Models of care editorial

Deborah Roberts PhD, Senior Lecturer, Health Services Management Unit

Department of Epidemiology and Preventive Medicine, Faculty of Medicine, Nursing and Health Sciences, Monash University, Prahran, VIC 3004, Australia. Email: deborah.roberts@monash.edu.au

If we accept that change is constant, does the health system actually develop as time moves forward or does it perennially suffer the same fate?

This is a question that many of us reflect upon who have worked in the service system for a number of years, since we see similar issues plaguing our health system over time and, for that matter, our broader culture.

You can read many articles on the Australian health system and globally that highlight breakdown in communication, lack of linkages between organisations and institutions, funding silos, dominance among certain health professionals and lack of collaboration, hierarchical administrations, narrow-mindedness, philosophical and value differences that can't be compromised and the list goes on.

However, you can just as easily find evidence in the literature where communication is better than ever before (and technologically easier), funding models have expanded to incorporate services from multiple service sectors (especially for those with complex healthcare requirements), more and more health professionals are working in teams, administration levels are flatter, people are more open minded, and philosophical and value differences are being openly discussed and debated resulting in renewed respect.

Where do you fit between these dichotomies? Are you looking at the world through a lens of the former or the latter? The articles in this section should further your knowledge and provide evidence of some recent health service developments.

The first article in this issue's Models of Care section is 'Barriers to comorbidity service delivery: the complexities of dual diagnosis and the need to agree on terminology and conceptual frameworks' by Rachel Canaway and Monika Merkes.[1] This article highlights the different cultures and philosophical underpinnings among two different service systems (among other differences) and the need for an agreed upon terminology and conceptual framework to move forward.

The next article is entitled 'Medically-managed Hospital in the Home: 7 year study of mortality and unplanned interruption' by Michael Montalto, Benjamin Lui, Ann Mullins and Kate Woodmason.[2] This article concludes that over a reasonably long period of time, over 95% of care was completed without a return to inpatient care, and that hospital in the home is a safe and effective method of delivering acute hospital care.

Following from this 'The reported benefits of telehealth for rural Australians' by Jennifer Moffatt and Diann Eley[3] is included in the section. An international literature review of the self-reported benefits of telehealth for patients and health professionals in geographical areas distanced to urban service settings are disclosed. A notable finding is the reported benefits to practitioners in telehealth education between clinicians. The use of telehealth as a model of care and medium for care delivery appears to be beneficial for rural Australians and professionals alike. The quality of care delivered, access to care and a professionally fulfilled and stable workforce are all important factors to consider.

The final article is 'Readmission to an acute psychiatric unit within 28 days of discharge: identifying characteristics of those at risk' by Tom Callaly, Mary Hyland, Tom Trauer, Seetal Dodd and Michael Berk.[4] The article reminds us that arbitrary markers of quality of care need to acknowledge the complex and multitude of variables involved in readmission requirements.

Although there are many cynics out there with evidence to suggest the contrary (and just as I embark on the seventh year of teaching a Master of Health Services subject called 'Reform and Development of Health Services'), I remain confident that change is, for the most part, positive and 'development' connotes that overall our health system is slowly but surely advancing over time.

Dr Deborah Roberts
Associate Editor – Models of Care

References

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