Summary points

Barriers to coordinated care for chronic illness in Australia include multiple sources of funding, and general practice that focuses on acute care, with doctors working individually, not in teams

Definitions of managed care, coordinated care, and disease management models have not been agreed

SA HealthPlus successfully implemented a generic model of coordinated care with improved health outcomes but savings that were not sufficient to pay for all coordination costs

Self management capacity is a necessary component of assessment in determining allocation to coordinated care for chronic conditions

in both rural and urban settings. Cost savings were not sufficient to pay for coordinated care. However, the contribution to costs by service coordinator non-clinical roles suggests that a longitudinal study (five to 10 years) is required to assess the effects of service substitution on costs. Service coordination was found to be a necessary additional role than is currently available in the Australian health system. Better targeting of coordination should be based on prior admission to hospital and a potential to improve self management.

Source data was obtained from local and national evaluations of the coordinated care trials.

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Commentary: Trials should inform structures and processes needed for tailoring interventions

Jean Macq

Coordinating care for people with multiple needs is inherently complex as it relies strongly on social dynamics at various levels of the health systems. Designing fruitful regulation policies to make care efficient requires a proper systems analysis for tailoring the care model to the context. The SA HealthPlus trial was original for its ambition to test one coordinated care model for people with multiple needs across different chronic conditions and local healthcare

systems in South Australia, and it seems to have been tailored realistically to local services and needs.¹ The key elements—targeting patients who need coordinated care, the general practitioner's role as a care coordinator, and a tool for patient self management—have to be tested further in the Southern Australian context. As for similar programmes tested for one chronic condition,² results regarding cost and effectiveness are mixed: the overall implementation of the SA

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HealthPlus model did not reduce costs, but it improved people's health outcomes.

The paper is only a summary, and refers to numerous other papers describing and discussing the trial's outcomes and implications. The main policy lessons that could be learnt from the trial are complex. International readers interested in policy would want to learn more about how the coordinated care framework was tailored to local conditions and how this process could generate knowledge for future analysis, before and during development of coordinated care in other contexts. Such analysis needs an understanding of three intertwined types of structure and process, which have been partly documented for another trial of coordinated care in Australia.³

Firstly, analysing at baseline the interaction between care providers and their roles towards people with multiple needs should help to identify structures within the healthcare system that might hamper properly coordinated care. For instance, the difficulty healthcare professionals have in working as a multidisciplinary team could create problems when one type of healthcare professional coordinates services and another coordinates care for individual patients, as they did in South Australia.

Secondly, monitoring the interactions between stakeholders while the coordinated care model is being implemented can highlight the social structure patterns needed to tailor coordinated care programmes. The framework proposed by Cretin et al for

evaluating collaborative interventions to improve chronic illness care in the United States includes issues such as the characteristics of the organisation, environment, healthcare team and patient.⁴ The SA trials identified patients' capacity for self management as important for targeting those who would benefit from coordinated care—but the variety of local contexts in which the trial was implemented and the apparent variety in the outcomes of the various trials were not analysed to identify patterns of care providers.

Thirdly, a better understanding of national regulatory processes in South Australia and their relation to the health system's structure and culture might inform systems analysis in other settings and countries. One example is the comparison of developments in English and Dutch integrated care.⁵

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A memorable patient

Trouble at sea

I once worked as a locum for the regular ship's doctor of a large transatlantic passenger liner. Two days out from port a tall good looking 67 year old man came to the surgery. The diagnosis soon became apparent from his unhappy history of the previous 48 hours. He and his 28 year old wife were on their honeymoon, having got married just three days earlier. The daunting spectre of his impotence had become a depressing reality, and the survival of the marriage was already in the balance. "Maybe you can help me, doc," was his *cri de coeur*.

Treating impotence in a man in his 60s had a poor prognosis before the advent of sildenafil, yet something had to be done quickly. But what? I advised the patient to return to his cabin and that some powerful male sex hormone tablets would shortly be delivered to him. These would have a dramatic effect, I said, and would cure his problem within 24 hours.

Unfortunately, an intensive search in the ship's dispensary failed to elicit anything remotely suitable for improving his condition. On the point of giving up, I noticed a small dust covered bottle at the back of a drawer which had a few bright purple tablets in it. Looking at the label on it more out of curiosity than expectation, I read, "Tab Aspirin." I put all seven tablets in an envelope with directions to take one at bedtime and one early morning with a warning on no account to exceed the prescribed dose. They were delivered to his cabin forthwith.

During the next two days of the voyage neither he nor his wife was anywhere to be seen in the public rooms of the ship, and a "Do not disturb" notice was constantly on their cabin door. The awful thought that he might have jumped overboard occurred to me, so I was relieved when, shortly before we arrived at our destination, he came to the surgery again.

He was a changed man, confident and exuberant. "Fantastic tablets, doc—worked like a miracle. Will you give me a prescription for some more in case I need them when I get home again?" It was with considerable diffidence that I gave him a prescription for "Tab acetyl salicylic acid (purple)," hoping that no one would reveal the proprietary name before both of us had left the ship.

Gabriel Jaffe *retired general practitioner, Bournemouth, Dorset*

We welcome articles up to 600 words on topics such as *A memorable patient*, *A paper that changed my practice*, *My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. Please submit the article on <http://submit.bmj.com>. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.