

Patient Education and Wellness

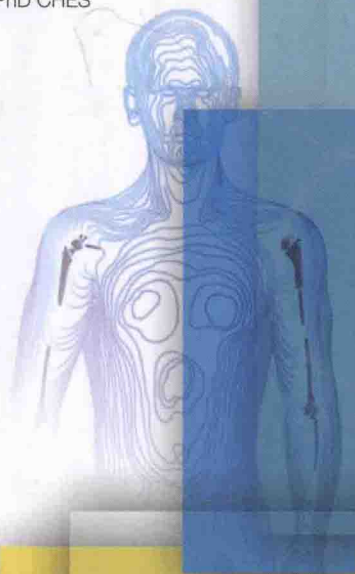
A handbook for manual therapists

Jennifer R **Jamison**

With a contribution by
Cheryl Hawk DC PhD CHES



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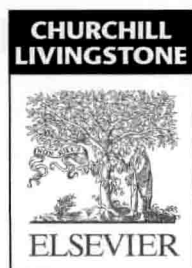
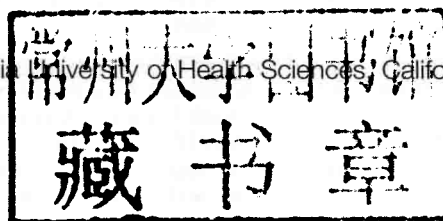
A handbook for manual therapists

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Points to ponder!

- *Self-care represents a sea change in healthcare.*
- *Wellness requires responsible self-care.*

The 2008 report of the World Health Organization draws attention to the growing need for an increased emphasis on primary health care.¹ The report discusses how the early approaches of improving hygiene, water, sanitation and health education in primary health care have now been replaced by a need to promote healthier lifestyles and mitigate the health effects of social and environmental hazards. It debunks the belief that primary health care is a cheap alternative requiring a modest investment. It recognizes that although primary health care requires considerable investment, it delivers better value for money than the alternatives.

Primary care is a hub from which patients are guided through the health system. A major feature of primary care in the 21st century is its person-centredness. Successful primary care is perceived to put 'people at the centre of health care, harmonizing mind and body, people and systems'. People-centred primary care provides a regular point of entry into the health system and offers comprehensive and integrated care catering for a wide range of health problems. It supplies continuity of care, making it possible to build an enduring relationship of trust between people and their health care providers. Successful person-centred primary care is achieved in ongoing relationships between patients and health professionals within which patients participate in decision making about their health and health care.

Primary care affords opportunities for disease prevention and health promotion as well as early detection of disease – not merely treating common ailments. It is provided by health professionals with diverse backgrounds, all of whom have specific and sophisticated biomedical and social skills. Primary practitioners are educators and motivators. Person-centred primary health care providers enable lay persons to use evidence-based information to make health-promoting lifestyle choices, avoid hazardous

alternatives and recognize early evidence of dysfunction. Primary health care providers introduce consumers to, and facilitate them to undertake, self-care.

Self-care promises to transform both the tired health care system of the 20th century and those who practise it. Given the shift from acute infectious conditions to chronic non-communicable disorders, an ageing population and financially strained health care, self-care is rapidly being transformed from an option to a necessity. Successful self-care requires a change in the role of both health consumer and health professional; it shifts the emphasis from treatment to prevention, from dependent patient to active consumer. Self-care, by focusing on the individual rather than the condition, moves the emphasis from the passive recipient to interactive self-reliant client. It is only when individuals take personal responsibility for their wellbeing that the necessary population shift from high to low risk can be achieved. This text provides primary practitioners and patients with resources to aid them achieve the health shift fundamental to a sustainable health care system.

This book provides a blueprint for implementing self-care. It hypothesizes that a change in biomedical thinking is a prerequisite for addressing global health problems. Drawing on constructs used in complementary and alternative medicine and supported by scientific research in psychoneuroimmunology, a solution based on the infomedical model is proposed. This solution changes the clinical focus from disease care to health promotion and requires that the patient take personal responsibility for promoting their wellbeing. The impetus for self-care arises from a cognitive shift, its potency lies in the behavioural changes it effects.

Part I of the text alerts the primary practitioner to the evolving role of the health professional and the changing needs of the consumer in primary health care. It outlines strategies to enable patients to embrace self-care. The practitioner is made aware of the challenges facing health care in the 21st century and is provided with guidelines on how to assume the role of a facilitator who motivates and acts as a resource for evidence-based information.

Parts 2 to 4 of the text provide health professionals with resources they can use to inform and motivate patients. Part 2 identifies healthy lifestyle choices and considers how each contributes to wellness. It explores lifestyle choices and identifies green flags signalling healthy options. It considers how diet, spinal care, physical activity, sleep, mental fitness and sexual prudence all contribute to wellness. Part 3 examines how risky lifestyle choices jeopardize well-being. It identifies orange flags that signal hazardous options. It discusses how substance abuse, tobacco, alcohol, stress and environmental hazards can compromise health and reduce longevity. Part 4 focuses on detecting dysfunction. It identifies risk markers which suggest that the organism is being stressed and homeostasis is compromised. The more technologically advanced the diagnostic tool, the greater the potential to interrupt the progression of the disease process. Part 4 identifies the red flags of impending disease and suggests, at best, how homeostasis may be restored, or, at worst, how disease

progression may be limited. Risk markers for inflammation, obesity, diabetes, hypertension, ischaemic heart disease and osteoporosis are identified and their health implications discussed.

Resources for patient education and motivation are provided on a CD. It provides health professionals with handouts to alert, inform, motivate and guide patients to pursue a long, healthy life. The CD constitutes a handy toolbox to enable health professionals to provide more cost-effective person-centred primary care. The Pathway to Wellness template provides an overview of resources available on the CD.

Reference

1. World Health Organization. The World Health Report 2008 – Primary health care (now more than ever). <http://www.who.int/whr/2008/en/index.html> Accessed 12.02.08.

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PART 1

Sketching a path to wellness

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Points to Ponder !

- The health care system is struggling to cope with the needs of an ageing population.
- The situation is likely to worsen as government coffers increasingly rely on a shrinking workforce.
- A sustainable health care system requires not only that the emphasis changes from treatment to prevention but also that individuals actively strive for wellness.

Part 1 delineates problems threatening health care and identifies some strategies individuals can employ to meet the challenges ahead. It provides the theoretical background upon which the practical information in the remainder of the text is based. Chapter 1 considers how changes in demography

and disease prevalence coupled with technological and therapeutic advances in medicine have paradoxically resulted in an ailing health care system. Chapter 2 considers how a paradigm shift may provide the basis for developing a sustainable health care system. It explores how an integrated approach which draws from conventional health care and complementary and alternative medicine (CAM) therapies may provide an answer and identifies a new role for 'patients'. Chapter 3 focuses on chiropractic and describes how this vitalistic profession draws from the biomedical model to offer health care straddling discrepant paradigms. Chapter 4 identifies the mindset required for achieving a sustainable health care system with respect to both the cognitive framework in which care is offered by clinicians and the personal responsibility assumed by patients. It explores the changed relationship between patient

to adopt a self-care ethos. Chapter 7 considers how individuals may take increased responsibility for their wellbeing and outlines guidelines for undertaking safe self-care. Chapter 8 looks at strategies used to empower individuals to undertake self-care and identifies the vital role for health professionals in promulgating a sustainable health care system.

A health care system in crisis

Points to Ponder !

- The success of modern medicine has enabled survival of the weakest.
- Demographic changes have resulted in fewer taxpayers and more people relying on a shrinking health care budget.
- To survive, the cumbersome bureaucratic disease-focused system caring for a high-risk population needs to be transformed into a responsive, people-centred system promoting wellness care in a low-risk population.

Advances in medicine have revolutionized health care. Technology has made it possible to detect early pathological changes before signs or symptoms are discernible. While advances in diagnostic medicine have made it possible to detect potentially pathological changes while they are reversible, improvements in therapy have made remission of some previously fatal diseases feasible. Early diagnosis, drugs, radiotherapy and surgery prolong the lives of cancer patients. Patients, who in another health care era would have died, survive with any number of transplanted organs. The sophisticated system of health care developed in the 20th century does, however, come at a cost. Conventional health care systems disproportionately focus on disease rather than health, on the hospital rather than the community clinic. Instead of comprehensive service provided by a generalist, health care tends to be fragmented and specialized. Health is perceived as a commodity and health services are becoming increasingly commercialized.

Health: a costly government expenditure item

Health expenditure per capita in 2004 in the US was US\$6102; in Canada, US\$3165; in Germany, US\$3005; in Australia, US\$2876; in the UK, US\$2546; and in New Zealand, US\$2083.¹ As shown in Tables 1.1 and 1.2 the health care budget is an important item in gross domestic product (GDP) expenditure of both well and less developed countries. Health care expenditure is an important indicator of the capacity of a health care system to service a population's needs. Yet, despite the US spending a greater proportion of its GDP on health care than do many other countries, the US lacks a satisfactory health care system.² Michael Moore's film on health care in the US lays bare the sad state of America's health care system. He describes how Americans slip across the border to Canada for health care they cannot afford in their own country and how prisoners in Guantanamo Bay received better health care than American citizens. In spite of having the most costly health care system in the world, health care provided in the US is considered inferior to that available in Canada, Australia and the UK. The US rated lowest with respect to quality, access, efficiency, equity, and healthy lives.¹ Access to health services is a major problem in this country. The US, unlike the UK and Canada, does not offer universal health coverage insurance. While insured Americans enjoy rapid access to specialized health care services, lower-income earners have difficulty gaining access to affordable health care. On the other hand, government-subsidized health

Table 1.1 The cost of health care in well-developed countries*

	Canada	USA	UK	Australia
Gross national income per capita (ppp internat \$)	36,280	44,070	33,650	33,940
Government expenditure on health as % of total expenditure on health	70.4	45.8	87.4	67.2
Total expenditure on health as % GDP	10	15.3	8.4	8.7
Hospital beds/10,000 population	34	32	39	40

*2006 Figures derived from <http://www.who.int/whosis/data/>

Table 1.2 The cost of health care in less-developed countries*

	USA (for comparison)	South Africa	Zimbabwe	China
Gross national income per capita (ppp internat \$)	44,070	8900	?	4460
Government expenditure on health as % of total expenditure on health	45.8	41.9	52.6	42
Total expenditure on health as % GDP	15.3	8.6	8.4	4.5
Hospital beds /10,000 population	32	28	30	22

*2006 Figures derived from <http://www.who.int/whosis/data/>

care, although ensuring access for all, does not necessarily provide timely care for non-acute cases. While patients in the UK, Canada and Australia have little to no financial burden, they experience long wait times for specialized services. So problematic are hospital waiting lists that rather than making use of the government-funded Medicare system, many Australians choose to take out and bear the cost of private health insurance.

It is not only hospital care draining the health care budget. In Australia in the 2003–04 financial year, although hospital services accounted for more than one-third, pharmaceuticals consumed over one-tenth of the recurrent health budget.³ The Australian government provides a subsidized universal system of pharmaceutical provision, the Pharmaceutical Benefits Scheme (PBS).⁴ Despite incorporating patient copayments, with differentials for the general population compared with concessional beneficiaries, the PBS devours around 14% of total government health care. It has been estimated that pharmaceutical prescriptions are up by 41% over the latest decade. An untoward consequence of

successful medical intervention has been creation of a population group whose ability to function depends on regular medication. Prescription drug use is escalating and its impact on the health care dollar is cause for concern. The disproportionate distribution of the health care dollar to secondary and tertiary levels of health care leaves little for primary health care services. In contrast to the vast amounts spent on hospitals and pharmaceuticals, the Australian government allocated a mere 1.7% of recurrent health expenditure in 2003–04 to disease prevention and health promotion.³ The disproportionate expenditure on disease care versus health promotion is also apparent in the US.

Davis has identified a disjunction between what Americans pay for health care services and the contribution those services make to longer and healthier lives, relief of pain and anxiety, and quality of life.⁵ Compared with other industrialized nations, the US spends twice as much per capita but ranks 19th on mortality amenable to medical care. It was proposed that greater health gains would be possible if all Americans had access to modern medicine and

had a source of primary care that ensured they received all appropriate care. The lack of national health insurance was deemed, in addition to denying lower-income families access to hospital services, to undermine access to preventive care and better health outcomes. Americans without health insurance are less likely than those with coverage to receive preventive care services at appropriate ages.⁶

Modern medicine has been extremely successful at managing disease and prolonging the lives of sick people. The downside to this success is the evolution of a health care system which focuses on disease rather than health care. The disease care system has started to unravel. Medical advances, whether they be diagnostic or therapeutic, are costly. The overall growth of health expenditure per Australian grew by an average 3.8% each year between the 1997–98 and 2002–03 financial years.³ At that time, although over two-thirds of health care costs were shouldered by the Australian government, dissatisfaction with the ability of the current health care system to care for the nation's health was growing. The ability of any government to satisfactorily fund a population's demand for contemporary medical care is currently questionable. The situation is predicted to steadily worsen given demographic trends.

Changing demography: straining government resources

In the 15 years from 1990 to 2005, population growth rates decreased in both highly and less developed nations (see Tables 1.3 and 1.4). During this

period, the growth rate in Australia dropped from 1.5% to 1.1%; in Canada, from 1.3% to 1.0%; in the US, from 0.3% to 0.5%; in China, from 1.4% to 0.6%; in South Africa, from 2.3% to 0.8%; and in Zimbabwe, from 3.0% to 0.7%.⁷ The UK proved the exception, where the growth rate rose from 0.3% to 0.5%. Growth rates dropped despite people living for longer. In 2000, average life expectancy at birth was highest for Australians (80 years), followed by Canadians (79 years) and those living in the UK (78 years). In these countries the infant mortality rates also dropped during this period. In fact, the infant mortality rate in Canada dropped from 8 per 1000 live births in 1990 to 5 per 1000 in 2000, where it remained in 2006. Australia reported similarly low infant mortality statistics over the same period (8, 5 and 5), as did the USA (10, 7 and 7) and the UK.^{8,6,5} In 2000 in these four countries the probability of dying before the age of 5 years was low, around 6 per 1000 live births. The apparent paradox of decreased population growth in nations with reduced mortality among the young and increased longevity is explained by reduced fertility rates, helped somewhat by active contraception, e.g. in the UK the prevalence of contraceptive use was reported to be 82%. These altered statistics are best visualized in the changing demographic pattern. The pyramid shape used to describe population distribution no longer provides a satisfactory fit for developed countries. The previously dominant demographic population pyramid, with its large base of young people and relatively small peak of elderly people, is now assuming a form more reminiscent of a skyscraper. The change is most dramatic in countries with relatively low birth rates that have a large baby boomer cohort. An inevitable outcome of this changing demographic is an increased dependency ratio.

Table 1.3 Population statistics for well-developed countries*

	Canada	USA	UK	Australia
Population annual growth	0.9	1.0	0.4	1.1
Population median age	39	36	39	37
% population >60 yrs of age	18	17	22	18
% population <15 yrs of age	17	21	18	19

*2006 Figures derived from <http://www.who.int/whosis/data/>

Table 1.4 Population statistics for less-developed countries*

	USA (for comparison)	South Africa	Zimbabwe	China
Population annual growth	1.0	0.7	0.8	0.6
Population median age	36	24	19	33
% population >60 yrs of age	17	7	5	11
% population <15 yrs of age	21	32	39	21

*2006 Figures derived from <http://www.who.int/whosis/data/>

The relative numbers of children, working-age and older persons are changing. The percentage of older people is becoming disproportionately large. In 2000 there were approximately 605 million people over the age of 60; by 2050 this number is predicted to increase to almost 2 billion.⁸ Currently, the elderly constitute around 10% of the global population, with this figure being doubled in developed countries and halved in underdeveloped countries. By 2050, people 60 years of age and older are projected to make up 22% of the world's population, with one-third of the population falling into this age group in developed countries. Not only will there be a larger number of elderly people in the future, people will be living longer. There will be more older-aged elderly persons.⁸ Two-thirds of seniors who have ever lived are alive today!⁹ Babies born today in Australia can expect to live for over 80 years on average.³ For females, life expectancy at birth in 2002–2004 was 83 years, and for males it was 78 years. At age 65, Australian men in 2002–2004 could expect to reach the age of 82.5 years on average and women to reach 86.1 years – respectively about 6 and 8 years more than their counterparts in the early 20th century. It is predicted that 9 out of every 100 persons will reach 80 years of age in developed regions in the next four decades.⁸ By 2050, the number of the oldest old is projected to be five times as large as at present and to constitute 4% of the total population.

Based on a determination of the number of people presumed too old or too young to work, the dependency ratio provides governments with an estimate of the likely demand for future government subsidies. The youth-dependency ratio (the number of children per 100 persons of labour-force age) and the elderly-dependency ratio (the number aged 65 years or older per 100 persons

of labour-force age) provide insight into the escalating burden being placed on a shrinking taxpayer base.⁸ By definition, labour-force age is considered 15–64 years. The baby boomers that fired the industrialized powerhouses of developed nations are entering retirement and global demography is being transformed. Baby boomer-rich countries are particularly vulnerable to a rapid ageing transition. The dramatic increase from 14% to 21% of the population in the 65 years and older age group in Canada and the US reflects the baby boomers' progression into retirement.⁸ Alarmingly, there is mounting evidence that health care systems are failing to meet their populations' health needs even before the baby boomer wave enters retirement. The inadequacy of the health care dollar to meet current health care costs is going to escalate as the taxpayer base shrinks. The shortfall in the provision of health services is predicted to soar as governments vainly attempt to provide health care for an expanding elderly population. As people age, they require more health care. On average the health care expenditure required for persons over 75 years of age is almost sixfold that of persons in the 25–45 age group.¹ The health care system of the 20th century lacks the financial wherewithal to meet the needs of the ageing population of the 21st century.

The success of disease-oriented care available in developed countries has enabled sickly adults to live for longer and sickly babies to survive. In 2006 there were 5 infant deaths for every 1000 live births in Canada, Australia and the UK; in the US this rose to 7. A low infant mortality rate is a measure of the success of a health care system. Less developed nations have a higher infant mortality rate. In South Africa the infant mortality rate increased from 45 per 1000 live births in 1990 to 50 in 2000, and to 56 in 2006. In Zimbabwe the figures are