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New structures and principles in health services

Graham Walton

Introduction

In almost four years, since the companion volume (Booth and Walton, 2000) to this title was first published, the fast rate of change in health has continued apace. The approach taken in Walton (2000) has again been applied in identifying broad sociological, technological, economic and political trends. This chapter provides a perspective on what is shaping the health sector in 2004, informed by a workshop (Herman, 2003) organised by the United Kingdom's Chartered Institute of Library and Information Professionals (CILIP) This workshop identified key issues facing health librarians.

Sociological

Patient empowerment

Probably the most significant recent trend has been the pressure for empowering patients, stimulated in the United Kingdom by publication of the Bristol inquiry report (Learning from Bristol, 2001). This report revealed an 'organisational failure of foresight based on a series of systemic and communication failures which contributed to oversight of an incubating hazard which led to disaster' (Alasqewski, 2002). The report acknowledges a defining moment in health and social care (Smith, 1998) and its recommendations are intended to improve confidence by enhancing public involvement through empowerment. This requires both respect and honesty for users and carers. Direct involvement with the public is seen as a mechanism for breaking down a defensive and insular culture.

This trend to adopt a client-centred, patient empowered approach is characterised by patients wanting to be better informed and better educated (White, 2002). Patients will have less time to get things done, be less deferential, and want more control and choice. They expect treatment to be safe and high quality. Active participation by patients is significant in achieving better care and greater satisfaction (NHS Executive, 1999). However, many clinicians continue to treat patients as ‘passive recipients rather than as equal partners in their own treatment and care’ (Kendall and Lissauer, 2003).

Within libraries, an emphasis on undertaking user needs’ analyses is similarly aimed at ensuring that the customer is at the centre of service developments. Project teams working on developing new library and information services (LIS) gain added value from active library user involvement.

Health clinician roles and working practices

This shift in the role of the patient is mirrored by changes within the health care team. Political, environmental, and professional pressures have, in the United Kingdom at least, included the reduction in junior doctors’ working hours, recruitment and retention problems and government targets for health outcomes. The NHS Plan (Secretary of the State for Health, 1999) emphasised the need to review and develop the scope and levels of practice, thereby having a significant impact on the nursing profession (Jones, 2003; Daly and Carnwell, 2003). Job titles such as clinical nurse specialist, nurse practitioner, advanced nurse practitioner; higher-level practitioner and nurse consultant have been adopted, often with little understanding or consensus as to the nature of, or differences

between, such roles. Related initiatives are exploring the role of a generic health worker who can undertake activities previously divided among different health professionals.

Changes in roles are accompanied by pressures for clinicians to develop different working practices. Multidisciplinary teamwork encourages nurses to work in partnership with domestic and support staff to improve the ward environment. This 'new professionalism' embraces care based on 'shared practice, knowledge and values rather than differences based on jealously guarded systems of regulation, education and pay' (Kendall and Lissauer, 2003). Different professional groups need to develop new ways of working together, including adopting roles as local change agents to influence and improve service provision (Wanless, 2001).

Librarians must keep abreast of such changes and revise and develop information services to accommodate these developments. It will become increasingly difficult to justify providing different services to different user groups. Libraries also need to stock materials around change management and related management areas.

Collaboration and partnership

In writing about the so-called 'Third Way' (an alternative to socialism and capitalism), Giddens (1998) identifies a duty to collaborate and to link quality and equity with efficiency and permanence (Macdonald and Smith, 2001). These challenges focus on partnership working. The pressure to work more collaboratively was enforced by the NHS Plan (Secretary of State for Health, 2000) which signalled the integration of primary health and social care services within one organisation called a Care Trust. As

primary care and social services sectors become more closely integrated LIS will have to adapt to reflect new partnerships with new working styles. For effective collaboration organisations and professionals need to have common achievable goals (Rummery and Coleman, 2003).

The competitive ethos that pervaded the 1980s and early 1990s is slowly eroding. Partnership working is one way to bring in expertise and skills not currently present in an organisation. Within health, collaborative work is going on between the NHS, the higher education sector, voluntary agencies, charities and the commercial sector. As Chapter 11 attests, collaboration and joint working have obvious implications for the development and delivery of future LIS.

Ageing population

Across the world governments are ill prepared to cope with the growing ageing population. In Japan, by 2025, 26% of the population will be over 65 with the percentage of the national income spent on the elderly rising from 2.5% to 10%. Numbers of people aged 75 and over continue to increase at the highest rate (Hardey et al, 2001). By 2031 there will be an estimated 34,000 people in the United Kingdom over 100 (a 425% increase since 1994).

The same trends are common to many countries: people are healthier, live longer and demand better medical care. Diseases such as Alzheimer's, dementia and osteoarthritis will become more prevalent as the number of elderly people rises. The economic impact of these trends for governments include a surge in numbers of people seeking surgery for

advanced stage osteoarthritis, hip and knee replacements. Governments need to meet the escalating costs of treating these diseases. Librarians will witness an increased demand for material on all aspects of elderly care as increasing numbers of clinicians become involved in geriatrics.

Globalisation

Globalisation is another factor which has impacted on health. Evans (2002) has explored different interpretations of the term 'globalisation', placing the 'borderless world' at the centre of globalisation where 'internationalisation, interdependence and universalisation' are key concepts. New global economic, financial, social, cultural and political links bring societies and nations into increasingly closer contact (Banta, 2001). With global travel growing from 25 million in 1950 to 500 million in 1993 and estimated to reach 1 billion by 2010 (Rodriguez-Garcia, 2001) the spread of old, new and re-emerging infectious diseases will intensify. Globalisation involves the creation of links among corporations, international organisations, governments, communities and families (Waters, 2001).

As a result of globalisation librarians will encounter an increasingly international health worker population. Some will have limited English language ability and will expect access to professional information in their own language. Libraries will require staff who can meet these needs placing a further imperative for effective staff development programmes.

Technological

Biological warfare

Although there is little evidence to indicate that biological warfare and bioterrorism are prevalent the terrorist attack on the United States in September 2001 has made the threat of biological warfare a predominant concern for most Western governments. Infectious diseases have been used as weapons for many years. Biological warfare agents are cheap and easy to obtain and disperse - even a small volume of an agent can cause high morbidity and mortality. The resulting public panic and social disruption can multiply the impact. As Western governments try to establish the best approaches to possible bioterrorism attacks theoretical exercises have revealed logistic weaknesses and false assumptions in treatment and prevention strategies (Beeching et al, 2002). The challenge is for libraries to make information on such threats available to health professionals in a timely fashion, if and when needed.

Pandemics

In recent years pandemics have had a major impact on many aspects of life. The most recent of these was the severe acute respiratory syndrome (SARS) that originated in China and resulted in a death toll of 770. While this outbreak now seems to be contained (Spread of SARS slows, 2003) pandemics, such as SARS and AIDS, have a devastating effect on many, especially in developing countries (Stephenson, 2003). As of the end of 2002, 42 million people worldwide were infected with HIV, the virus that causes AIDS. In many countries, the loss of farm workers to AIDS has caused food shortages and potential famines. New diseases can appear very quickly with wide-ranging implications

for the world. Media involvement is increasingly influential on the nature and level of impact of such diseases.

In many ways, libraries are central to ensuring that health professionals and health service users develop a realistic understanding of these pandemics. Information that is balanced, clearly presented and grounded in scientific evidence needs to counter-balance the information produced by the media.

Electronic patient records

There appear to be many advantages in moving to an electronic patient record.

Computers can manage care co-ordination and documentation and electronic patient record systems can monitor care (Safran, 2001). This frees clinicians to concentrate on interpersonal interactions and the provision of healthcare. Progress can be updated collaboratively via the shared electronic patient record with such records allowing access from a range of locations. Morgan (2003) defines an electronic patient record as the ‘universal or longitudinal integration of all historical patient medical data, such as test results or drug allergies, into a single, secure electric record available to care providers from hospital to GP surgeries to community care facilities’.

At a theoretical level, the electronic patient record should lead to greater operational efficiency but a recent conference (‘Electronic records target unlikely, 2003) predicted that the government would miss its target of giving each patient an electronic record by March 2005 (Secretary of State for Health, 2000). Problems abound in the wholesale introduction of the electronic record. For example, a state of the art £1140 million electronic patient record project in the West of England to produce records for 11 million

people was recently aborted (Rogers, 2003). Various cultural issues must be addressed when introducing electronic patient records. Clinicians need to be involved from conceptual design through to implementation and maintenance. Relevance to practice and tangible benefits must be established. The developed interface must be easy to use and have a very fast response time. Having a powerful champion and advocate is also beneficial. Morgan (2003) reports that acceptance can come from demonstrating that an electronic patient record allows the reduction of medical errors, improvement of patient care and the saving of time. It is possible that a combination of newly educated health professionals with computer skills and health care consumers who demand digitally enhanced quality will drive through the adoption of the technology (Safran, 2001).

Electronic patient records provide opportunities for library services. Using information and communication technologies (ICT), electronic library services can be delivered in tandem with the electronic record. Lessons learnt in moving to electronic delivery of the patient record also have parallels when developing electronic library services.

Health informatics and evidence based practice

Georgiou (2001) argues that health informatics is the very engine room driving evidence based practice (EBP). Clinicians must have access to the best available evidence to reduce uncertainties associated with clinical decisions (Thompson et al, 2001). Without access to quality research knowledge, evidence based decision making is not possible.

EBP involves “integration of individual clinical expertise with the best available external clinical evidence from systematic research” (Sackett et al, 1996). Practitioners perceive a lack of access to systematic research, often cited as a reason why some professional groups fail to use this material (Thompson et al, 2001).

Evidence based practice needs robust clinical information systems to ensure its success. Health informatics is defined (Georgiou, 2001) as a discipline that integrates biomedical sciences, computer sciences and healthcare policy, management and organisation. Advances such as on-line databases, World Wide Web, e-journals, e-books have improved communications and spurred the development of EBP. The delivery of the National electronic Library for Health (NeLH) is covered in depth elsewhere in this book. As Turner et al (2002) state, a key function of NeLH is to provide fast and easy access to evidence based information to assist decision making. The challenge for the future is to integrate the electronic patient record with access to evidence provided by NeLH. Providing the information is not enough, work is also needed to ensure health professionals have basic computer skills as well as specific knowledge of available resources (Griffiths and Riddington, 2001). Distinctions between the roles of the health informaticist and the LIS professional will become increasingly blurred.

A major development in the United Kingdom has been the provision of 'NHS Direct Online' (Jenkins and Gann, 2003). This service is intended to increase citizens' access to health information and care services. Straightforward health information needs are answered by this service and its development focus has targeted a personalised, individual service for users.

Economic

The costs of health care always raise considerable controversy. The two core issues (rationing and cost containment) are considered elsewhere (Walton, 2000) but recent

high profile economic issues have included cost effectiveness and public/ private initiatives.

Cost effectiveness

Economic evaluation compares the costs and consequences of one treatment against the costs and consequences of at least one other. Classic cost effectiveness involves achieving the same results more cheaply. Information is needed on both the resource use (costs) and benefits (often health gains) that would result from alternative approaches. Richard and Griffiths (2000) state that when measuring cost effectiveness it is important to consider reduced mortality, increased longevity and reduced complications. In health, cost effectiveness is often used to determine the least expensive way to achieve a given output, to establish if the same output can be gained with less input and the best way to spend a budget for a given group of patients (Donaldson et al, 2002).

Costs in an economic evaluation can be attributed within three sectors. Patients and carers have costs, including out-of-pocket spending and allowances for their time (including employees' salaries, overheads incurred and facilities used). Other provisions for care must also be costed as savings in health care can lead to the costs being transferred (e.g. residential care, home help, social work). Then there are direct costs incurred in the health sector (medication, GP visits, inpatient costs). Cost effectiveness cannot be applied where new treatments require more resources. Within this environment, libraries too must demonstrate the cost effectiveness of their services. Librarians need to apply local data to demonstrate the benefits that their services deliver. Published studies on the costs and benefits of health LIS need to be identified and used to support such a case.

Public/private funding

Private finance initiatives (PFI) have existed in the United Kingdom for the last decade.

They were introduced primarily to reduce the cost of public sector capital projects.

Within the NHS the usual process is to set up a limited company, which enters into negotiations with a NHS Trust to supply the building, 'bed space' and the non-clinical services. An annual payment is made by the Trust for these services. These contracts can last between 30 and 50 years. After this period the hospital may (or may not) be owned by the Trust. Over £7000 million has been committed to the development and management of major NHS assets by means of PFI (Dawson, 2001).

Proponents of PFI claim it will lead to more investment without increasing public sector borrowing requirements. Value for money is seen to come from costs over the life of the project being lowered because of greater private sector efficiency and by the private sector assuming the risks normally carried by the public sector (Pollock et al, 2002).

Debates are currently taking place about the actual benefits around private finance initiatives (Dawson, 2001; Pollock, 2002). Opponents argue that using private finance to build hospitals is expensive, constrains services and limits future options. With resourcing constraints, funding from both the public and the private sector needs to be considered by librarians. Charities, national lotteries and commercial concerns might provide funding. Service development projects could also be sponsored by external agencies.

Political

Organisational change

Health services continue to encounter increasing organisational change. Walshe (2003) demonstrates that such reform and restructuring has continued for two decades or longer with some organisational change taking place almost every year. The cumulative effects of this change and upheaval is succinctly summarised (Walshe, 2003):

- Benefits from the change are usually not realised as subsequent ideas are implemented before the previous ones are evaluated
- Each reform introduces costs in financial and human terms.
- Very often changes take the NHS back to where it started
- Short termism is encouraged where there is rapid, major change on a regular basis. Innovation is very difficult to promulgate in this culture. This is further emphasised by Fairey (2003) (NHS' first Director of Information Technology) who argues that the major obstacles to the widespread use of IT in the NHS are the negative impacts of this level and rate of change.

Health LIS are not immune to constraints resulting from organisational change. Services need to be developed to meet changing user needs but this is difficult when the library itself has to cope with fundamental changes to library structure, reporting lines and sources of funding.

Local accountability

Various political strategies have been implemented to make health services more accountable to the local populations. For example, the establishment of foundation trusts (Department of Health, 2002) is intended to create a wholly new type of public interest

organisation (Lewis, 2003). Foundation hospitals will be freed from central control and be owned by members drawn from local residents, patients and staff. They are intended to hold greater freedom over pay, non-pay rewards and recruitment. Jobanputra and Buchan (2003) identify such advantages as increased localism, devolved decision-making, improved morale and improved performance. A disadvantage is that a two-tier service could emerge.

Lifelong learning

Numerous political strategies in the United Kingdom promulgate lifelong learning (Audit Commission, 2001: Department of Health, 2000:Department of Health, 2001). This reflects an increasing acceptance that lifelong learning should continue throughout the working life of all health care professionals. The Government also acknowledges that there should be a culture of lifelong learning with all NHS trusts expected to be learning organisations. The infrastructure for this is being established through the creation of Workforce Development Confederations and the NHS University (NHSU). Continuing professional development (CPD) is also explicitly identified in government strategies. By adopting CPD and lifelong learning, Trusts can ensure competent and educated health care professionals are at the forefront of care delivery. The importance of lifelong learning for health LIS is similarly intense. David Stewart explores these issues in more detail in Chapter 13.

Quality

The Commission for Health Improvement (CHI) was established to improve (<http://www.chi.nhs.uk/eng/about/whatischi.shtml>) the quality of patient care by reviewing care provided by the NHS in England and Wales (Scotland has its own regulatory body, the NHS Quality Improvement Scotland). Its statutory functions are to monitor patient care and to improve quality by carrying out clinical governance reviews. It also monitors and reviews how the NHS meets the recommendations of National Service Frameworks (NSF) and National Institute for Clinical Excellence (NICE) guidelines. CHI also investigates serious service failures in the NHS. CHI leads, reviews and assists NHS healthcare improvement, while aiming to collect and share notable practice.

Concern has been expressed that the pressure on United Kingdom's public services to measure achievement may skew priorities and encourage short termism. The award and withdrawal of quality scores to different hospitals has provoked further controversy. Health LIS must similarly address how quality is measured and reviewed (Hewlett and Walton, 2001). The mechanisms and approaches developed by health LIS, must fit within the culture and ethos of their overarching organisations.

Extending access

In responding to pressure from consumers, health services seek to establish how to offer increased access to services within existing resources. As part of the U.K. government's aims (NHS Executive, 1999) to modernise the NHS, walk in centres have been created with long opening hours, no need for appointments and at convenient locations. They provide information and treatment for minor conditions and also serve a health promotion purpose. Similar developments have occurred in Australia, South Africa and

United States, known variously as emergency centres, ambulatory care centres or urgent care centres. Evaluation has shown (Andersen et al, 2002) that they are successful in meeting user needs. Problems have revolved around negative attitudes of other health professionals to their being nurse-led. There have also been some computer technology issues. Librarians who face similar demands from health professionals for extended access to LIS may learn from this experience. ICT provides the delivery mechanism for increased access but carries implications for service development.

Key points

- *Sociological*: Patient empowerment, health clinicians' roles and working practices, collaboration and partnership, ageing population, globalisation
- *Technological*: biological warfare, pandemics, electronic patient records, health informatics and evidence based practice
- *Economic*: cost effectiveness, public/ private funding
- *Political*: organisational change, local accountability, lifelong learning, quality, increased access

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