Who cares? With services overburdened by growing demand and restricted supply, what opportunities for health creation are there to improve the accessibility and sustainability of health services in the UK?

Introduction

The National Health Service needs to make efficiency savings worth up to £20 billion by 2015[1] so that funds can be better utilised in addressing the changing demands of patients. The success of health services in the UK therefore relies on innovative, sustainable and resourceful multi-sector action. Unless intervention happens now, the provision of health services in the UK will become untenable and accessible only by the few.

What is health? Why should we all concern ourselves with its sustainability? The definition of health as "the ability to adapt and self-manage in the face of social, physical, and emotional challenges"[2] distances itself from an absolute to a dynamic state of well-being and broadens the scope of health to include not just intrinsic, but also extrinsic factors which impact us all and our activities of daily living (ADLs). Holistic health creation must therefore be efficient, adaptable and far-reaching, much like health itself, in order to supply the demand of health services in the UK to those who need it most [3].

A New Person-Centred Perspective

Health means different things to different people and is largely dependent on context and circumstances[4]. Services must accommodate person-specific drivers and influences to minimise the gap in health inequality and to become sustainable in the long-term. Taking this into account, the individual must be placed at the centre of all health provision if services are to be relevant and accepted by users.

Given the popularity of person-centred care in recent years, it is perhaps understandable that many existing initiatives and policies associate person-centred provision with autonomy and self-management in health and illness. This approach, however, is not always workable or efficient. To provide a dignified and caring experience to all, equality in health should consider individuals or groups at risk of isolation; or who may not wish to, or may not be able to self-manage. This may include the very young, the elderly, underrepresented groups, the homeless or even the unconscious patient amongst others. Whilst many will be enthusiastic and motivated to engage in change and will therefore fit the conventional 'autonomous patient' profile, services must provide for users who traditionally, have not been empowered nor reached in health interventions.

Therefore, an opportunity exists to review the person-centric approach of health provision whereby resources are pooled together, re-organised and diffused across specific and targeted services accommodating variable and progressive levels of health intervention - demonstrated in Figure 1.
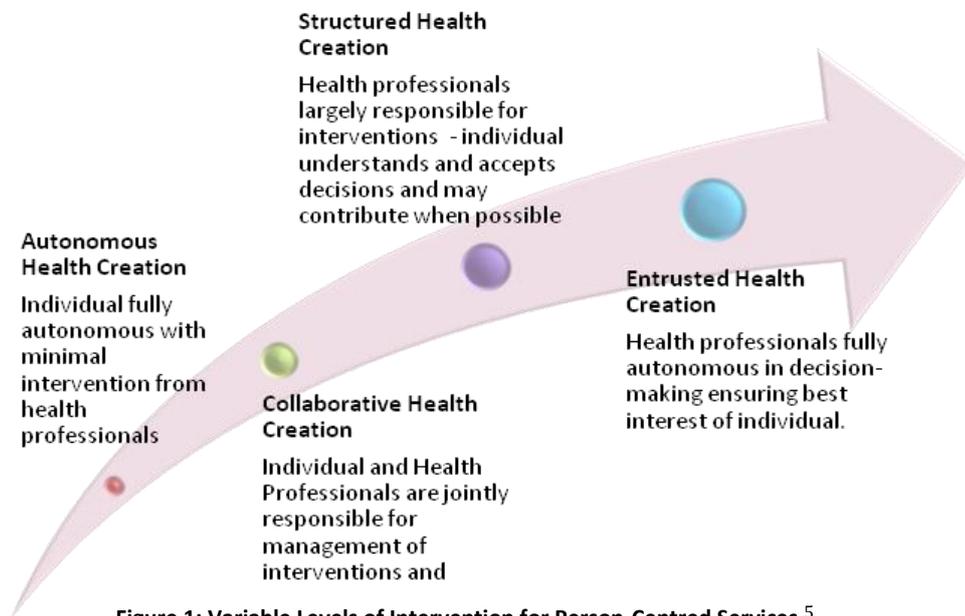
Structured Health Creation

Health professionals largely responsible for interventions - individual understands and accepts decisions and may contribute when possible

Autonomous Health Creation

Individual fully autonomous with minimal intervention from health professionals

Collaborative Health Creation

Individual and Health Professionals are jointly responsible for management of interventions and

Entrusted Health Creation

Health professionals fully autonomous in decision-making ensuring best interest of individual.

Figure 1: Variable Levels of Intervention for Person-Centred Services [5]

A Multi-Dimensional Approach to Health Accessibility

In delivering person-centred health services, no single set of methods and no single resource is suitable to manage the full range of factors of health and well-being. Since no solitary and linear solution is sustainable in the long-term, health creation requires a multi-dimensional (MD) approach[6]. Consistent and enduring accessibility to services must accommodate multiple dimensions and varying levels of intervention spanning an individual's life – exemplified in Figure 2.

This level of flexibility in health services will present its own challenges that may give rise to concerns of sustainability and cost. However, the key is not to provide an all-encompassing system that will cover every possible need or want in the
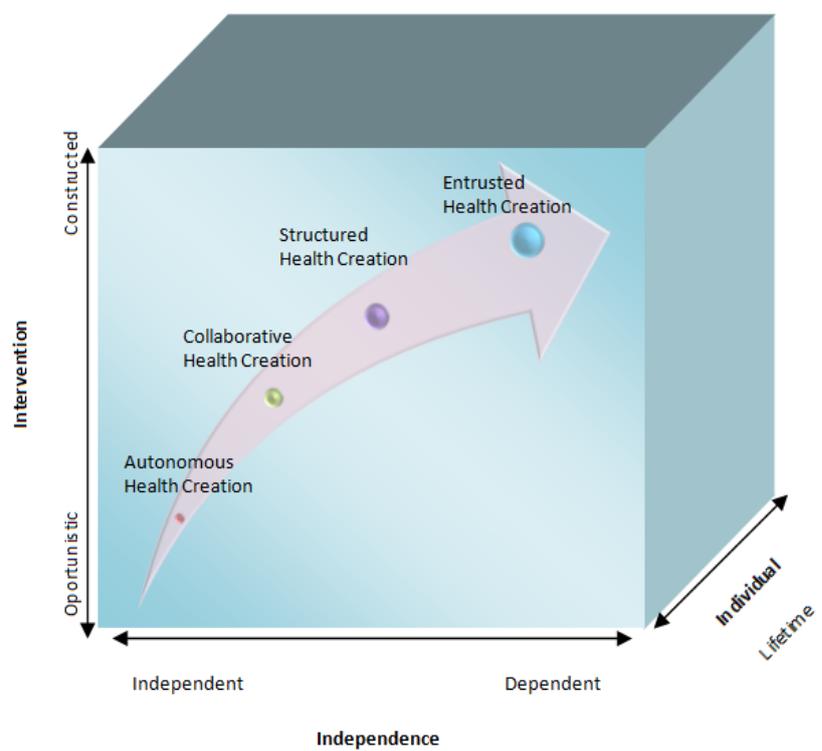
Constructed

Intervention

Opportunistic

Entrusted Health Creation

Structured Health Creation

Collaborative Health Creation

Autonomous Health Creation

Independent   Dependent

Independence

Individual Lifetime

Figure 2: Multi-Dimensional Health across a lifetime

hope one system will fit all since this would not be sustainable; but to provide a framework of services that enable individuals to pick and mix the level of intervention and support required as their needs, wants and abilities change over time – therefore creating truly accessible services.

In partnership with multi-sector and multi-disciplinary teams (MDT) this new model provides vital opportunities to deliver customised care and health promotion pathways, which meet not only the needs, but also the preferences of the individual [8]. This level of collaborative working encourages service improvements (and savings) through the identification of gaps and/or bottlenecks in service provision [9]. Furthermore, MDT working also reduces over-reliance on a single care provider thus helping maintain continuous and sustainable access to services and treatment and also providing a safe and resilient framework for health professionals; reducing stress and pressure within the health services through increased distribution of work and communication.

Addressing Influencing Factors in Health

In discussing accessibility, circumstances and influencing factors must also be considered. For example, with the UK becoming more ethnically diverse over time [10], the need to provide socially and culturally sensitive services is rising. Social and community influences, such as ethnicity, language and religion need to be better acknowledged and incorporated in health creation.

Case Study 1: Wellbeing for Ethnic Minorities Aged Sixteen Seventeen (WEMASS), Turning Point, Leicestershire [11]
Amongst a number of learnings, this study highlighted that focusing on ethnic minority groups could in effect be isolating people from people otherwise considered peer. This could as a result, reinforce differences. Rather than aim "culturally competent services" to specific ethnicities, focus on communities would be more appropriate.

The above case study considers the importance of peer influences. It should not be underestimated just how much personal behaviour and lifestyle can be influenced by conformity to social norms. The environment in which people find themselves can also greatly sustain or damage health. Therefore, a huge opportunity to improve health services exists within the community and with its leaders.

To improve sustainability and accessibility to health services in the UK, we must not only incorporate the MD health model in context, as displayed in Figure 3, but we must also make better use of the talents and skills found in our local communities[12] irrespective of gender, age, ethnicity, class, sexuality, disability, etc. and we must allow these resources to work together in order to create accessible, relevant and sustainable health services.
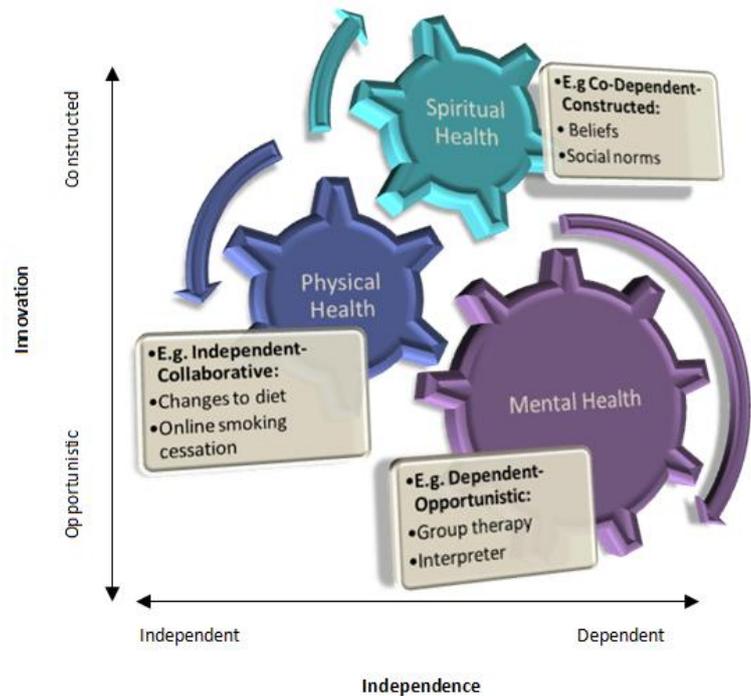

Figure 3: Individual MD health creation at a point in time

Mobilising and Streamlining Community Services with Technology

Communities and local governments are often best placed to direct resources and priorities to shape the health of a localilty[13]. However, when taking into account the diverse cultures and the potential geographical reach within a single community, it becomes apparent that managing and sustaining accessibility is a challenge. The Mobile Health Worker Project exemplified how technology can be used to tackle this.

Case Study 2: National Mobile Health Worker Project (MHWP) [14]
This study aimed to understand mobile working and its requirements to assess if changes to working processes would result in improved satisfaction efficiency and increased productivity for patients and health workers across with the use of mobile technology. Significant increases in productivity and available time for patient contact; reductions in unnecessary journeys as well as time spent travelling; and significant reductions in data duplication were key findings.

Process change and streamlining of resources in health provision has been previously discussed as a benefit of MDTs; A rollout of similar initiatives to MHWP across communities within the MD model would provide a manageable and sustainable foundation for health management, in which cost savings and service improvements would be achieved. In this example, the use of technology and online resources provided users with more relevant, up to date and accurate

information which they were able to access themselves (suitable in Autonomous/Collaborative levels of intervention). As a result of changes to these processes, health workers were freed up to increase contact time with service users (up to 104% - suitable in Structured/Entrusted levels of intervention). Mobilising and streamlining community services with technology within an MD health model therefore not only improves person-centred services, but also provides a sustainable framework for health which takes advantage of available resources.

In addition, technology can also help reduce waste. Case Study 3 features an example of how institutions are confronting the challenge of Did Not Attends (DNAs - missed appointments) to improve services and reduce costs. DNAs are avoidable, and yet have a significant impact on the health system in terms of cost and waiting times[15].

Case Study 3: Using technology to reduce Did Not Attends (DNAs) [16,17]
Portsmouth Hospitals NHS Trust is implementing technology to automate its reminder service with an expected reduction in service costs of 40%. Similarly, The Borchardt Medical Centre in Manchester has a dedicated mobile number which patients can text to cancel appointments. Both of these approaches aim to provide a sustainable method of reducing DNAs.

Conclusion

Health services in the UK are overstretched because resources are not being utilised efficiently. To address increasing demand, health inequalities and to improve access to services in an efficient and sustainable manner, we must all care, change and streamline our processes where we can be our most efficient, flexible and adaptable – in the community. Health services, with the help of evolving technology, must remain relevant and inclusive for service users and should encompass a multi-dimensional approach to ensure that an individual's physical, intellectual, emotional and social needs are being met with the adequate level of person-centred intervention. Alongside care system reforms, policy and other government initiatives, these holistic interventions will provide a much more sustainable model for health creation going forwards; resulting in increased quality and accessibility of health provision and improved patient satisfaction at an affordable and sustainable cost.

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