014). Intervention strategies that acknowledge the patient's physiological and personal psychosocial

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factors are more likely to promote positive care collaboration between health professionals and patients. This enables patients to set clinical goals which are cued by their priorities hence improving empowerment, adherence and subsequent better diabetes outcomes.

It is evident that self-management support forms the foundation of effective diabetes care and optimal patient outcomes. Although currently there appears to be an implementation gap between policy aspirations for the provision and delivery self-management support in general practices, the benefits of structured diabetes education in improving patient outcomes should not be underestimated and need to be continuously promoted among the health workforce to mitigate the growing burden of diabetes in Australia.