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Integrated System for Chronic Disease Management

Can We Apply Lessons Learned From France?

Can we study the experiences of one nation and adapt them to another? Can a solution for one population be expanded to meet needs of others? Are there universal principles that may be applied? What kind of understanding is required to do so?

In the current issue of CHEST (see page 695), Stuart and Weinrich challenge readers to reflect on these questions and compare France and America. The authors describe the long-term care crisis we face in America and argue why we have an opportunity now to “fix it” due to the US Supreme Court Olmstead decision (judicial mandate) and the President’s “New Freedom Initiative” (political support). The authors have sought international best practices as models for development of integrated community health systems for high-cost patients in the United States. They have described the background, evolution, and successes in the French regional approach to chronic respiratory insufficiency, and suggest France may provide lessons for a more global chronic care model for America.

A historical tradition exists for comparing France and the United States to answer these questions. In 1830, Alexis de Tocqueville officially visited America to learn about our new evolving democracy. He sought lessons that might apply to France where the 1789 revolution had created the possibility for “liberty, equality, and fraternity.” Democracy in America sought to determine if the American experience could be translated into models for France and other evolving European democracies. His footsteps have since been retraced and observations re-evaluated.

Like de Tocqueville, I traveled abroad to learn from another nation. Since 1967, I have visited France on several occasions to observe patients who need long-term mechanical ventilation and get community-based support not available in America. I interviewed many people representing a diversity of perspectives: government officials, professionals, patients/families, health-care and social service providers, and health industry representatives. I gained insights about social, economic, political, and cultural factors that must be understood. I learned why their system works and how it evolved over 40 years.

The long-term care crisis in America is severe and will only get worse unless addressed by long-term care policy. The 2001 Fred Friendly Seminar, “Chronic Care in America . . . Who Cares?” dramatized situations of victims who related personal stories describing the impact of chronic care on their lives. Web site data put the crisis in global perspective: three of every four US health-care dollars are spent on chronic diseases; 125 million Americans have some chronic health problem (60 million have multiple conditions); this will increase to 157 million in 2020 at an estimated annual cost of $1 trillion; 26% of American adults (mainly working women) currently serve as informal personal caregivers; many also making significant out-of-pocket financial contributions to the well-being of loved family members or friends; and 89% of Americans find it difficult to get insurance for chronic health needs. Situations and statistics like these should outrage all Americans!

The need to address population-based chronic care is not limited just to the United States. A health-care crisis challenges many other nations due to growing demands for long-term care. Existing health and social service delivery systems are not prepared for these new demands. A 1990 Max-Plank-Institut health-care summit of social scientists and experts in health-care policy was convened to address the growing need for chronic care due to demographic, social, and political changes in a unified Germany. Participants analyzed alternative delivery models suitable for the elderly and persons with chronic health needs. They reviewed the evolution of different community-based models in countries with national health systems, national health insurance, and evolving market/regulatory approaches. In addition to the analysis of finance systems, transnational analysis was undertaken to evaluate differences between nations’ health-care delivery models based on the same financial approach (France/Germany). German authorities wanted to know the following: (1) What are suitable models for persons with long-term requirements for health care and medical technology? (2) What can
other nations’ experiences tell us about optimal economic and finance systems to avoid limited access to care?

Conclusions reached were fundamental to understanding the future of global health. No matter what organizational model was described (traditional hospital, home care, community centers, nursing homes, or other long-term care alternatives), what happens in each nation is based on two factors: (1) funding—the finance system does not matter; what matters is that funding is made available to provide an incentive to develop an organizational system; and (2) culture—variations between nations with the same health-care finance system are best understood in context of cultural differences between nations and at regional and local levels. National policy does make a major difference. However, the community is where people work together to design a variety of innovative local solutions that work, encouraged by (or despite) national health-care policy. These conclusions validated my own after much reading and reflection about my experiences in France and the United States on the impact of culture on medicine.15–19

Why focus on chronic respiratory insufficiency as a model for the solution for all chronic care? There is already a precedent in the United States for this suggestion by the authors. C. Everett Koop, MD, FCCP (Hon), knew about ventilator-assisted children for whom he cared as Surgeon-in-Chief at The Children’s Hospital of Philadelphia.20 As US Surgeon General, Dr. Koop used the ventilator-dependent child as a “case-example” to analyze needs and recommend solutions that would be applicable to all children with chronic diseases and/or disabilities. The “tipping point” was his 1982 Surgeon General’s Workshop: a very carefully designed change management intervention inviting and engaging specially chosen people.21 The process involved many components: demonstration projects, regional conferences, health research evaluation, and government agency-sponsored initiatives.22–25 The ultimate result was change in public policy (Title V), which led to funding community-based services for all “children with special health needs” and development of concepts, programs, and services meeting their needs. This was done with sensitivity to political, economic, social, and cultural realities and an understanding of how to get things done in America.

What lessons from France are universally applicable to other nations?

1. Innovative leadership: Founders of French programs included magistrates, physicians, social scientists, and persons with disabilities who took charge and worked with patients, families, and committed community leaders to establish and develop programs adapted to each locality.

2. Creative management: Programs were designed with organizational development and cost accounting expertise developed in partnership with funding authorities. Program evaluation and modification for changing needs constituted a continuous process that remained flexible and adaptable to changing situations.

3. Critical numbers: Designated programs and integrated networks developed cost-effective solutions based on years of learning and experience.

4. Personal care services: Patients with chronic health needs require personal assistance. They not only require professional attention but also other caring people.

5. Quality of life: Patients with complex long-term needs can live meaningful and productive lives provided that they have easy access to support systems.26

6. Assistive technology: Medical technology design should have input of patient and professional users. Systems of care can provide useful feedback information for technology development, assessment, and re-assessment.

7. National/regional/local organizations: A national organization has value for advocacy and developing programs and public policies. A national approach is needed for data collection and analysis to understand the scope of issues and outcomes of interventions. Regional/local organizations meet needs identified and solutions determined by those who know why and how they will work in their own community.

The “Communications in Healthcare” project with Dr. Koop is a series of public dialogues under the auspices of the ACCP/CHEST Foundation.27 In these communications, which began at CHEST 1999,28 Dr. Koop attempted to address concerns about chronic care and to provide solutions that will work in the 21st century. As Dr. Koop mentioned in his Honor Lecture at CHEST 2000,29 global health must be our number one priority in the new millennium. The 2003 Surgeons General Conference at Howard University Medical Center focused on health-care disparity and cultural diversity.30 Surgeon General David Satcher and Dr. Koop noted that we must develop cultural understanding and address global health community by community. If we do not address the long-term care needs of our nation, we will neither have success in the global economy nor develop a secure, safe world.

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REFERENCES

8. Goldberg AI. Mechanical ventilation and respiratory care in the home for the 1990s: some personal observations. Respir Care 1990; 35:247–259