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Towards a new paradigm of healthcare: Addressing challenges to professional identities through Community Operational Research

Mike Walsh[a,*], Markus G. Kittler[a,b], Dawn Mahal[a]

[a] Stirling Management School, University of Stirling, Stirling FK9 4LA, United Kingdom
[b] MCI Management Center Innsbruck, Internationale Hochschule, Universitaetsstrasse 15, A-6020 Innsbruck, Austria

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ABSTRACT

Healthcare worldwide faces severe quality and cost issues, and the search for sustainability in healthcare establishes a grand challenge. Public interest is growing in a systemic re-conceptualising of healthcare, from primarily a consumerist problem of individual need for treatment to a need for communities themselves to become more effective in systemic prevention, coping and caring. In community led approaches, scarce resources are moved away from ever-increasing consumerist services to empower, develop and enable communities to plan their own health and community improvements in mutually interdependent patterns of care often seen as 'co-production'. This approach is exemplified by the innovative NUKA system of community led healthcare which originated in Alaska and which was trialled in Scotland in 2012, where it did not achieve similar acclaim as in the United States. In the Scottish NUKA trial opposition from professionals meant the trial was ended early. Our research found that omitting to account for the strong professional identity of GPs and other practice staff was instrumental in the failure of the trial. Beyond deficiencies inadequately considering professional identities, the trial also failed to engage the community and its patients as owners and architects of the system. We argue that the root cause of these problems was a more general critical systemic failure to manage participatory boundaries and associated identities. Community Operational Research practitioners have developed relevant theories, methodologies and methods to address issues of participation and identity, so could make a significant contribution to opening up new solutions for community led healthcare.

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1. Community Operational Research and healthcare

It is over three decades since Jonathan Rosenhead (1986), when President of the Operational Research Society, coined the term 'Community Operational Research' (COR), and substantially raised the profile of community-based interventions, especially in the UK. The relationship between COR and the work of health and social care professionals, managers and other workers, as well as those using health and social care services, is indicated by the growing number of published empirical examples of COR applied to diverse health and social care problems. A prominent early example is Ritchie, Taket, and Bryant's (1994) collection of 26 studies in community works, a substantial part of which deals with such topics as health needs assessment (Pepper, 1994), health strategy planning (Friend, 1994), maternal healthcare (Moullin, 1994) and also with vital cross-cutting health and social care themes such as community care (Vahl, 1994) and evaluation (Taket, 1994a; later further developed by Boyd et al., 2001, 2007). Since this key publication, others have addressed topics including healthcare quality improvement (Gregory, Romm, & Walsh, 1994; Walsh & Hostick, 2004), diversion from custody for mentally disordered offenders (Cohen & Midgley, 1994), mental health and employment (Midgley & Milne, 1995), family health (Taket & White, 2004), sustainability and health (Waltner-Toews, Kay, Murray, & Neudoerffer, 2004), community health schemes in developing countries (Smith, Harper, Potts, & Thyle, 2009) and critical decisions in the care of older people (Sommer & Mabin, 2015). To this may be added substantial theory developments, such as those of Frerichs, Hassmiller Lich, Dave, and Corbie-Smith (2016) and Midgley (2006).

The need for community-based participatory research and systems science to address health disparities has recently been highlighted by Frerichs et al. (2016). They argue that systems approaches have not often been combined with community-based participatory research, and they point to the value of the growing Community Operational Research (COR) literature. Nevertheless, COR as an approach to healthcare improvement remains relatively unknown to healthcare professionals compared with the many heavily promoted initiatives from quality improvement, such

* Corresponding author.
E-mail address: m.p.walsh@stir.ac.uk (M. Walsh).

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as those listed by Powell, Rushmer, and Davies (2009), which include, for example, Lean, Business Process Re-engineering and the very high profile Institute for Healthcare Improvement's '100,000 lives'-campaign (Berwick, Calkins, McCannon, & Hackbarth, 2006). But after decades of attempts to improve quality and yet contain costs, almost all health services around the world are faced with diverse and severe challenges. We argue that COR can contribute a timely, systemically consistent, effective and vital response to these challenges by helping to create more sustainable health and social care through community-led health and social care systems. Our recent research focuses on the obstacles to systemic community-led planning of health and social care arising from issues of social and professional identity. We suggest COR can help communities to overcome these obstacles by systemically addressing social and professional identity in community led healthcare.

Our paper is addressed at a heterogeneous audience: it is argued to be of relevance for the COR community, contributing to the ongoing debates focussed around health and social care, and discussing the merits of an alternative paradigm of healthcare delivery. It is also directed towards health and social care scholars, professionals and policy makers. While such a diverse target audience poses challenges to communication (Kittler, 2017), we see this as a worthy exercise to foster cross-pollination and bring the two communities closer together on a highly relevant and timely challenge.

We will begin by reviewing the severe nature of the challenges in healthcare, to which we argue COR can play an important role in fundamentally changing the conception, production, delivery and consumption of both health and social care. We will then assess the role of professional identity in the failure of a community led healthcare initiative: a trial of the Alaskan NUKA system in Scotland. Finally, we discuss how COR can address systemic resistance to change in healthcare by incorporating social and professional identity in COR led systemic transformations.

2. Quality and cost 'chasms' in healthcare

There is both a sense of great progress in medical care and yet deepening worries around the world about widespread quality and cost issues associated with health and social care. There is international recognition of pervasive health inequalities, both within and between countries (e.g., Marmot & Bell, 2012). There are acknowledged fundamental weaknesses in developing country health systems (US Government, 2012), and richer country health systems are seen as increasingly costly, with sustainability in doubt. On the latter point, Appleby (2013), a leading health economist at the King's Fund, forecasts that the costs of US healthcare will rise from around 17% of GDP to what will appear to many people as a staggering 50% of GDP by 2061 and British health care spending will rise from around 6.8% of GDP in 2016/2017 to as much as 16.6% by 2061; with the cost of long-term care rising from 1.1% to as much as 2.5% of GDP in the same period. Yet Appleby's analysis makes important assumptions (ceteris paribus as economists say), not only about long-term rates of growth (which may be much higher or much lower), but also about health technological, social and political factors—and may be, therefore, relatively conservative. In addition to the challenges stemming from a continuously increasing population, a variety of global systemic disruptions are possible. These might include the threat posed by antibiotic resistance (Davies, 2013; World Health Organisation, 2014), increasing demand arising from long-term conditions (Barnett et al., 2012), more need for end-of-life care for ageing populations (Gomes, Harding, Foley, & Higginson, 2009), and disrupted politics causing changes in spending in the face of international political turbulence. Climate change poses another severe disruptive threat, with immense health consequences within and beyond the timescales of Appleby's analysis (Intergovernmental Panel on Climate Change, 2015). Taken together, without change to the basic nature of healthcare, these possible developments imply that the risk of severe cuts or deterioration in quality in developed countries' healthcare is higher than Appleby (2013) suggests.

Given these enormous pressures, it is an international priority to rationalise healthcare in poorer countries by strengthening health systems, and in richer countries by improving quality whilst getting rid of waste and pursuing synergies and efficiencies. In recent years these kinds of initiatives have been led internationally by the Institute for Healthcare Improvement (IHI), with a focus on crossing the infamous 'quality chasm' (Institute of Medicine, 2001) in healthcare through patient centred care (e.g. Mason & Kittler, 2010) and high profile patient safety campaigns (e.g. McCannon, Hackbarth, & Griffin, 2007), typically by applying a Deming (1982) style 'plan-do-check/study-act' cycle. Another focus is the search for technological inventions and innovations in processes, treatments and tools, including new drugs, increasingly advanced treatments such as gene therapy (Kazemi et al., 2016), innovations like the roll out worldwide of the surgical safety checklist (World Health Organisation, 2008) and the innovative use of social media and other digital technologies (Gretton & Honeyman, 2016).

Unfortunately, innovative developments in improving the delivery of health and social care in developed (and also less developed) country contexts may themselves contribute to cost inflation by either increasing the range of diseases treated or adding to, not substituting for, existing treatments, or simply by contributing to the waste that Berwick and Hackbarth (2012) estimate is much greater than 20% of all healthcare expenditure. Indeed, action is needed, and Berwick and Hackbarth (2012) discuss overtreatment, failures of coordination, reliability and pricing, administrative complexity and fraud and abuse. Similarly, in UK healthcare the Kings Fund see the need to "transform" the National Health Service (NHS) in England by supporting self-management, prevention and better coordination (Naylor & Curry, 2015). The perceived local lack of sustainability in the NHS is recognised in the government requirement of the entire NHS in England to produce 44 regional sustainability and transformation plans (NHS England, 2016). For instance one plan, that of the North West London Collaboration of Clinical Commissioning Groups (2017), states that "over 30 percent of patients in acute hospitals do not need to be there", and "80 percent of people want to die at home, but only 22 percent do so". They further state that "if we don't take action, there will be a £1. 3 billion shortfall by 2021″ (p. 5). The action proposed is to move resources from caring for the ill to supporting "patients to stay well and take more control of their own health and wellbeing, as close to home as possible" (p. 2). Yet while the overarching goal seems clear, it is much less obvious how this transformation will be achieved nor what the relationship is between the planners and the planned for which appears to be top-down. For instance, the plan proposes to increase bowel screening uptake from 40–52% to 75% by 2020 (p. 23), but this is an efficiency target that does not itself address the sustainability of services. It also does not explain why the uptake of this highly desirable clinical activity is so low. More intriguing is the suggestion that there will be the use of patient activation measures to help patients take more control over their own care, but again the 'how?' is not addressed. The plan is silent on the details of these activities.

In contrast, in developing countries there remain large gaps between goals and achievements and this is mainly blamed on weak health systems (Roberts, Hsiao, Berman, & Reich, 2002) failing to deliver what is, at least in theory, already available. Hence, the World Health Organization (2007, p. iv) asserts that "the strategic importance of strengthening health systems is absolute". Indeed, the kind of strengthening proposed appears to lead weak

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