A Socio-health system, the system of the future

Summary of the book, Managed Care in a Public Setting

If one were to pool all of the resources tied to health and social services in a given community and had the opportunity to plan the delivery of health and social services with no limitations on the way these were planned except the sum total of resources, would the resulting system look like anything what we know today? Although this may sound like a preposterous proposition, thinking this way is nonetheless the only way to achieve movement towards an optimal system[1]. I have not met one individual with whom I have shared this thought who did not immediately recognize the potential for seriously positive development based on such a strategy. The question then arises, "What are we waiting for?" In the book, guidelines are given that are designed as a manual for moving in that direction with sound argumentation for most aspects of what this strategy could come up against from opponents who think that tradition should prevail.

The first angle into this thinking is managed care. As an idea it is at least 100 years old. The first references in the literature are about the forerunner of managed care, the health maintenance organization (HMO). The underlying principle behind the HMO is that it has the full responsibility for all of the necessary health promotion and care for the population that subscribes to the HMO. The system typically encompasses one or several hospitals, GPs, psychologists and any and every thinkable mode of rehabilitation. The budget is provided from a capitation which is set per a given actuarial analysis. An overview regarding the history of this development is given by B.Abel-Smith: The rise and decline of early HMOs: Some international experiences[2]. The motivation for the HMO is primarily to keep costs down either to compete with other providers or to make money in the health care market. Furthermore, the issue of treatment is tied to prevention, in that everything you save through prevention you earn in the long run. In principle, the typical tax based health system in the western world is an HMO, since the same principle regarding a common budget holds. Meanwhile, these systems are plagued by less that optimal leadership, long waiting times and serious deficiencies in coordination, communication and follow-up.

A second angle is the concept of community oriented primary care (COPC), which is almost as old as the HMO concept. COPC attempts to involve the community in the planning and delivery of prevention as well as the delivery of primary care services. The literature describing COPC is more theoretical than practical, since the concept never has been implemented fully[3], [4], [5]. The ideology is to create a fitting mix of public health and primary care in order to approach an optimal delivery of both based on a commonality of databases and knowledge regarding the population in question. COPC has commanded variable levels of interest over the decades and has been a central issue in Himmelstein and Wollhanders proposal for a national health system for the USA[6] and the Obama administration's Affordable Healthcare Act[7]. The experience to date is less interesting for us than the concepts behind this.

A third angle is the international movement known as Health for All which has developed over the years with social justice as it main predicator. The strategy that has developed from this thinking is far ahead of the implementation[8], [9]. The interest for these concepts has waxed and waned over the years, and the lack of practical implementation appears to be tied to a general perception that the changes outlined would cost all too much to implement.

A fourth angle is quality development within and outside HMOs. Quality development, or CQI, or TQM or whatever it has been called over the years, is highly developed in the USA. This is partly motivated by the need to protect oneself against patients claiming malpractice and partly motivated by the need to remain competitive in an active market. The concepts arose from industry, where it is clear that one must know where one is before one can move forward. This is less clear than it should be to a majority of those dealing with documentation in health care and social services, especially the latter[10], [11], [12]. One of the serious accusations against HMOs was that they cut short on necessary treatments in order to save money. The studies done showed that this was not the demonstrable, indeed, it seemed that the opposite was the case[13], [14], [15].

A fifth angle is the use of instructional rules to keep costs down. Such have been given the term gag rules to denote that staff physicians were instructed not to tell patients about treatments that did not have clear benefit ratios. It turns out that HMO physicians are better at discussing options with their patients than non HMO physicians[16], [17]. The concept is tied to the lowest effective level of care. Research in this area is sparse, but the logic is clear, why pay more when less can do it? If one follows this thinking, much could be saved that is now wasted leaving room for more expensive but effective treatment modalities for less clarified problems[18]. All forms of welfare would be weighed much more qualitatively, and areas now less visible, such as the activation and re-introduction into the work force of disability pensioned persons would become routine.

Planning of the socio-health system would demand a set of simultaneous activities. The first of these is recruiting and/or gathering of a critical mass of relevant local leaders. These would then be trained by the best available resource people, who would bring them up to speed in terms of operationalizing the plan so that it fits local conditions. This activity needs to be financed outside of the project budget, which will only slowly materialize.

The second activity is to create the budget for the project. This will be a complex task with many difficult entities in need of clarification locally and/or regionally. A good example is the actual savings from treating a patient at home instead of hospitalization, and another is price setting of savings from getting patients back to work faster after illness. Some treatments that are exorbitantly expensive would have to be omitted for financing through national channels, e.g. the treatment of hemophiliacs that have developed allergy against their medicine. A sufficient budget is of paramount importance for the envisaged system to be functional.

The third activity is to activate the population that the project will serve. The first problem is of course to choose the population. There is no empirically sound method for achieving this. In light of the cited COPC literature above, it is clear that a balance must be struck between the need to be able to keep an overview of what is going on while at the same time having sufficient numbers to achieve a reasonable economy of scale. This balance can be struck with a population somewhere above 10,000 and below 50,000, but these figures are merely suggestive. A given town with its environs would be obviously advantageous, but if the population exceeds 50,000, how would one go about dividing the community? This would be one of the challenges for the local leadership.

Community activation in health and social services could be motivated by informational meetings, bulk mail newsletters, advertising and the creation of special interest groups. A pre-system implementation health profile should be carried out to serve as a basis for system evaluation 1 and 5 years down the road. Such activities have been carried out previously[19], [20], [21], [22], but it cannot be expected that local staff can carry out this task without significant and intensive training. This and

many other staff functions will require serious retooling of educational systems for training and continuing education[23], [24].

This may sound far-fetched and outlandish, and this summary is, indeed, only an appetizer for the book, Managed Care in a Public Setting. The book gives a much more detailed and comprehensive argumentation, analysis and conclusions. The book is, however, less than a cookbook, since many issues are contingent upon local conditions that cannot be described until the target population is established. It would not do to barge headlong into a complete system overhaul along these guidelines without first piloting it. Meanwhile, the only obstacles in the way of piloting the system are our attitudes. There is no doubt that the described process will lead to mobilization of large sums which can be utilized in different ways than they are bound to under current structures. It is highly probable that overall savings can be achieved under simultaneous and serious quality improvement in the primary care and social service sectors. It is also clear that leaders going through this process will discover a number of good and progressive changes that would not have come to them without this process.

The book URL is:
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