LSE PSSRU

8th July 2015
ESSEC Business School, Paris

Health: The social model of health

Annette Bauer & Gerald Wistow

PSSRU, Social Policy Department
London School of Economics and Political Science

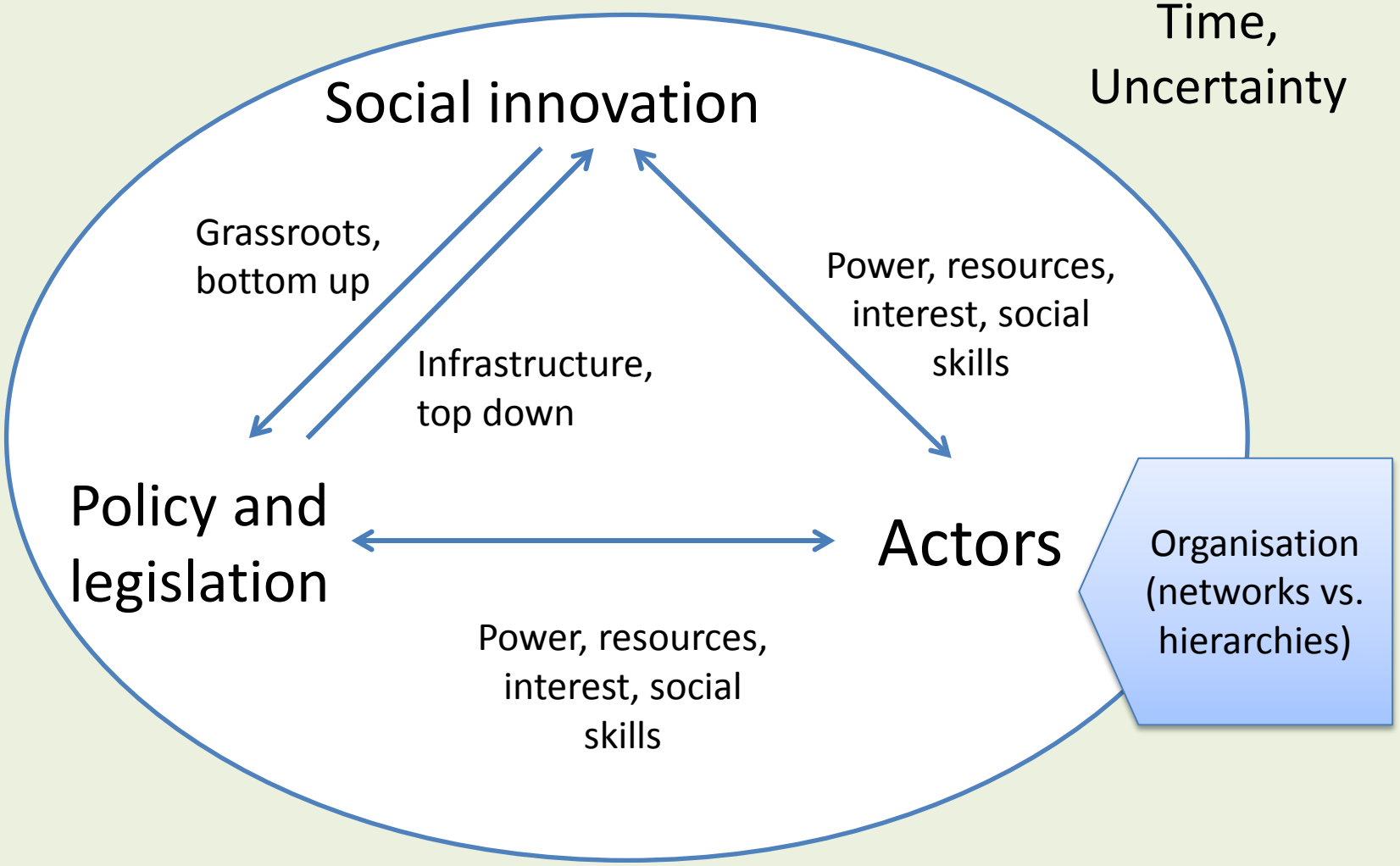
About us (briefly)

- Stands for Personal Social Services Research Unit
- Director: Martin Knapp, Co-Director: Jose-Luis Fernandez
- 40th Anniversary and at LSE since 1996
- Research in social care, mental health and long-term care with an economic focus
- Mission: “the production and dissemination of high-quality research and policy analysis in health and social care”
- Funding from government research grants and other public funds for longer-term projects/partnerships

Why the social model of health (what is it..)?

- Evidence that good health not simply outcome of good health care
- And wider health and wellbeing aspects influenced by social determinants (WHO 2006, Marmot 2010)
- Implications for government responsibilities (addressing 'causes of causes')
- Changing role and responsibility of government, individuals and communities (→ co-production, asset based, capacity)

A way of thinking about the 'field' (*in development*)



Methods

Literature review

1) Key policy and legal documents → 'Social model of health' innovations incorporated in policy and legislation?

- Screen for innovations → *evidence for top down and bottom up innovations*
- Screen for actors → *to inform 2)*

2) Statements by actors in press releases; media articles; policy briefings; minutes; protocols; websites → actors' interests, resources, collaborations

Expert interviews

- To validate findings from lit review
- To complement findings from lit review

Health systems in the four countries

UK and DK: tax funded (Beveridge); principle of free and equal access to health care; most healthcare free of charge

FR and CR: insurance financed (Bismarck); universal coverage

Health spending as proportion of GDP: DK 11%, FR 11.6%, CR 7.5%, UK 9.8%

Health expenditure funded by public funds: DK 85% FR 77%, CR 90%, UK 93%)

Conceptualisation in national legislation & policy

- DK: explicit goals to increase quality and quantity of life through prevention and reduction in health inequalities
- FR: cost containment of health care system through increasing wellbeing preventing conditions
- CZ: European Union driven public health
- UK: cost containment, new policies and legislation to personalisation and co-production, communities role and asset based approach; devolution

Role of actors and institutions

DK: Patient associations; Membership body of municipalities

FR: Patient associations; insurance organisations

CR: Public Health Network

UK: Public Health (national; local), local government; mental health (e.g. RCPsych), collaborations involving the third sector (incl. patient associations and disease specific charities),

High level of grassroots innovation in all countries but system barriers prevent scaling up!

Drivers

- Public health authorities
- Integration .. *potentially!*
- Patient associations and collaborations

Barriers

- Lack of financial incentives (dedicated budget)
- Fragmentation
- Lack of clear responsibilities between national, regional and local level
- Role of government given to third sector

Towards a framework for understanding social innovation in health.. *For discussion !*

	General population	Vulnerable groups	People with Long-term condition
Main responsibility with health providers and commissioners (incl. insurance companies)	Wellbeing oriented birth centres (FR)	Migrant access to healthcare (FR); Safe drug injection rooms pilot (FR)	Diabetes programme (FR); Self-management and user involvement (DK; UK); social prescribing (UK); personal budgets (UK); multi-disciplinary care in the community (UK); universal access to psychological therapy (UK)
Main responsibility with local authority	Community capacity with health focus (UK)		Integrated care (incl. housing) for people with dementia (FR, UK); Screening, prevention, rehabilitation programmes (DK); social support for people with dementia (UK);
Across sector	Stop smoking (DK), Healthy school schemes (CR), Information campaign for cancer and IBS (CR),		
Initiated by patient association (collaboration)			Screening, prevention, rehabilitation programmes (DK)
Other third sector		Self-help groups for people with alcohol addiction	Social support for children with disabilities and long-term inpatients (CR); Arts/culture/music for long-term psychiatric inpatients (CR); Community and work integration for people with physical or mental illness (CR); Social prescribing (UK); social support for people with dementia (UK)

Towards a framework... Other aspects

Required legislation change (e.g. smoking)

Priorities over time (evolution?):

- patient rights → involvement → personalisation;
- public health → wellbeing focused clinical care;
- community development → asset based approach

Public participation in democratic system

... and related to this the concept of citizenship

Top down versus (?) bottom up ... but can only be distinguished in dynamic analysis ('tracing')

Preliminary selection of case studies
Themes

Mental health: Important driver for the social model of health; likely to be identifiable across countries; narrowing down might be challenging

Dementia: Important area; highly relevant to challenges of ageing society; sufficiently specific

Public health/health promotion: Narrowed down for particular model (e.g. community) and/or population (e.g. children & young people)

Integration: Important but potential driver only

Patient (and possibly citizen) capacity: Across all countries, extent to which it contributes to social model differs, further exploration would be required

Preliminary selection of case studies
Issues

Purpose of case selection:

- To compare case studies that are of central relevance to the social model of health in all countries
- By observing the case study we observe an information rich example of how the social model has been implemented

Issues:

- Being to broad can make the comparison less meaningful
- Narrowing down the case study can be ‘artificial’ and increase bias, reduce relevance
- At the interface with social care (and community development)