Happenings

A System-Linked Research Unit on "Health and Social Service Utilization"

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History

The McMaster System-Linked Research Unit on "Health and Social Service Utilization" has been in operation since 1991. It is funded by the Ontario Ministry of Health and is in alliance with 16 community health and social service partner agencies. Partner agencies who help shape the relevant research agenda include visiting nurses, family practices, regional departments of social services and public health as well as the District Health and Social Planning Councils from the two regions of Hamilton-Wentworth and Halton, Ontario.

Rationale for Unit Emphasis

The reasons for the emphasis of this unit on the effectiveness and efficiency of new versus existing models of health and social service are as follows: A major portion of health service is currently consumed by a small proportion of patients, regardless of the country, method of organizing, or financing of that service. Seniors, adults and children with multiple chronic conditions (stresses of illness and/or family and finances, coupled with social disadvantages and unfavourable attitudes) are routinely cited as "expensive" groups.

The use of health services by the chronically ill has been shown to be independent of the type or severity of disease, prognosis, and treatment status. Rather, use of health resources is more closely related to disability, patient demand, and poor adjustment to illness. A combination of patient social and cognitive characteristics in interaction with the supply, organization and financing of insured services explain the high use of multiple health and social services.

Objectives of the Unit

A forum was needed to disseminate existing and new information to planners and agency providers.

Planners and providers need information about client characteristics in combination with the characteristics of a system of health and social insurance which explain the high utilization of these services. From this information, ideas are generated regarding the potential for "new" interventions. In addition, providers and planners need evaluations of innovative ways of pooling their resources to serve the clientele with co-existing problems who are often shared among agencies. Peoples' problems can be expressed in medical and social dysfunction and sometimes reinforced by current health and social service delivery models. "System" characteristics include provider characteristics as well as legislated structures (eg., fee schedules, segregated funding, policies governing eligibility) which create reactive versus preventive services. Service evaluations address the clinical effectiveness, the economic implication of resources used (cost-effectiveness of the intervention), and policy implications of the future implementation of such interventions. The unit strengthens the capacity of partners to evaluate their own services.

Finally, in order to create and facilitate the implementation and co-ordination of interventions found to be effective and efficient as local service policy, there is a need for active involvement of a consortium of community agency partners simultaneously involved in the provision and planning of regional community care services.

An Intersectoral Perspective

The effectiveness and efficiency of proactive joint service ventures are being tested for people evidencing co-existing chronic circumstance: chronic illness, poor adjustment, functional disability, school problems, poverty, joblessness, psychiatric disturbance, poor problem solving capacity, care of cognitively impaired relatives to name but a few. Projects already funded investigate coordinated, intersectoral interventions aimed at improving the coping ability of the chronically ill, the functional capacity of elderly attending family physicians, children's adjustment within schools, and the functional outcomes of disabled receiving community rehabilitation services.

The innovative and linked service strategies coordinate previously somewhat segregated services. In the unit's projects, autonomous services have often been coordinated with each other. Proposals have been submitted to coordinate social services with emergency department services; public health services with a spectrum of social assistance services; children's mental health services with primary education services; in-home nursing services with counselling services; hospital services replaced with community home services.

Initial Findings

A synthesis of new information from partner agency alliances enables us to specify more of what? is more effective and less expensive? for whom? with what combination of circumstances? Common measures and methods across intersectoral studies allow the synthesis.

One study in one of our regions illustrated that from the point of view of public health, 47% of 4646 clients visited by nurses were also receiving social assistance and were thus shared clientele. On the other hand, from a point of view of social services, only 5% of their 45,000 clients received visits from the public health nurse.

Three other local studies have documented the relationship between adjustment to chronic illness and expenditures for services used. Neither the degree of adjustment nor the use of services was adequately explained by the nature, type, or severity of illness. In these three studies, poor adjustment to chronic illness exceeded the importance of disease severity and levels of disability in explaining a disproportionate level of expenditures for a subgroup of ambulatory chronically ill (34% to 55%) attending specialty medical clinics. The cost of augmented treatment for this group was less than the dollars expended in maintaining their poorly adjusted state by conventional clinic care alone. The implications for targeting clients who may benefit from counselling is being discussed with partners.

Five more of the unit's studies were designed to quantify the well-being outcomes and expenditures associated with different community approaches to the care of the person's chronic condition when all of the approaches are covered under a system of national health insurance. Expenditures for insured services provided to clients while waiting for or declining a specified proactive community-based service were compared to expenditures for clients engaged or enrolled in the specific service. In comparison to non-enrolled caregivers or clients, client and/or their caregivers enrolled in a comprehensive, preventative, ambulatory community services exhibited equivalent or superior well-being while consuming fewer per patient annual dollars of health and social service. In this system of single payer government insurance, it appears to be equally or more effective and less expensive to society as a whole to treat people with a more complete, preventative, proactive community treatment rather than have them wait for treatment often using expensive yet insured hospital resources.

During a three year trial, operative in 27 medical outpatient clinics, 293 newly referred, consenting and representative chronically ill subjects with fair to poor levels of psychosocial adjustment to their physical illness were

randomly allocated to receive either experimental problem solving counselling intervention, or additional phone call support provided by nurses, or conventional clinic medical care alone over a six month period. The effectiveness of the three types of health interventions was related to specific combinations of psychosocial characteristics of the person treated: their coping methods, purpose-in-life, and living situation.

Policy Implications

Studies of the unit consistently support the proposition, in a system of insured services, that it is equally or more effective and less expensive to offer certain people proactive care upon referral. Existing resources might be better allied and deployed to target more complete, proactive, preventative versus reactive, piecemeal service. More can be done with less. It appears that many people will attempt to get what services they need to maintain their well-being. What type of service they get service can be more or less expensive for the system.

Further downsizing of staff in community agencies can lead to piecemeal versus complete attempts to serve clients. Our evidence highlights that the expenditures associated with not engaging clients and under servicing the poorly adjusted chronically ill outpatients with co-morbid circumstances or in need of rehabilitation are greater than expenditures associated with serving them more completely in the first place.

Future Directions

Future research of the unit involves eight externally funded randomized trials of the effectiveness and efficiency of intersectoral mixes of interventions tailored to meet more of the needs and coping styles of people in high risk circumstances versus any one intervention alone. The randomized trials involve chronic psychiatrically ill in lodging homes, caregivers of cognitively impaired relatives living at home, single parent mothers and their children receiving social assistance, well elderly in an ambulatory H.S.O., cultural sensitive training for in-home providers, group problem solving for nursing staff resourcefulness, poorly adjusted chronically ill out-patients, to name but a few. The whole of this research unit's structure, strategy, style, streams and systems allows for spontaneity of our "travel" on many roads at once, the snowballing of service alliances, and for the synthesis of observations across samples, settings, sectors, and services. Already we have similar observations about clients from a variety of community settings with a myriad of co-morbid circumstances. Intersectoral service alliances are a way of doing more with less.

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