GOOD AND CLOSE CARE - ANOTHER WAY TO RETHINK HEALTHCARE?

VBHC THINK TANK DECEMBER 11TH 2020

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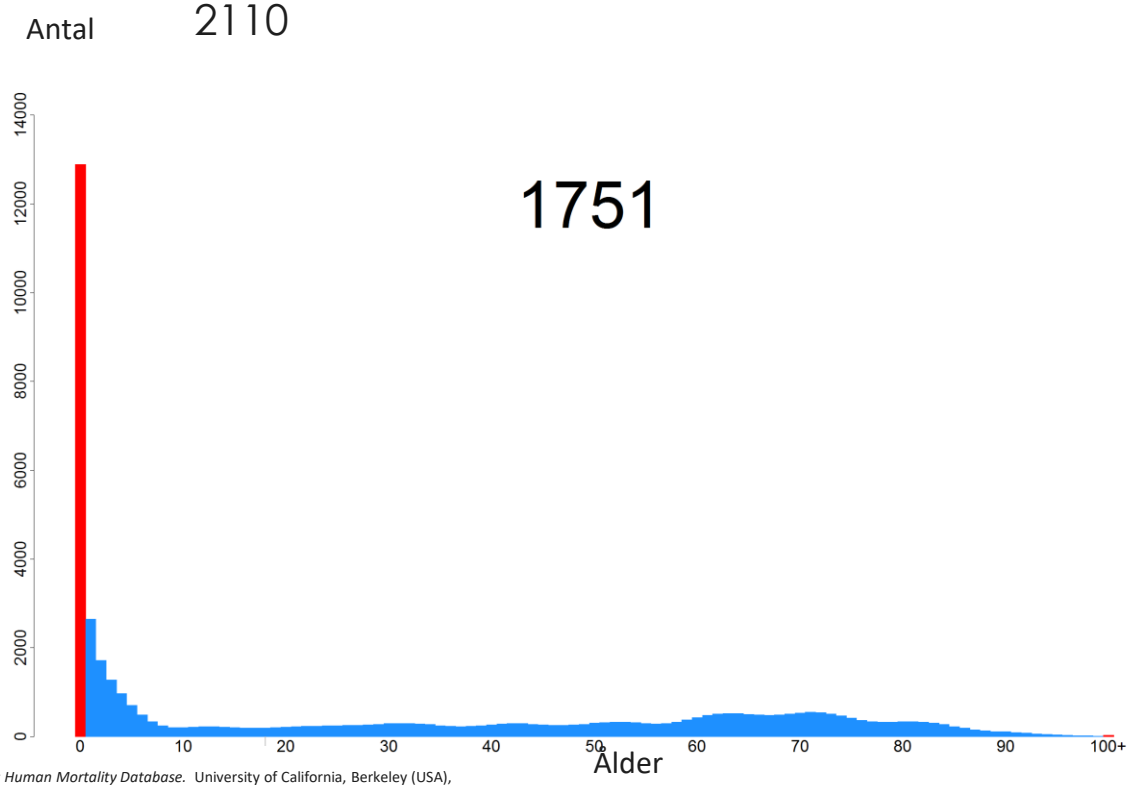
No. of deaths at different ages, Sweden1751-2110



Sources: Human Mortality Database. University of California, Berkeley (USA), and Max Planck Institute for Demographic Research (Germany), SCB.

Roughly 3% of patients -

- account for more than 50% of the costs.

MEDICAL REVOLUTION
DIGITALISATION
ORGANISING

YOU CAN'T SOLVE PROBLEMS WITH THE SAME THINKING THAT CREATED THEM

A NOTE ON TERMINOLOGY

In Sweden the transformation of our healthcare and healthcare system to move it into the future (see picture 9 for transition highligts) is labelled Good and Close Care. This has no immediate translation in English, but closest to our label is Integrated Care. It has absolutely no reference to in-patient care or care homes, it simply deals with closeness to citizens, patients and care takers whole lives.

This means that geography and houses gives way to the best possible medium to provide health services – be it physical, through digital meetings or via other connected technologies.

EFFECTS?

- The Report ”Close care – new ways of evaluating purpose and systemic effects Published in June 20
- Purpose labs runs since fall 2019 with 15 regions and local governments
- Network for controllers as well as national decision makers just started
- A number of case studies will be initiated

NECESSARY TRANSITIONS

From	To
Organisation	Relation
Reactive	Pro-active and preventive
Fragmentised	Connected
Passive recipient	Active co-creator
Illness	Health

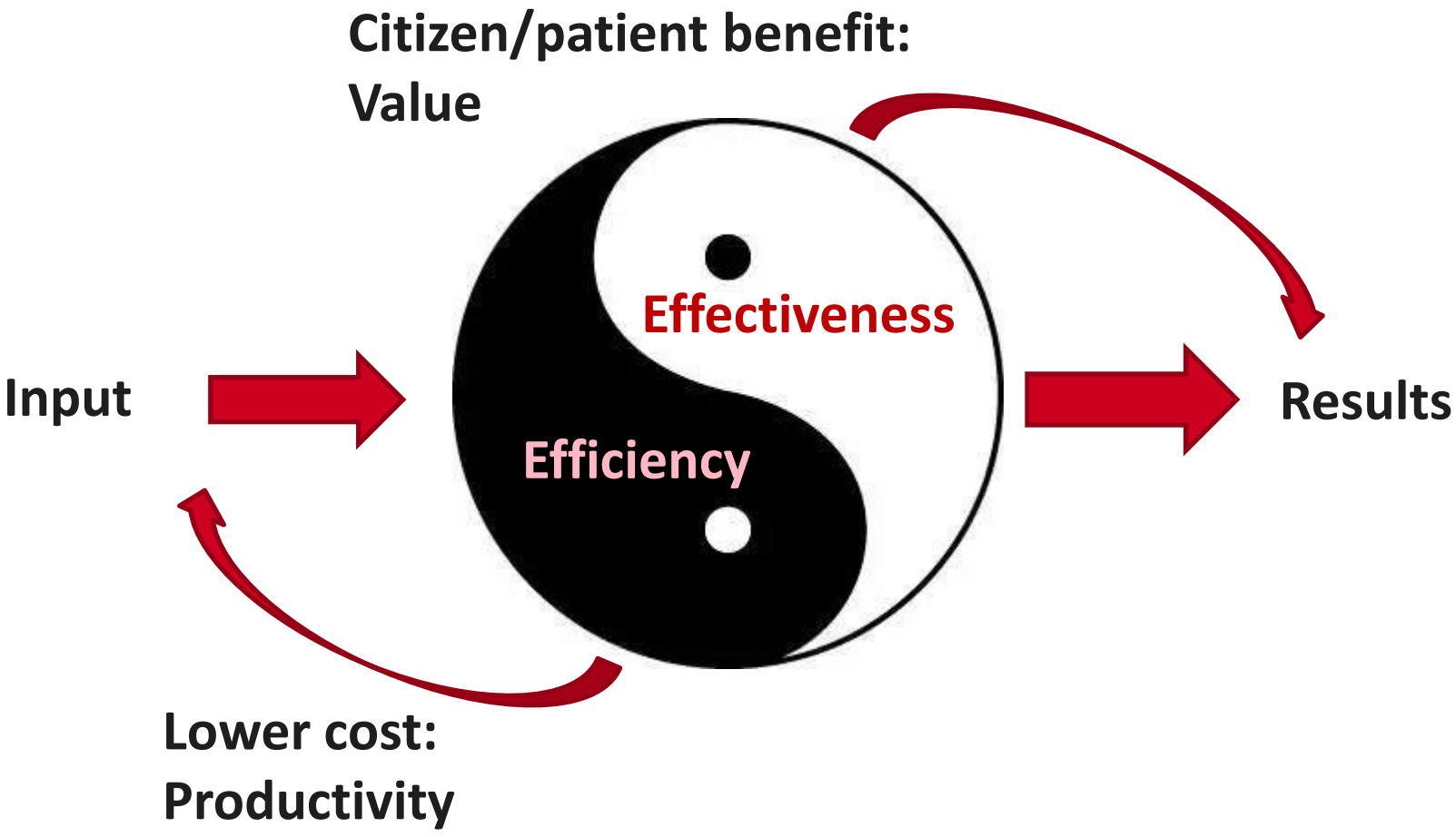
And the all implicate changes in:

- Knowledge
- Competencies
- Data

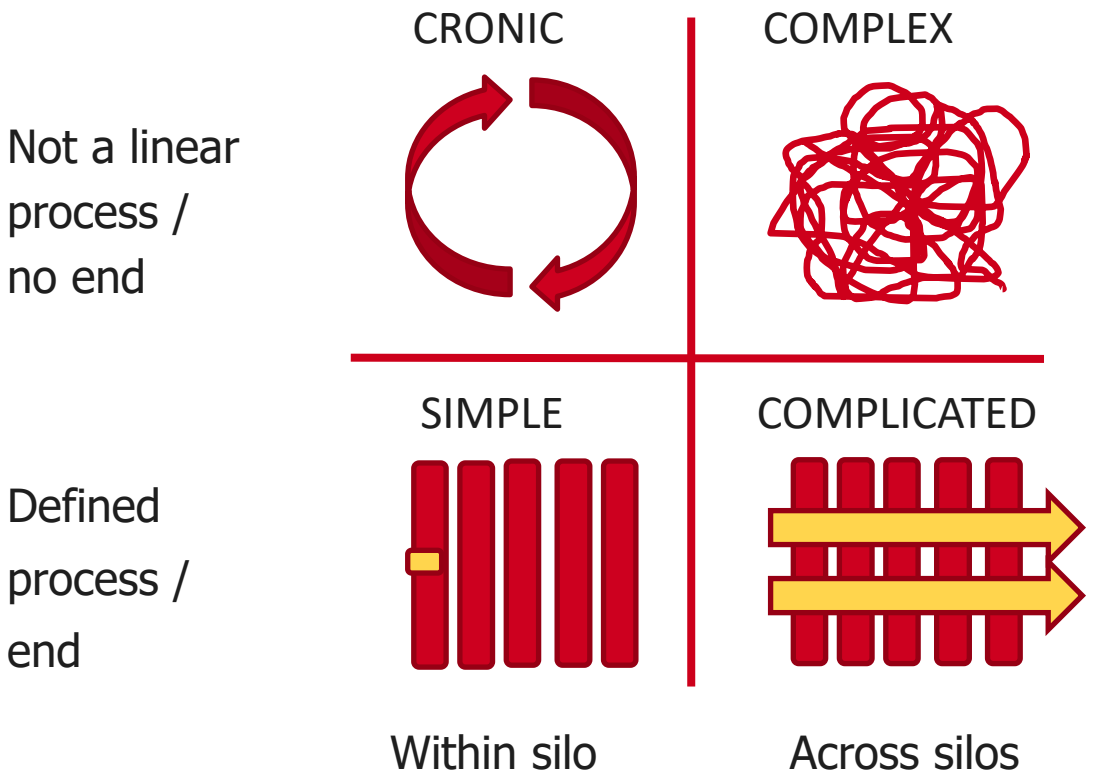
ECONOMY IS MORE THAN MONEY

Concept vs control

ETERNAL DILEMMA: EFFICIENCY VS EFFECTIVENESS



CARE SEGMENTATION

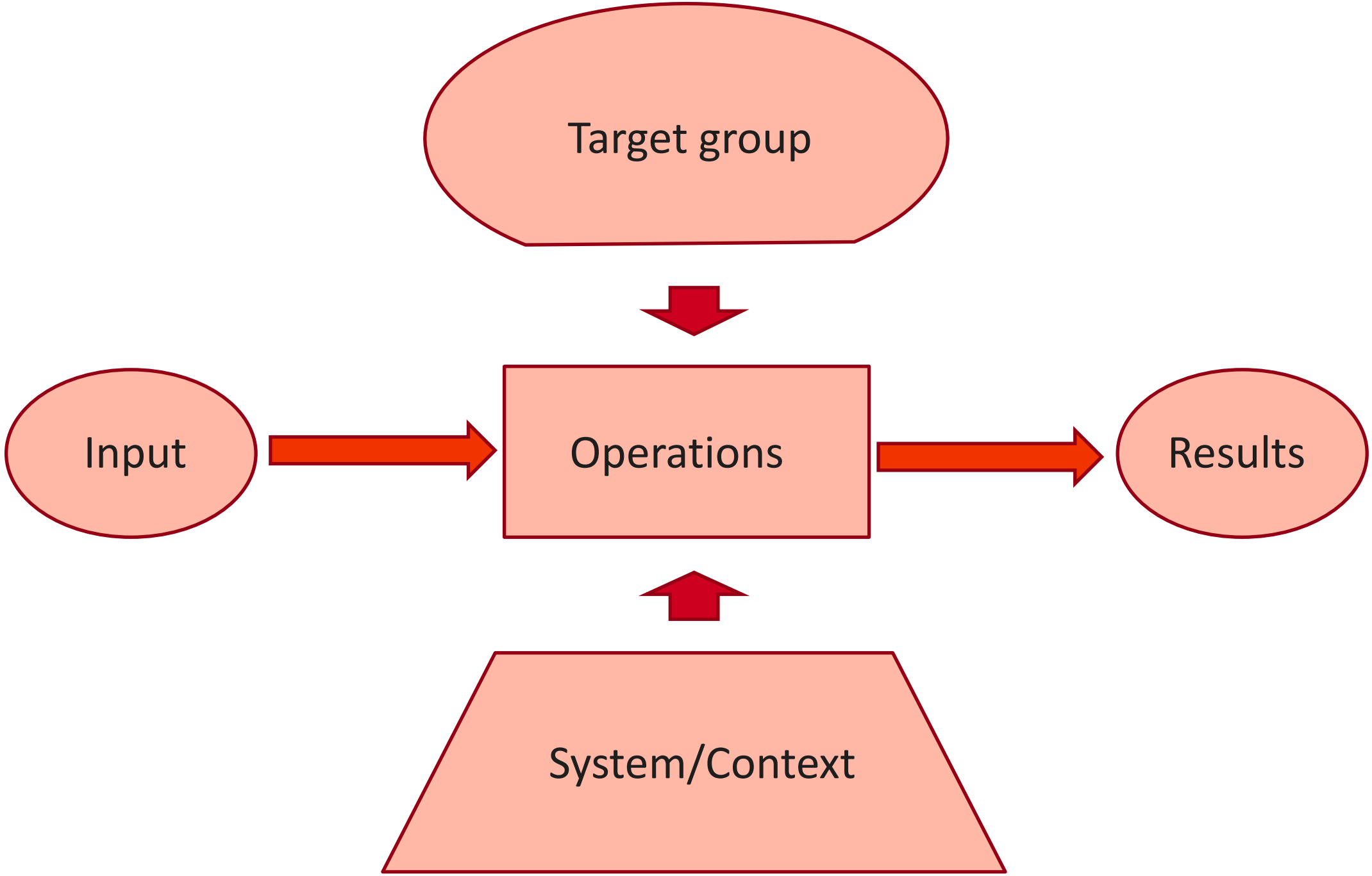


BORDER PROBLEMS

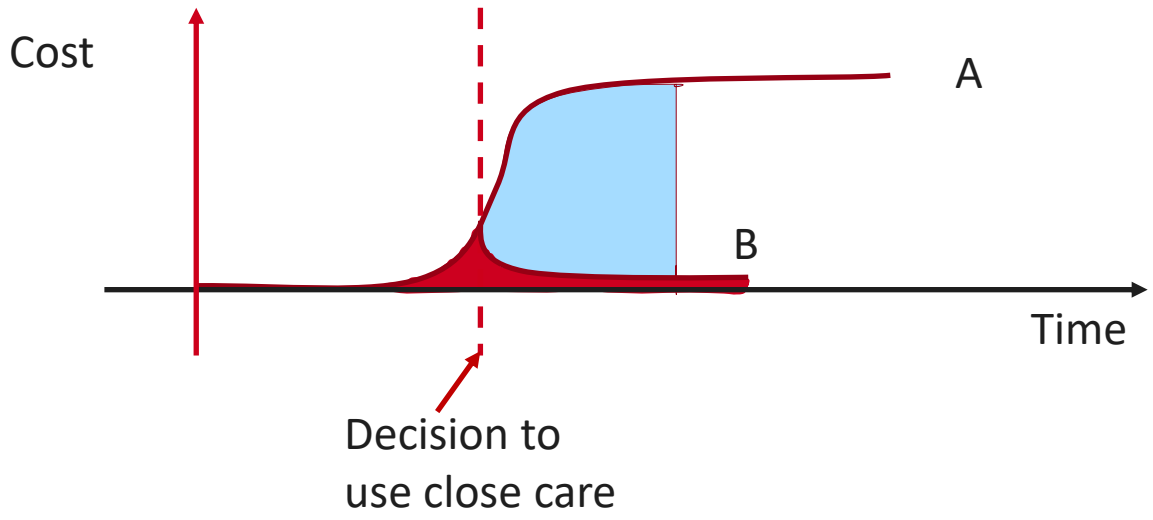
- Close care: new missions; new targets; new target groups
- Makes comparisons difficult, both with other operations and over time.

- Input resources as well as relation to the surrounding system is intrinsically changed.

- All of the above needs to be taken care of when we describe and evaluate.


Target group
Input
Operations
Results
System/Context

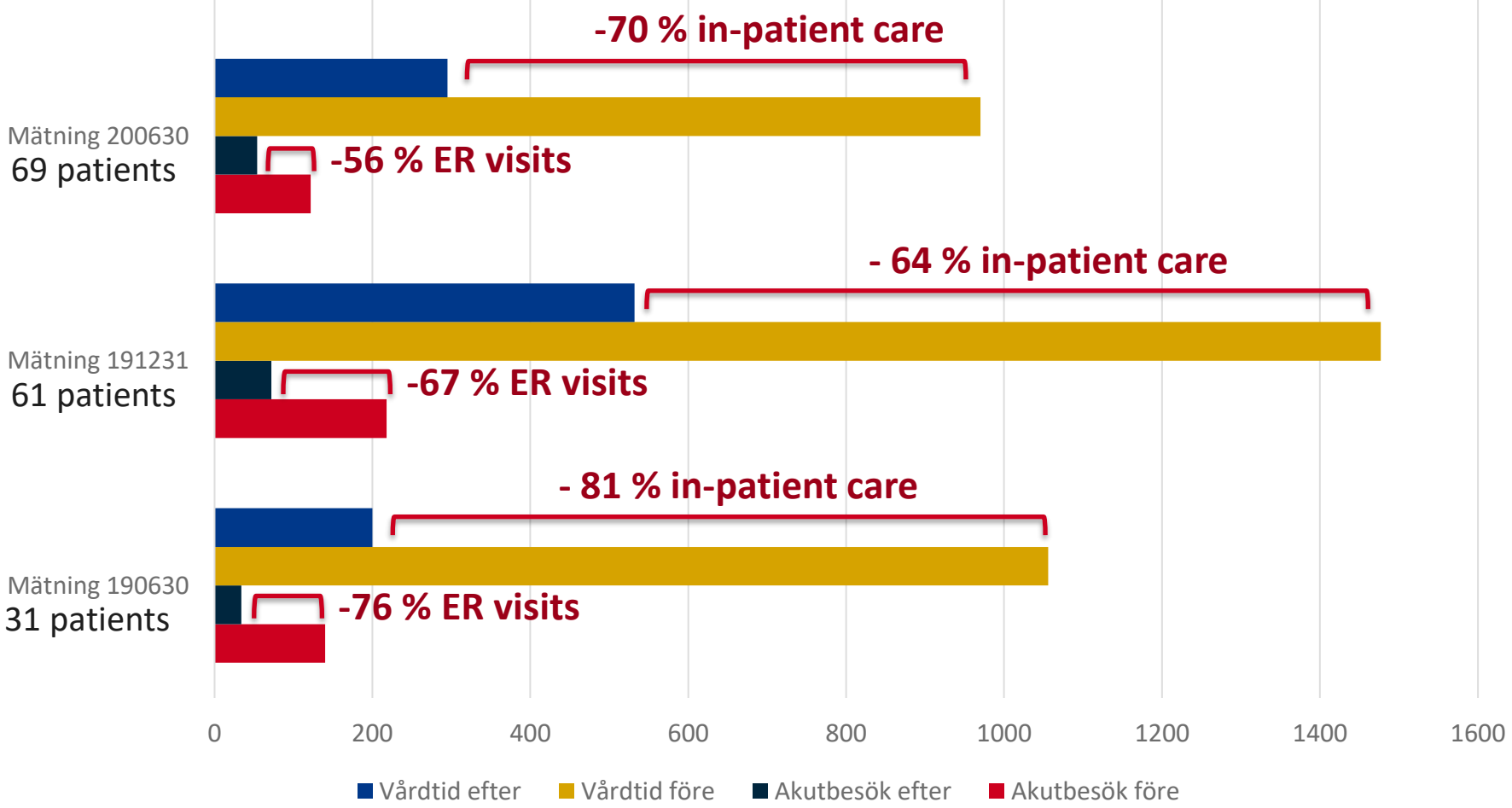
Contrafactical analysis



A = Cost at admission/ hospital care / repeated acute visits
B = Cost of close care under control – e g home care

PATIENTS IN TARGET GROUP FOR MOBILE TEAMS:

NUMBER OF DAYS IN IN-PATIENT CARE AND NUMBER OF VISITS TO ER, COMPARISONS 6 MONTHS PRIOR AND AFTER ENROLLMENT



A NOTE ON STANDARDS VS CONTEXT

PARADIGM SHIFT: TAKE-HOME MESSAGES

- Approximately right is better than exactly wrong – be careful what you standardize and at which levels
- CONFORMANCE is often the result, not PERFOMANCE
- Local development needs local DATA – not generalized INDICATORS
- ORGANIZE networks around patients – STRUCTURE comes second
- You can’t OPTIMIZE incoherent values – they need to be BALANCED
- UNIVERSAL models have a bad fit everywhere - LOCAL context eats strategy for lunch