Author's response to reviews

Title: Macro and meso level influences on long term condition self-management: stakeholder accounts of commonalities and differences across six European countries

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1) Self-management in chronic diseases is hard work, and highly depends at the macro level on health system structure and organisations, as well as environmental policies. Self-management is not only at stake at the micro level (the individual and his/her "behaviours"), or even the meso-level in the interaction with health professionals or structures. This qualitative investigation study among varied stakeholders with comparison between countries yields important data on macro level issues, and highlights the need to extend more systematically at the macro level the research agenda on self-management.

We thank the reviewer for the positive comments about the overall focus and worth of our submission.

2) CIM: abbreviation to be defined; There are some typographical errors: line 126: "focus on s of individual strategies"; line 717: interventions

CIM now defined as Chronic Illness Management and CIM abbreviation attended to.

We have attended to the typographical errors throughout the manuscript

3) References cited of the article are in majority from the same UK team as the authors. Results could be more discussed in light of other researches linking self-management with macro level issues (see Greenhalgh 2012), and of the existing relevant policies in the countries studies.

We have added the Greenhalgh reference to draw attention to the macro level issues as suggested and added a table with the background information which makes reference to the existing relevant policies and trends in the countries studied in a separate table (Appendix 1).

4) This paper addresses the prerequisites for facilitating diabetes type 2 self-management on a so called 'meso-'or macro-level in six different countries. To measure these prerequisites 90 semi-structured interviews are held. My main concern regards the many indistinctnesses in the paper. Key variables are not well-defined, namely: what is considered self-management?

We define in the first paragraph what self-management support is.

'SMS approaches stress individual motivation, goal setting, problem solving, life-style modification and information provision for individuals. For some conditions, such as diabetes type 2, attention has been paid to addressing the complexities of adjusting behaviour and practices through multiple behavioral and lifestyle change interventions [1,2].'

For clarity we have also added a definition of self management in relation to processes on macro and meso level.

'Self management has been defined as “the care taken by individuals towards their own health and well being: it comprises the actions they take to lead a healthy lifestyle; to meet their social, emotional and psychological needs; to care for their long-term condition; and to prevent further illness or accidents”. Self-management support includes the development of new technologies, information skills training and support from health professionals and self-care support networks.'
There has been some research focusing on the key barriers to engagement to self-management from the patients' perspective, which have included personal inconvenience (i.e., time and money), lack of information, and support from health professionals. Previous reviews have suggested that multi-level influences are likely to be implicated in the uptake and use of self-management support. Here we attempt to place an emphasis on macro-level influences—those related to political economic context and institutional arrangements and meso-structuring factors—those procedures, rules, and guidelines impacting on meso-environments of support (e.g., primary care).’ (pp. 4-5)

5) The lines 203-204 are a rough description; what is a trans-historical factor? If it is a government’s policy to organise self-management at a local level (which might be quite reasonable), it seems to be classified as ‘Reluctance / inability of policy makers to regulate processes and environments.’ One could call this policy a shift from macro to meso level.

Because of the confusion of the term we have removed the term trans-historical.

We have attended to what the referee is concerned here.

6) What do the authors mean with the variable ‘Social Environmental Influence on diabetes self-management’? We discuss this point on p. 7:

‘The most prominent macro-level social environmental influences identified as impacting on capacity for diabetes self-management were social inequalities, stigma, and the presence of a diabetogenic food environment. Respondents in the UK, NL and NO discussed the multi-faceted nature of unequal access to resources. This included the impact of social inequalities on prenatal predispositions, embedded unequal access to resources within urban planning policies (e.g., the location of food outlets, differential access to transport and exercise opportunities, diabetic-friendly diet, housing and health education). Social inequalities were identified as having a long-term impact on people’s resources to self-manage.’

7) Who decided on the sub-themes?

This point is clarified on p. 6 of the paper:

‘We undertook two comparative data analysis clinics with each participating partner. This was followed by additional discussions with individual partner countries. Each partner’s initial coding was subjected to an adapted comparative method to identify convergent and divergent themes across topics. The process was inductive and flexible. Consensus of the meaning of key topics was obtained through the cross-cultural analysis undertaken in the data clinics with the researchers from each country working towards shared meanings.’

8) The six participating countries are divided into two or three groups. Was this a specific research question? Spain is called a medium income country, in contrast to the UK. On what basis? Some countries have well-established social democratic traditions (line 650) Who defines?

This was a facet of the data which emerged as a facet of the data analysis and we have now made this more explicit.

‘The stakeholders in all partner countries identified a range of factors operating at macro and meso-level shaping diabetes SM. From the organisation and data analysis undertaken (described above) three themes: 1) social environmental influences on diabetes SM, 2) reluctance or inability of policy makers to regulate processes and environments related to chronic illness management, 3) biomedical focus and gaps in provision of SMS through the healthcare system (see Table 2). Through this process
of analysis we looked at the range of factors across the countries and presented data to show how a clustering around three groupings (see table 3). (p. 7)

We have added an appendix detailing differences in income between the countries included in the paper.

For clarity we have followed the advice of the reviewer and have now removed our reference to countries with well-established social democratic traditions. (p. 15)

9) The lines 652-655 are not a result, but a political interpretation.
Also the usage is not always clear, for example the following lines are difficult (or not) to understand: 91-93, 96-97, 99-100 (austerity measures? 'shaping illness management? ), 102-106, 206-208, 321-322, 338, 395-398, 574-5

We have made it clearer that the respondents were responsible for the interpretation rather than us imposing it on the data ourselves.

10) The Analysis is not very clearly described. 'Within interdependent systems': what does this mean? How were links analysed? Which software package was used? What does mean' through the cross-cultural analysis taken in the data clinics' (lines 220-221)?

We have changed the wording and incorporated the use of the software package (Word) in the description. We used word to identify key themes. We have described the stages of analysis further. With regard to the transcripts these were analysed using thematic analysis in three stages.

'The thematic framework emerged from analysis of a preliminary set of interviews from each partner which were called and shared with other partners to arrive at a consistent set of themes and topics across the five countries. Each participant country undertook reading and re-reading of transcripts and field notes which formed the bases of thematic and textual analysis arriving at a set of key themes and re-current sub-themes (see Table 2). Relevant quotes were translated into English and discussed with all partner countries involved. We undertook two comparative data analysis clinics with each participating partner. This was followed by additional discussions with individual partner countries. Each partner’s initial coding was subjected to an adapted comparative method to identify convergent and divergent themes across topics. The process was inductive and flexible. Consensus of the meaning of key topics was obtained through the cross cultural analysis undertaken in the data clinics with the researchers from each country working towards shared meanings.’ (pp. 6-7)

11) Table 1: In 5 out of 6 countries most respondents belonged to the category 'other professionals, besides doctors and nurses'. More details are necessary.

We have provided additional information as requested on p. 5:
'The same overall methodology was followed in all partner countries, but the recruitment process was adapted by each team in order to reflect the specificities of each national context. Depending on country specificity the number of health professionals in our sample varied and our sample also included other professionals involved in the policy development and implementation, such as economists, psychologists, social scientists, healthcare researchers, representatives of drug and technology companies, and representatives of local authorities, policymakers.' (p. 5)

12) Minor issues:- abbreviations are used, but not clarified: CIM (360), SN (461), CDM (618)
- the Abstract should clearly state that the study regards type 2 diabetes self-management and clearly define it.
This has now been included in the abstract and attended to all the abbreviations provided in the background (see earlier response).

13) line 212. Five countries?

This error has been rectified its settings in six countries and these have now been described.