Editorial

# Arthritis Health Promotion Versus Comprehensive Arthritis Management. Is There a Difference?

Comprehensive management of arthritis and its related disorders is entering a new and dynamic phase as we begin the 21st century. Let us take a moment to review, from an historical perspective, two key components that have driven arthritis care during the 20th century: research with the acquisition of knowledge and economics.

Our knowledge of the more than 135 different types of arthritis has increased both in the basic pathophysiology as well as in the outcomes. Research to develop new medications, taking advantage of our new knowledge of pathophysiology, has resulted in new opportunities for disease control (e.g., in rheumatoid arthritis, RA), and at times for disease cure (e.g., Lyme disease). Research has also provided insight into different and more aggressive uses of our historical and standard medications. The inversion of the pyramid, first by Wilske[1], with the support of retrospective research by Pincus[2] and others, established the need for new models of care. This has been reinforced by prospective studies, which have demonstrated the success of therapies based on clinical outcomes, begun early in the course of RA, and the value of aggressive therapy, such as combination therapy. The development of biologic therapies has given hope to many with previously difficult-to-control disease, and given opportunities to not only control the disease, but possibly to reverse it.

Economics has been the other major force in the development of health care. Health care costs have been increasingly scrutinized, with attempts to contain those costs. In the United States, the introduction of health maintenance organizations has permitted the development of new initiatives to improve the health of individuals through health promotion, as well as disease management programs. These initiatives have lowered some disease occurrence, improved patient care, and lowered some health care costs. The overall health of communities has benefited by these initiatives of chronic disease management programs. However, by the beginning of the last decade the key components of research, knowledge, and economics became intertwined. This combination gave rise to a new outcome model driven *more* by economics and health promotion, and *less* by comprehensive disease management. The development of the Arthritis Self-Management Program (ASMP) by Lorig, *et al* at Stanford University was seen as an initiative to improve outcomes of disability, pain, depression, and fatigue. Subsequently, self-management programs were seen as having potential implications for both direct and indirect cost savings. The major difficulties relating to these programs include implementation, dissemination, and quality control, as well as the longterm maintenance of outcomes. Economic issues seem to further drive the evolution of self-management courses in arthritis.

To further "improve" the cost:benefit of the ASMP, Fries, *et al*[3] studied a mail-delivered Arthritis Self-Management Program, and Lorig, *et al* in 1998[4] compared the benefits of the traditional 6 week ASMP to a 3 week and a 1.5 hour version. Fries's study demonstrated a decrease in medical resource utilization and positive patient outcomes; Lorig's study concluded that the traditional 1.5 hour, 6 week community program was effective in increasing knowledge, self-efficacy, and contact with the Arthritis Foundation. However, while many of the outcome measures would improve, other conclusions were perhaps less encouraging. A 1993 study by Lorig[5] concluded that health education in chronic arthritis might add significant and sustained benefits to conventional therapy and at the same time reduce costs through reduced pain and decreased visits to physicians. The unsettling finding of the study was that physical disability increased in the arthritis patient population.

In this issue of *The Journal*, Solomon, *et al* question whether self-management education benefits all populations with arthritis[6]. The authors attempt to report the use of ASMP in the context of primary care physicians' practices. The ASMP program remains popular, being used not only in the United States but also in other countries, including

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Canada and Britain, and it has been translated into other languages. The ASMP program has been assessed in structured environments, usually based on patients who were recruited from larger populations on a voluntary basis, and who, perhaps, were "ready for change."

The study[6] used a network physician group, consisting of 1000 primary care physicians and 1100 community specialists linked by common insurance contracts. All sites agreed to participate in the study. Individuals with diagnoses including RA, osteoarthritis (OA), and fibromyalgia were identified and recruited by letter. The recruitment rate was about 12% in both arms, with 43% attrition rate afterwards. Of those who had completed the study, the baseline and 4 month questionnaires were compared. The comparison groups included those who were involved with the standard 6 week program with an experienced leader, and including use of the ASMP Handbook, versus a control group who were provided only with the Handbook. Satisfaction levels were similar between the two groups. Resource use was not different between the two groups. The authors suggest possible explanations for this outcome: their recruited volunteers were more "actively recruited" than those of other studies, and perhaps were less motivated to adhere to suggestions made in the ASMP course.

In a study by Keefe, *et al*[7], 177 patients (103 with RA, 74 with OA) enrolled in a self-management program to define phases of behavioral change. It was shown that 44% were in the pre-contemplation phase and 11% of the sample in the contemplation phase, and 45% were in the phases in which change may be expected. Expected change was defined as preparation phase, unprepared action phase, prepared maintenance[8,9].

The study by Solomon[6] should not discourage the use of self-management programs. More importantly their clinical trial indicates the need to further highlight the differences between health promotion and comprehensive disease management programs. As well, additional studies are urgently required to examine the determinants of improved outcome, including (1) identification of patients ready for change; (2) methods to facilitate patients to a readiness for change; (3) role of physicians and other allied health professions in the provision of a comprehensive program to improve outcomes; (4) the identification of the necessary components of a comprehensive care plan, which might include education, assessment/reassessment, and discipline-specific care delivery. With the promise of new therapies (biologics) and their significant associated increased costs, the emphasis should not be on finding the *least costly* self-management programs for people with arthritis, but the *most effective* programs.

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