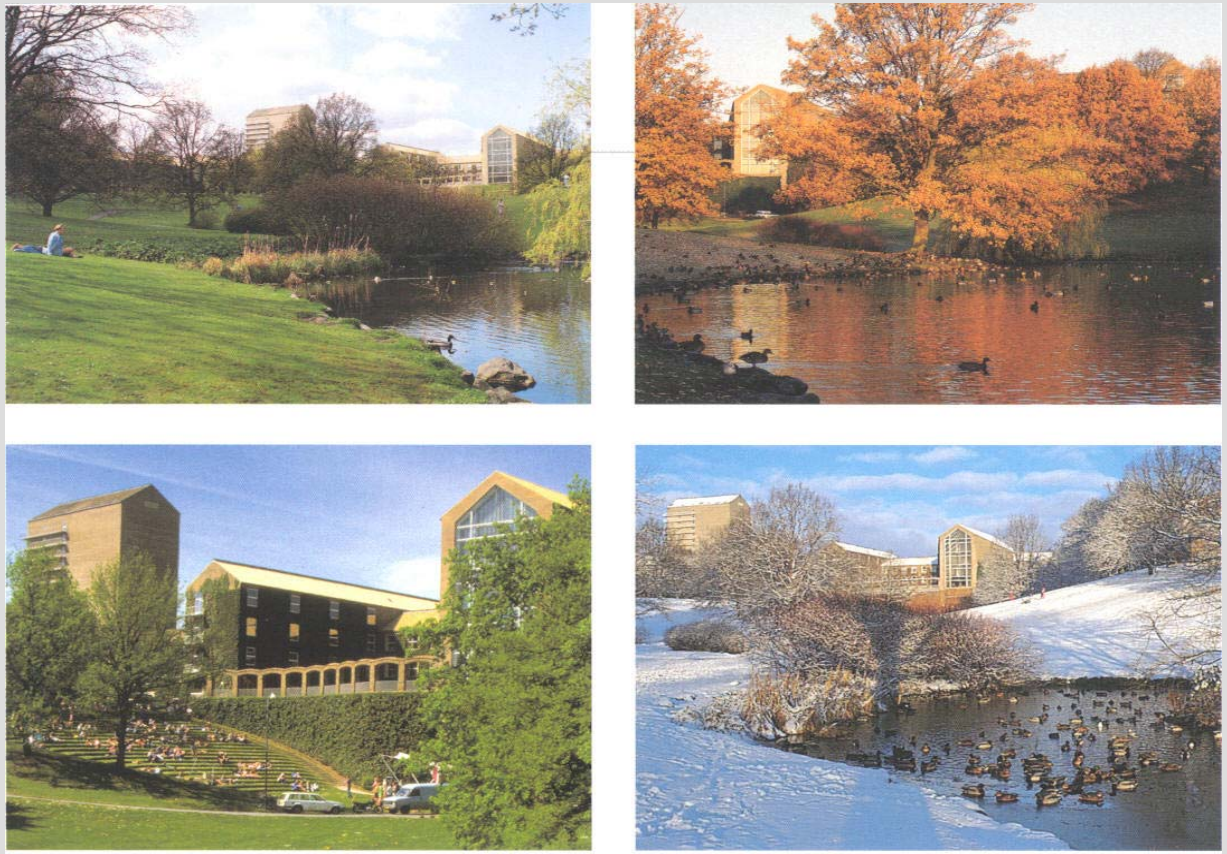
How can academics help transform health and social care systems?

- Frede Olesen, Professor, MD, GP, DrMedSci, FRCGP (hon.)
  - The Research Unit for General Practice
    - Aarhus University, Denmark



First answer

- **Data is the currency in health care systems – create valid data**
  - without data no transformation
    - *case stories*
    - *qualitative data*
    - *valid quantitative meassures*
- **Create trustfull transparancy**
  - valid knowledge about demand, need and outcome
- **Data + transparancy = Create a valid basis for decision**

Next answer

- **Decisons should be guided by but not necessary based on evidence**
  - Reseach = ‘we know’ – take care – be humble - any research has inborn values
    - *be explicit about values behind research questions & knowledge*
  - Health technology assesment
    - *the biological knowledge*
    - *the organisational aspect – can we do it?*
    - *the patient aspect – patients values and knowledge*
    - *cost – marginal cost – discounting – QUALY – opportunity cost*

Third answer

- Reseach and health technology assesment is a platform for decisions
- Research can never be decisive for decisions
- Have respect for the political decison proces
- Politics is a well-organised quarrel about values and priorities

Fourth answer

- **Research can raise relevant and obvious questions**
  - classic ‘the reseach question is …’
    - *may be not the most important question*
  - Often a reseacher is a good craftman, who can
    - *adress questions, which remove blind spots*

Remember: only reseach that is undertood has impact…

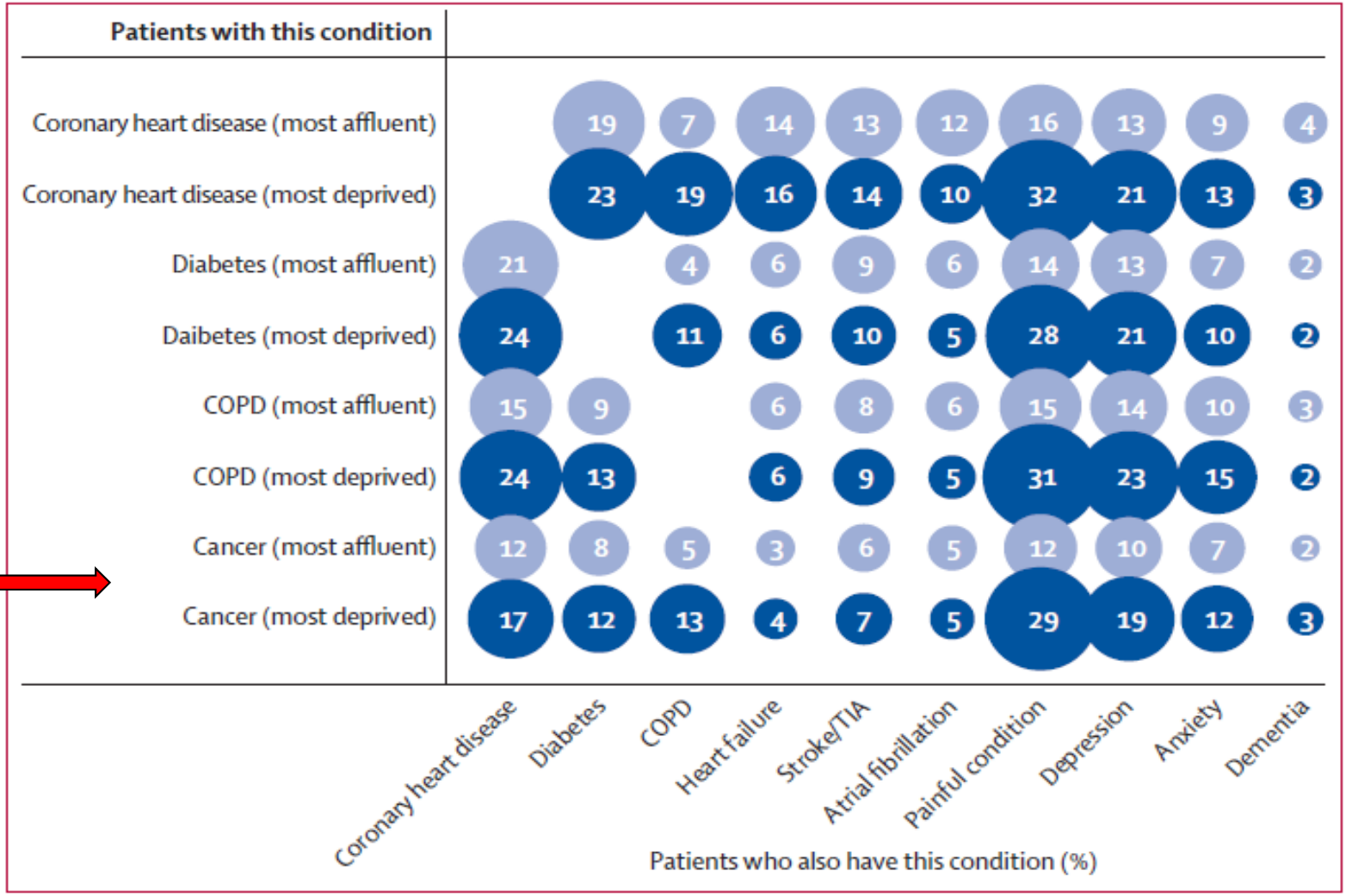


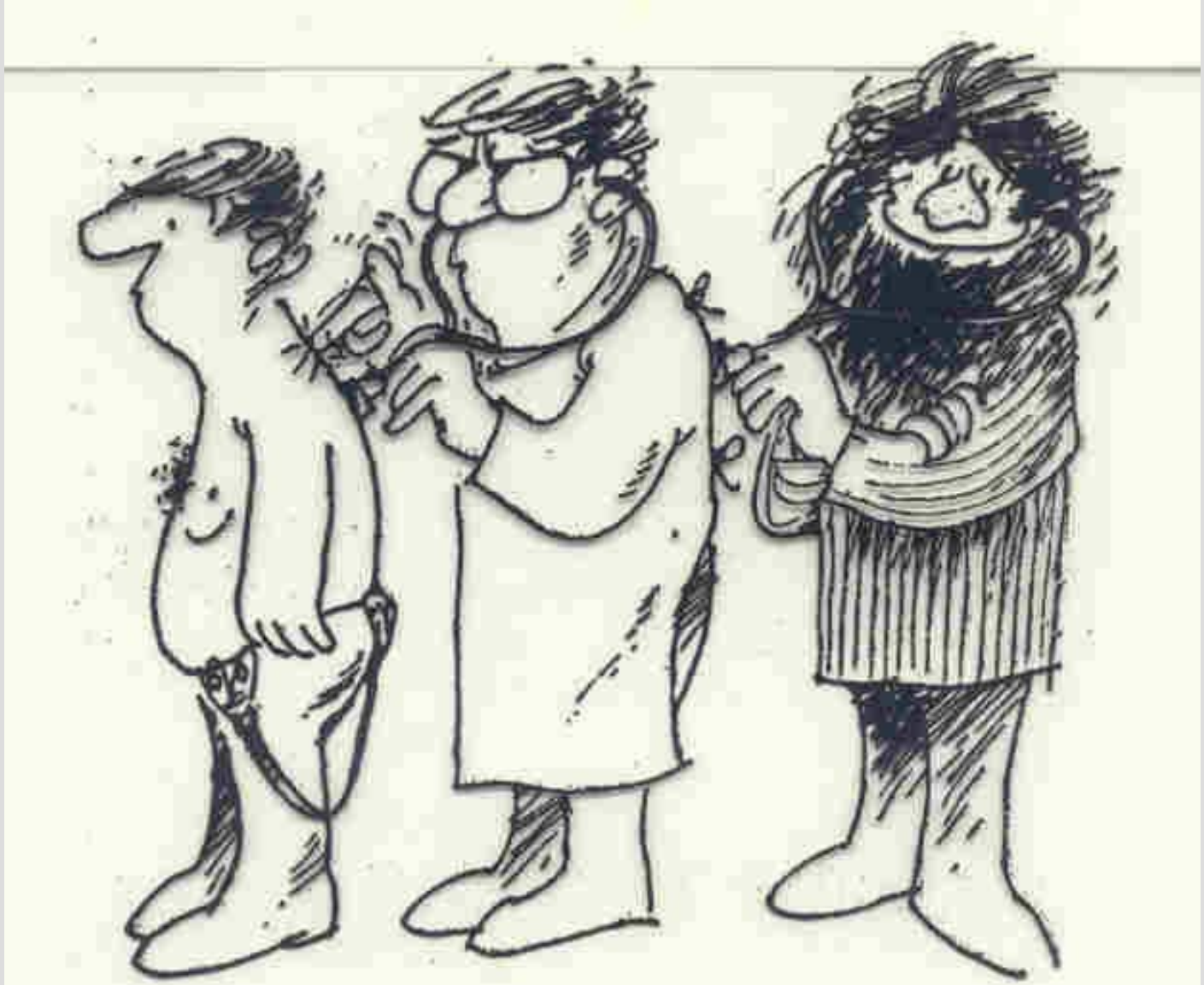
Figure 4: **Selected comorbidities in people with four common, important disorders in the most affluent and most deprived deciles**

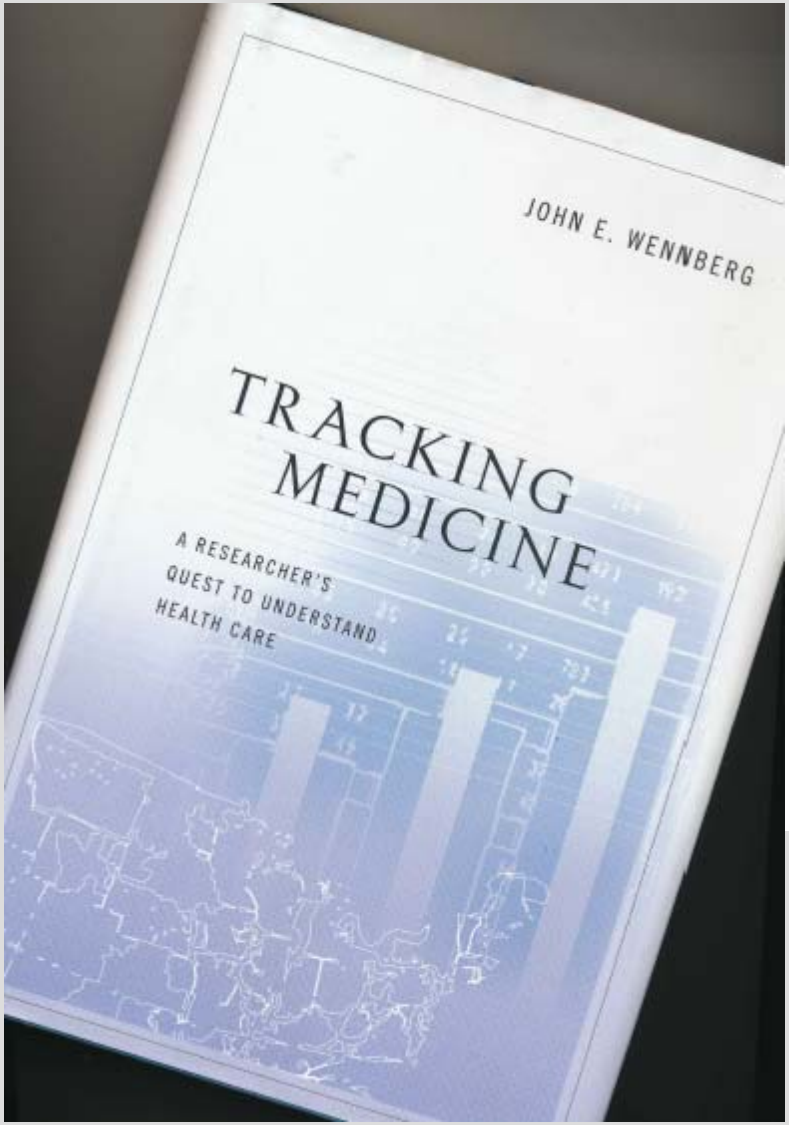
COPD=chronic obstructive pulmonary disease. TIA=transient ischaemic attack.

Barnett K, Mercer S et al.

www.thelancet.com **Published online May 10, 2012 DOI:10.1016/S0140-6736(12)60240-2**

Is the focus the patient or the performance of the health service and organisation of the service





bmj.com/podcasts Fiona Godlee interviews John Wennberg, http://bit.ly/excBMC

Time to tackle unwarranted variations in practice

Much of the variation in use of healthcare is accounted for by the willingness and ability of doctors to offer treatment rather than differences in illness or patient preference. Identifying and reducing such variation should be a priority for providers, says **John Wennberg**

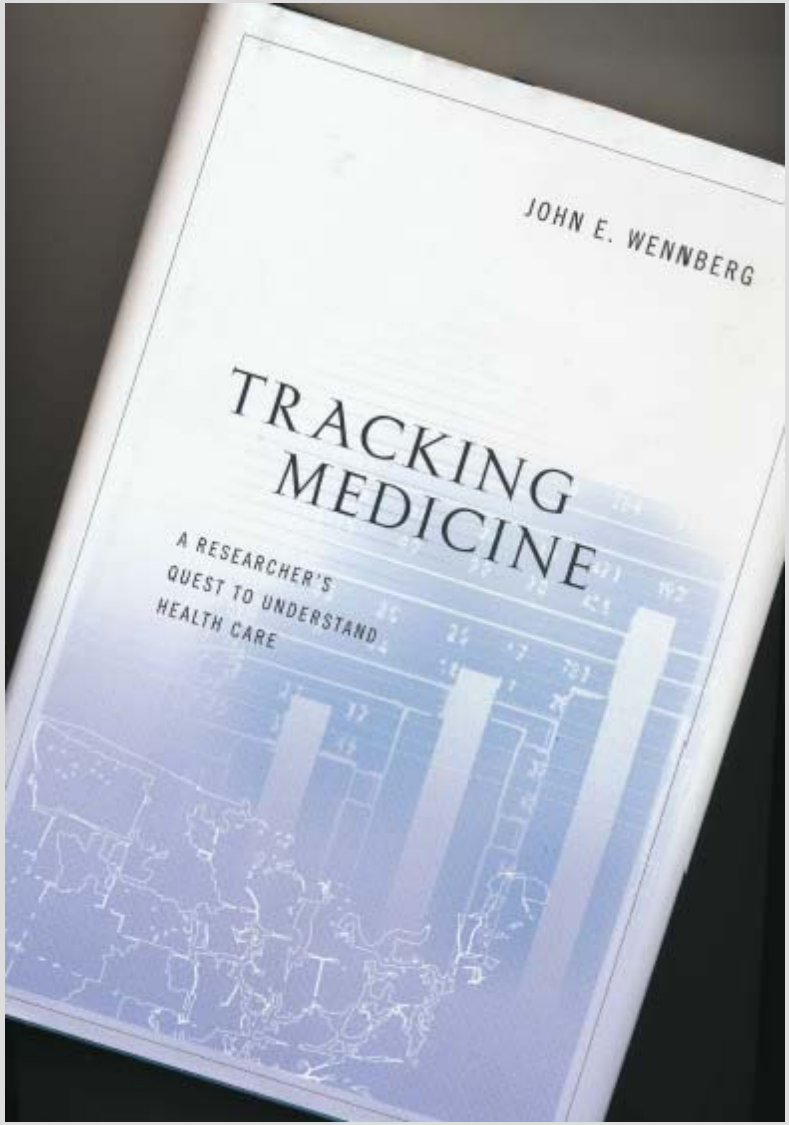
Since Alison Glover's classic 1938 study showing local differences in rates of tonsillectomy among British schoolchildren,[1] health service researchers have documented extensive variation in the delivery of healthcare in many parts of the world.[2-5] Information on practice variation is important for examining the relations between policy decisions and clinical decisions and raises important questions concerning the efficiency and effectiveness of healthcare. I have therefore argued that population based

Evidence and health care delivery

- **Effective care:**
  - Advantages much bigger than disadvantages
  - Everybody in the guideline target group should be treated
  - Variation = underconsumption = bad performance
- **Preference-sensitive care:**
  - There are different treatment options(for instance: operation/prescription/wait and see)
  - Information of the patient and shared decision-making are essential
  - Variation sensitive to doctors preferences and doctor-paternalism
- **Supply-sensitive care :**
  - Supply and access will increase consumption
  - For instance number of follow-up visits. Interval between follow -up. Available medical technology

Jim Young Kim – president Dartmouth College – now CEO for World Bank

- We can be certain that any reform effort that fails to incorporate Wennberg's insights will fall short of succes…
- We need a national institute of health care delivery…



Balance in clinical decision making - choosing wiseley

Good, but …

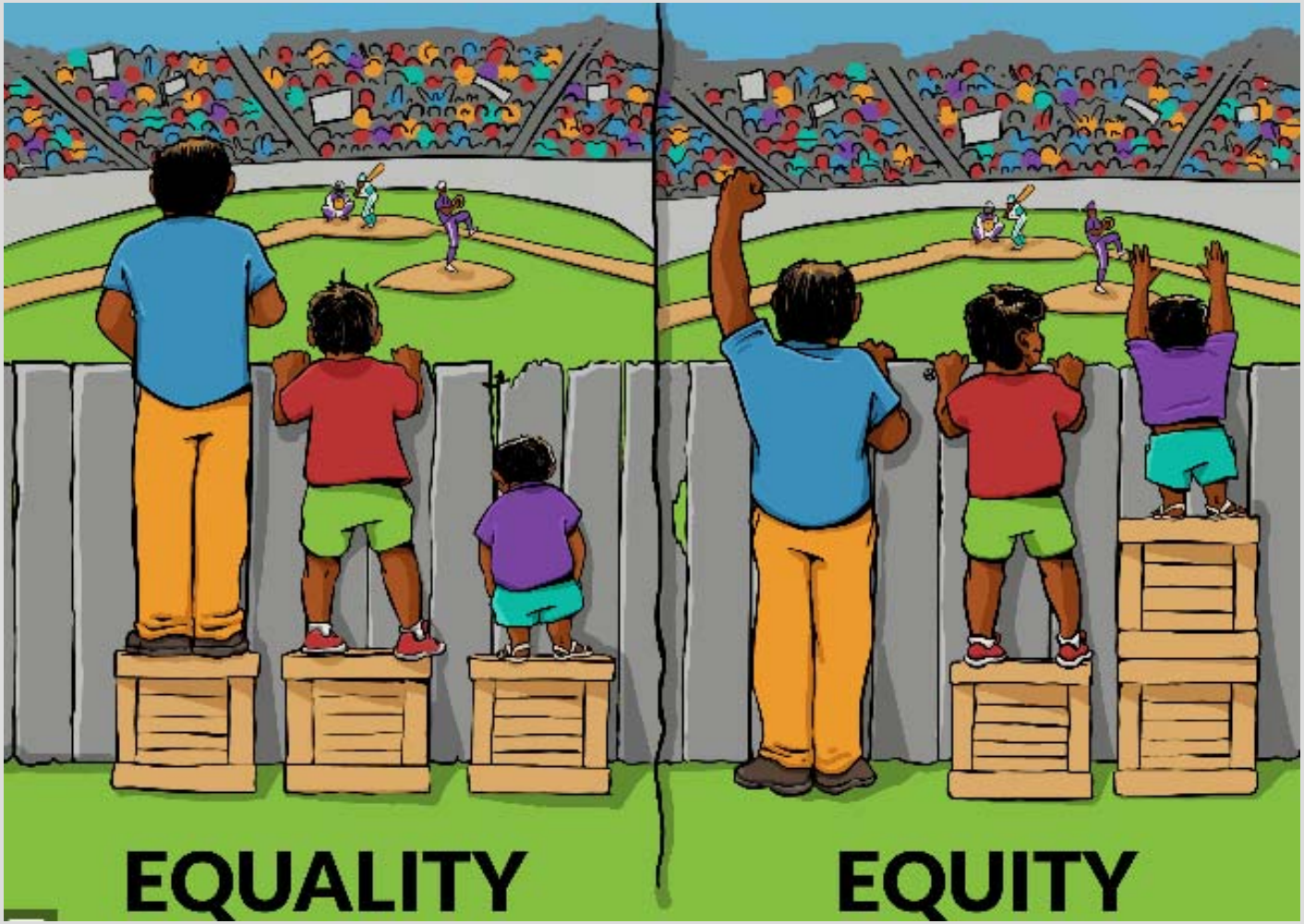
Is there a risk when research and evidence is not part of this poster.

Is the Wales approach better?:

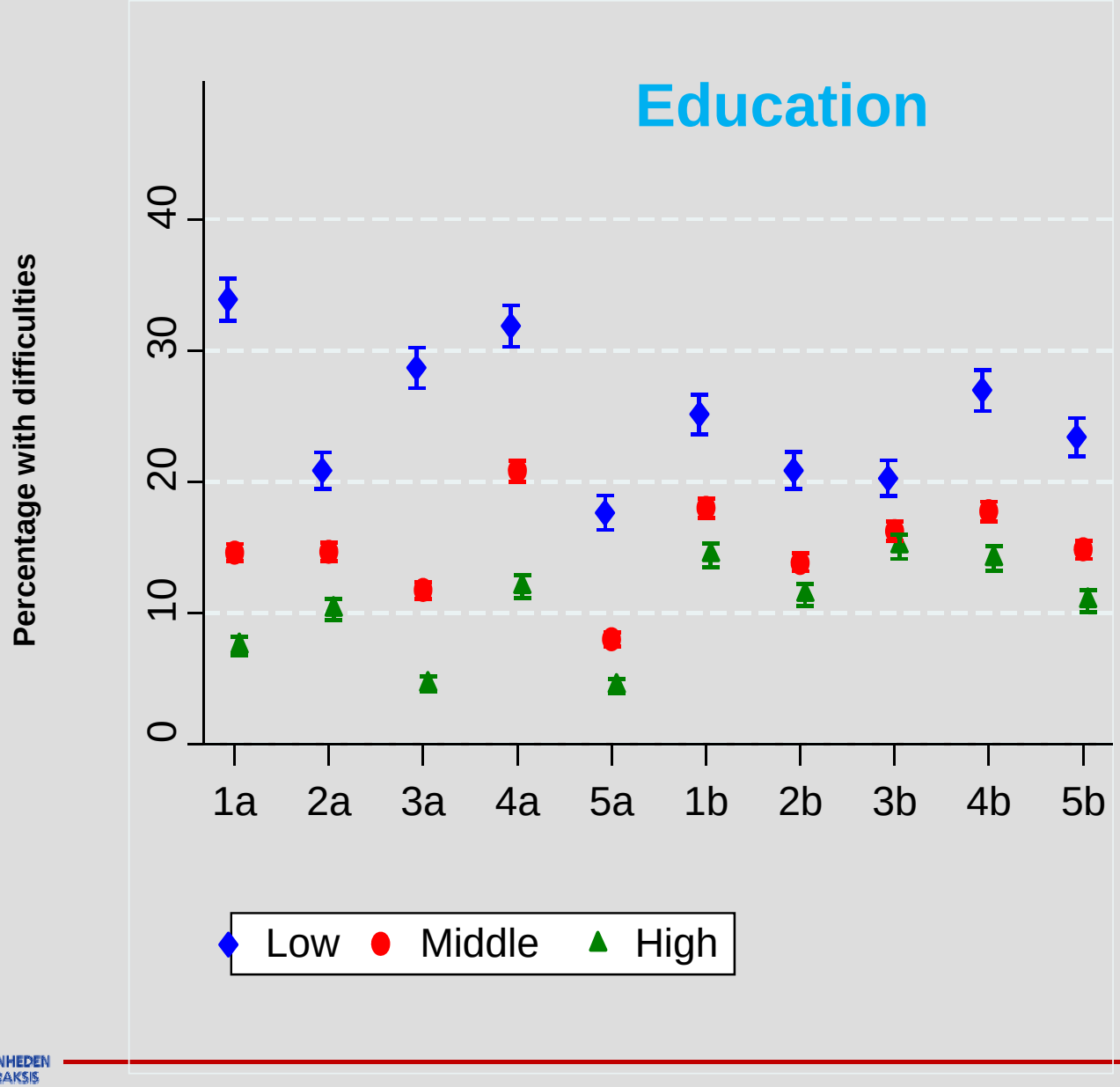
Talk about evidence

Talk about care for those in greatest need

Reseach should (also) be the consciensnes of a society



Are we creating a health care for the middle and upper class? Do we forget the problem with health litteracy?



Group a: to read, understand and act

Group b: to ask an run dialogue with foreign prof.

The largest steps forward are often based on (political) values

An enormous biologic succes …

- **The specialisation in health care**
  - better treatment, better outcome, better equality for each disease

- **But is specialisation about to reach the end of its added value?**

- **Can specialisation deal with all our symptoms and complaints?**

Time with an enourmous growth in staff and cost to hospitals is about to come to an end - time has come to restart a good development in primary care

Scotland: Transforming Primary Care

"My vision puts primary and community care at the heart of the healthcare system, with highly skilled multidisciplinary teams delivering care both in and out of hours, and a wide range of services that are tailored to each local area. That care will take place in locality clusters, and our primary care professionals will be involved in the strategic planning of our health services. The people who need healthcare will be more empowered and informed than ever, and will take control of their own health. They will be able to directly access the right professional care at the right time, and remain at or near home wherever possible."

Shona Robison, Scottish Parliament, 15 December 2015

"We will transform primary care, delivering a new Community Health Service with a new GP contract, increased GP numbers and new multi-disciplinary community hubs." SNP Manifesto, May 2016

Polical value: the balance between

- basic reseach and applied health service research

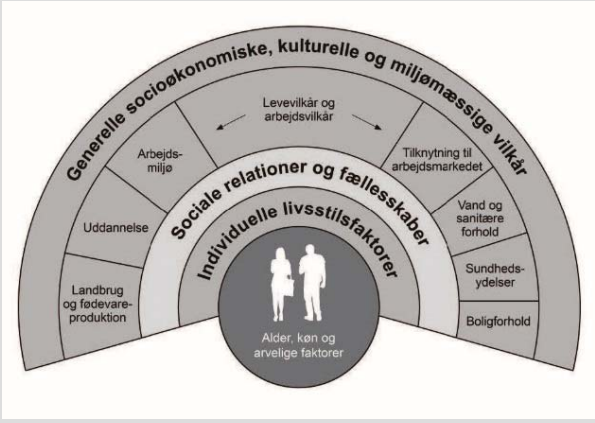
- biologic reseach and softer humanistic research

- the generalist and the specialist research

- classic medicine and social medicine

Values lost in modern biological research

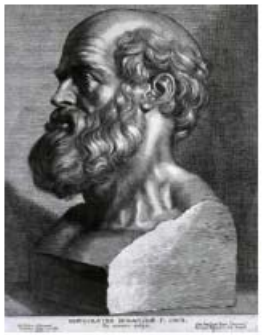
- **The importance of society as a deteminant for health**



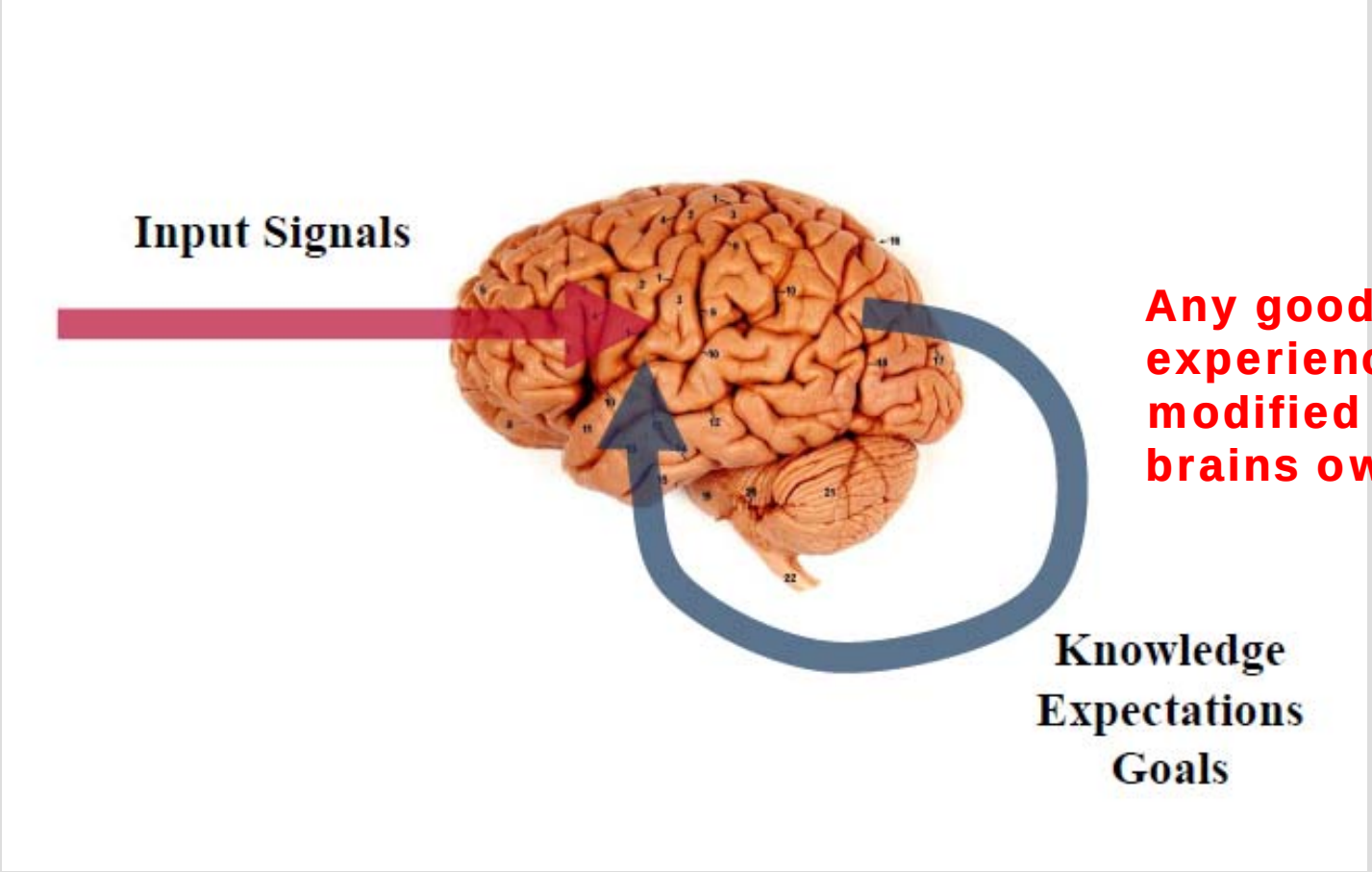
- **It is about individual persons and not diseases - multimorbidity**

"I would rather know the person who has the disease than know the disease the person has."

– *Hippocrates*



Forgotten or overseen facts in modern medicine
Signals + the brain = perceived symptoms



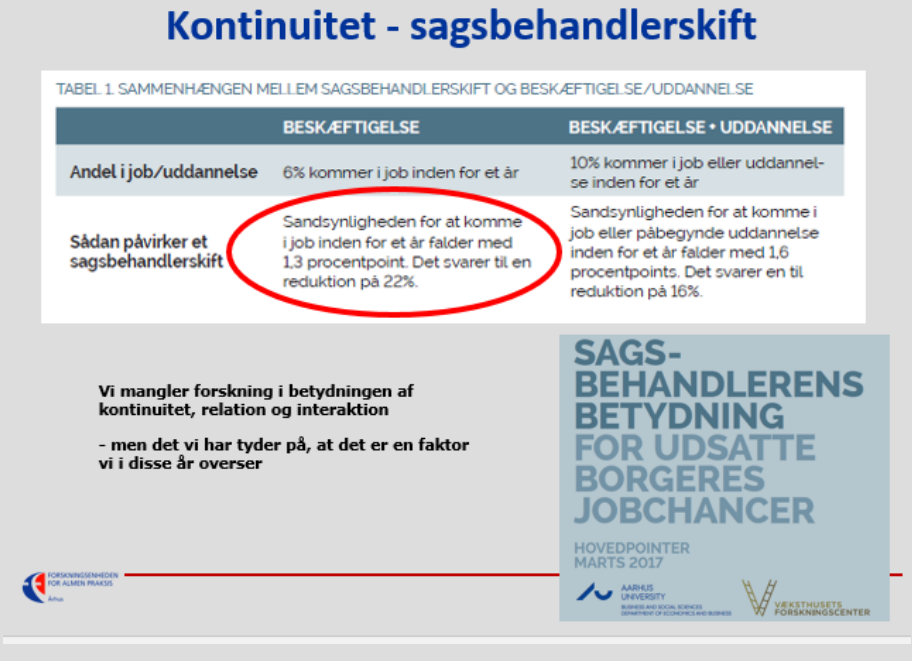
Any good or bad experience is modified by the brains own pharmacy

Our knowledge, expectaions, goals, opinions, feelings, trust, relation and perceived empathy is the manager of the brains own pharmacy.
This pharmacy determines symptoms, compliance and health behaviour

A recent Danish report

Long term unemployment and social problems:

If you change the attached social worker you have 20 % less chance for a new job



Skadestue London Kings-College-Hosp.

Bemanding : Senior Yngre læge Prakt. læge
Inklusion : Patienter med "Primary care" problemer (41%)
Metode : Kontrolleret intervention m. follow up
(interview + spsk til pt & prakt. læger)

Resultat
(n = 4641pt)

Tilfredshed : ingen forskel (ca. 80%)
Brug af praksis < 10 dage efter : ingen forskel

Omkostning incl. afledte :

	excl. henv.		incl. henv.	
	£	Relativ	£	Relativ
Senior :	19,30	100	68,25	100
Yngre :	17,97	93	44,68	77
Prakt :	11,70	61	32,30	55

Dalet & al. BMJ 1996;312:1340-4.

A&E London
- patiens walking in…
- randomised to 3 types of doctor

	Cost excl. referrals		Incl. referrals	
	£	Relativ	£	Relativ
Senior :	19,30	100	68,25	100
Yngre :	17,97	93	44,68	77
Prakt :	11,70	61	32,30	55

Dalet & al BMJ 1996;312:1340-4.

Can modern GPs avoid 2 roadside ditches

-

The dangerous paternalist who knows best:
overtreatment
overdiagnosis
too much use of technology
do not se the patient but only a disease
no patient autonomy

Another dangerous paternalist:
nihilist
afraid of modern specialisation
afraid of new technology
do not know enough about modern medicine
take away patients autonomy

Realistic medicine

Can modern GPs avoid 2 roadside ditches

-

The isolated doctor in the consultation
do not interact with society
do not act in a comprehensive health care
do not realise that society determines health
can not work in teams
lack respect for other prof-s'

The doctor who forget the value of the relation in a consultation
can not handle multimorbidity
can not handle soc. and med. complexity
do not use the doctor as a drug

The empathic, compassionate doctor with relation to patient and society

EDITORIALS

General practice is making a leap in the dark

New models of working risk throwing the baby out with the bathwater

Martin Marshall *professor of healthcare improvement*[1], Denis Pereira Gray *emeritus professor*[2]

[1]Department of Primary Care and Population Health, UCL Sir Ludwig Guttman Centre, London E20 1AS, UK; [2]University of Exeter, Exeter, UK

A strong case is being made in many countries that the traditional model of general practice needs to change. Critics claim that practices are too small and too isolated, that they are increasingly unable to meet their patients' needs and expectations, and are unfit to lead the necessary redesign of health systems.[1 2] As general practice in the UK in particular struggles with a demoralised workforce and inadequate resources,[3] these criticisms are being taken on board. Quietly

the costs of overmedicalisation. Fourthly, while specialists are generally better at adhering to single disease guidelines, generalists are more effective at dealing with the growing epidemic of multimorbidity. Finally, general practice care is more likely to focus on prevention and on enabling patients to look after their own health. A commitment to continuity of care and general practitioners' sense of responsibility for individual patients underpins these mechanisms.[9]

The well known organisation of GP

1: acces – also in deprived areas
2: the 'whole person' – not only the disease
3: dealing with risk and uncertainty
4: manage multimorbidity
5: empower individual self care

Faciltated by continuity and the relation

Are new reforms better?

'The jury is not just out in this question. It has not even been convened'

BMJ 2016;355:5698


Thank you for listening ...