

Uk nhs framework for coronary heart disease | analysis



A Critical Analysis of the Impact of a Current Healthcare Policy on a Group of Clients/Users

Introduction

In considering the impact of a current healthcare policy on a group of clients/users, the United Kingdom's National Service Framework (NSF) for Coronary Heart Disease (CHD), offers a classical example for examination of the foregoing. In particular women as a subject group provides an interesting basis by which to analyze user experience, quality of service as well as fairness/justice. Globally, 10 million of the 27 million deaths of women are as a result of Coronary Heart Disease with one third of the foregoing total, 10 million, occurring in developed countries (Bonita, 2000). And while Coronary Heart Disease is known to be a leading cause of death among men, it is also 'the' leading cause of death for European women (Mcguire, 2000).

In the United Kingdom Coronary Heart Disease is the number one cause of premature death among both men and women and shows a marked skew with regard to social classification. The death rate attributed to Coronary Heart Disease among males from manual worker classifications is forty percent (40%) higher than for those from non-manual segments (National Health Service, 2005). And while coronary heart disease is four to five times more prevalent in males than females for the age groups under 65, the gap narrows considerably after this age. And this particular age occurrence discrepancy is one of the critical sources of misunderstanding, focus, appropriation, resources and service as the medical profession, insurance industry, and public in general tend to view coronary heart disease as primarily affecting males.

And while the preceding is true, in terms of the age groups under 65 (Mcguire, 2000), the fact is that women live longer than men thus as the incidence of coronary heart disease and the associated care is spread out over a longer period as well as at a more advanced age. The circumstantial inequities that the preceding give or gave rise to shall be the examination points addressed herein in terms of considerations with respect to the impact of current health care policy in terms of analyzing user experience, quality of service as well as fairness/justice, with particular emphasis on women. In order to accomplish this broad and sweeping analysis, an understanding of the disease, and allied points will need to be established to provide the foundation from which to reach a determination as to the three subject areas indicated.

Coronary Heart Disease

A distressing fact that has been uncovered as a result of a study by the World Health Organization (1997) is that coronary heart disease is rising in developed countries. The World Health Organization (1997) attributed the foregoing to the increased overall age of relative populations as well as the onset of increasingly poor health behavioral patterns. Dr. Abby King (2000) indicated that of the forty plus studies that have been undertaken on a global basis concerning various aspects of coronary heart disease it was found that there was a correlation between physical activity and premature mortality. Dr. King (2000) stated that said study consisted of a field that was comprised thirty-three percent (33%) of woman. Said studies have shown that inactivity in women revealed on average a two-fold risk or the development of cardiovascular problems as compared to their peers who

were or are more active. It was also uncovered through these studies that the economic costs in terms of not only the direct treatment but also, those associated with the relative inactivity of patients amounted to substantial outlays.

The increase in coronary heart disease has also been attributed to the elevated cholesterol levels that are prevalent in Western countries. Dr. Anita Schmeiser-Rieder (2000) has found that approximately forty percent (40%) of women above the age of fifty-five (55) have serum cholesterol levels that are elevated. Dr. Schmeiser-Rieder (2000) indicated that the preceding condition peaked in women between the ages of sixty-five (65) and seventy-four (74) and that fully sixty-one percent (61%) of those researched had hypercholesterlomia. The disturbing finding that was uncovered in studies by the World Health Organization (1997) is that coronary heart disease and stroke will continue to be the leading cause of death among both men and women over the next twenty years, increasing to the second and third causes of death from its present ranking of fifth and sixth by 2020. The World Health Organization (1997) cites that the major causes of both stroke and coronary heart disease are:

1. smoking
2. high blood pressure
3. cholesterol
4. body mass index

And while studies conducted by the WHO (World Health Organization)

MONICA (2000) Project shows a decline in smoking trends, a rise in smoking among young woman as well as adult women has been noted in:

1. Russia (Novosibirsk)
2. Germany (Augsberg)
3. Belgium
4. Spain (Catalonia), and
5. Poland,

where the recorded increase has been as much as ten percent (10%). As the number one cause of stroke and coronary heart disease, the rise in female smoking is alarming, made even more dramatic by the fact that females historically smoke less than their male counterparts across all age groups.

The findings of varied studies has conclusively indicated that the incidence of stroke and coronary heart disease increases with respect to those individuals whose lifestyles expose them to the additional risks that are associated with the two conditions. The World Health Organization (1997) has determined that changes in lifestyle as well as personal habits effectively reduce the risk associated with contracting these diseases. The foregoing is of particular significance to women, as the emphasis on efforts to change lifestyles and habits has been primarily focused upon the male segment of the population whose rate of incidence with respect to stroke and coronary heart disease has been higher. The corresponding increase in poor lifestyle and smoking habits among females in the countries indicated reveals that such an approach has not only been short sighted, by failed to take into account the longer life cycle of females thus increasing the onset of

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coronary heart disease and stroke in later years as a result of higher age where female incidents almost match those of males. The foregoing factors are important base line informational points to develop an understanding of the varied inputs and considerations that comprise the complex variables inherent in equating the range of aspects to be addressed in analyzing user experience, quality of service as well as fairness/justice.

The preceding points out the need to utilize what is termed as a ' high reach' strategy (Bonita, 2000) that reaches both the male and female segments of the population in terms of alerting them to the relative risks, preventive measures, lifestyle augmentation, and allied aspects known to have demonstrated a decrease in stroke and coronary heart disease when utilized in a proper manner. Such an initiative when conducted on a population-wide (high reach) basis helps to alert individuals to the relative dangers and causes of high blood pressure, negative connotations associated with smoking and lack of physical activity, the three highest contributors to the condition. Alerting populations to reduce the intake of salt, alcohol, saturated fat as well as the benefits of increased physical activity would reduce the relative levels of blood pressure and thus the corresponding reduction in medical costs assumed not only by individuals, but society at large.

By combining the aforementioned with what is termed a high-risk strategy (Bonita, 2000), in efforts that are directed at the identification of women in this category, along with offering treatment to the women within this group whose risk factor(s) are above the norm in terms of the potential for a coronary disease event can generate significant improvements in long term results. The utilization of educational media efforts in combination with <https://assignbuster.com/uk-nhs-framework-for-coronary-heart-disease-analysis/>

treatment availability is a preventive measure that recognizes the need to head off the high costs of medical facilities, and allied costs to the government via preventive measures. As the subject country being utilized for this examination is the United Kingdom, the foregoing is applicable. The same holds true for countries where insurance coverage's are used to supplement individual treatment costs, along with the calculated losses to society with respect to the associated costs that accompany coronary heart disease events. In the case of the United Kingdom, with the taxpayers bearing the cost of medical care under the country's socialized medical program, the realities of the treatment and after care costs of coronary heart disease are a real expenditure concern. In particular the recognition of the heretofore hidden costs in this area as a result of the scant attention paid to the real costs associated with women, the foregoing represents an opportunity to make an significant impact in cost controls, and more importantly the health of an entire segment of the population.

And while women as a group have an overall lower absolute risk factor than men, in terms of the potential for women to have a coronary heart disease event, this differs depending upon the age group category. As indicated by Dr. Anita Schmeiser-Rieder (2000), forty percent (40%) of females who are above the age of fifty-five (55) years of age have elevated cholesterol levels and this condition actually peaked for the age group between sixty-five (65) through seventy-four (74) where sixty-one percent (61%) if the research group had this condition. The aforementioned supports the view that strategies aimed at high-reach in conjunction with high-risk represent a necessary approach to bring the incident of the risk of conditions that

contribute to increased onset of coronary heart disease under preventive type control program measures. The preceding analysis takes on additional importance when one considers that estimates regarding the probability factors concerning woman above the age of fifty, as well as the increased incidence of smoking in young women and the need for education regarding lifestyle and health preventive measures to reduce probabilities later in life represent contributory factors that can be somewhat controlled.

Prevention approaches to call attention to the risks of smoking, high cholesterol diets, and the lack of proper exercise represent measures that have shown to produce a reduction in coronary heart disease numbers over specified periods. Classified as lifestyle and personal habit changes, the reduction or elimination of known contributors that increase the potential of CHD (Coronary Heart Disease) has yielded positive results. It is important to note that in the instance of women, the absolute risk of coronary heart disease remains at relatively low levels until they reach their seventies and eighties, however, the reduction in conditions attributable to said condition in earlier years has been shown as a positive preventive measure (Bonita, 2000). As pointed out by Dr. Bonita (2000) the primary contributors to the coronary heart disease epidemic are:

1. the onset of population aging,
2. rapid urbanization,
3. changes in nutrition,
4. and smoking patterns,
5. along with reduced physical activity

Any program that purports to achieve relative success will need to incorporate the preceding along with post CHD treatment and follow up measures as well.

Cardiac Rehabilitation Services

The United Kingdom's National Service Framework for coronary heart disease is under a revision program which the Secretary of State for Health, Alan Milburn, states the primary focus is the " saving of lives" by the reduction of "...the death rate from heart disease and ... stroke ..." by "... two fifths..." for individuals under the age of seventy-five (75) by the year 2010 (National Health Service, 2005). The preceding will be accomplished through the following measures (National Health Service, 2005):

1. the development of a new vision concerning coronary heart disease,
2. the establishment of a government-wide agenda,
3. further development and improvement of the National Service Framework for CHD
4. providing effective services to all individuals in the United Kingdom that can benefit

The preceding directly address the three points user experience, quality of service as well as fairness/justice, along with other concerns. Through the modernization of the National Health Service's treatment, care and public awareness approaches the objective is to improve the foregoing across age, gender, cultural, race, disability, locale, and religious lines, as well as being "... responsive..." to the needs of individuals (National Health Service, 2005).

Some examples of the need to revise and modernize the system is evidenced by the following facts (National Health Service, 2005):

1. The wives of workers in the manual class are at twice the risk factor in developing coronary heart disease and stroke than the wives of workers whose jobs are of a non-manual classification.
2. The morbidity rate among the manual class group is also higher than in the non-manual group designation, and this group also reflects increased incidences of angina, heart attack and stroke.
3. The disparity in come between poor and rich has widened over the previous twenty years creating a further gap in health survivability as the more affluent segment of society has been able to afford private medical care as well as increased nutritional guidance and lifestyles that promote as well as can afford more physical activity.
4. Historical records have shown that death rates are higher in the northern locales of the United Kingdom, representing almost three times the rate for individuals over the age of sixty-five (65) in cities such as Manchester than for Richmond or Kingston.

The preceding further illustrates the inequities in terms of user experience, quality of service as well as fairness/justice. The new National Health Service program sets forth that it seeks significant improvement in the following areas, all of which will enhance the indicated three examination points (National Health Service, 2005):

1. Standards

The National Health Service is aiming to establish a 'standard of care' that includes an invitation for individuals whom have been admitted to a hospital for coronary heart disease to participate in programs consisting of cardiac rehabilitation and secondary prevention. The preceding is aimed at reducing future risk of cardiac problems and to help them to return to a normal life.

2. Rationale

Admission to a hospital represents individuals whose condition is severe. This signals that their lifestyles to this point have consisted of various high-risk exposures, such as smoking, high cholesterol diets, and other conditions that if changed can lead to significant improvements in rehabilitation. To accomplish the preceding said patients must be analyzed and then coached concerning the lifestyle changes and modifications needed to aid them in returning to a healthier manner of living to reduce future incidents and effect recovery.

The World Health Organization (1997) defines cardiac rehabilitation as consisting of a "... sum of activities..." that are necessary to effectively influence and identify the underlying causes of the disease to individuals through their own actions can help to effect their recovery. Through increasing the quality of service that offers comprehensive assistance that is custom tailored to their individual circumstances. The aforementioned provides the foundation to enable counseling and aiding individuals in understanding ways in which to change their lifestyle habits, as well as better understand their illness and effect the transition back to as normal and full a life as possible. The aim is to make rehabilitation "... an integral..." aspect of the active as well as secondary preventive care regime. By <https://assignbuster.com/uk-nhs-framework-for-coronary-heart-disease-analysis/>

establishing rehabilitative procedures immediately after discharge and the establishment of a long term formal program that focuses on returning the individual to the best health possible the government estimates a net gain of approximately £15, 700 per instance over a three year period.

In the case of women, they represent one third of the individuals with coronary heart disease, yet just fifteen percent (15%) of their total utilize rehabilitative services (Green, 2000). The attention to improving the quality of service the initiative also aims at removing the disproportionate care provided that does not adequately cover rural parts of the country.

3. Effective Interventions

Participation barriers can be a result of varied causes, such as the lack of proper motivation to difficulties in attending rehabilitative sessions. In the case of women it was discovered that there was a lack of appropriate provisions, which the current modernization program seeks to correct to provide fairness as well as justice throughout the system. The foregoing also includes minority groups as well.

In terms of improving the quality of service the new program consists of Four Phases (National Health Service, 2005):

1. Phase 1

This Phase comes into effect before the discharge of an individual from the hospital, and is to be offered as a part of the acute care plan. It includes the following elements:

1. review and assessment of psychological, physical and social needs for rehabilitation
2. development of a written plan to meet identified needs
3. counseling and advice on detrimental lifestyle aspects such as smoking, cholesterol, exercise, alcohol, etc.
4. prescribing of medication and education on its proper use
5. information concerning cardiac support groups

2. Phase 2

As part of the early post discharge period individuals will receive the following:

1. a comprehensive assessment of their cardiac risk which will include their psychological, social and physical needs for rehabilitation and the plan to achieve these ends
2. lifestyle advice from trained therapists
3. resuscitation training for members of the affected individual's family

3. Phase 3

This segment of the four phase plan comes into utilization four weeks after the cardiac events initial phase and consists of a series of structured exercise sessions along with ongoing access to support and advice from people trained to provide them with psychological interventions, promotion of health, exercise and associated advice.

4. Phase 4

The final aspect of the four-tiered program that consists of:

1. long term primary care follow up
2. local cardiac support group involvement
3. referrals to identified support services as initiated in Phase 1

The modernized and revised National Service Framework is a highly structured series of interlocking programs that are designed to alleviate as well as eliminate the missing components of the prior coronary heart disease plan which evolved over decades, into a comprehensive system that has been revised based upon today's understandings. It aims to achieve coverage of all groups and categories of individuals through education, assessment, contact and a cardiac event that provides qualified, balanced and comprehensive coverage and care whose major components are as follows (National Health Service, 2005):

1. The identification of individuals that are likely to benefit from a structured cardiac rehabilitation program before discharge from a hospital,
2. the assessment of individual risks as well as needs, along with the development of a structured plan to achieve successful cardiac rehabilitation,
3. the documentation and provision to deliver the proper treatment as well as advice
4. the integration of required and agreed upon care that is weaved into the patients local network of primary and secondary treatment, preventive and related care,

The experiences gained under the prior system, as well as all of the inequities have been addressed under the National Health Service's new <https://assignbuster.com/uk-nhs-framework-for-coronary-heart-disease-analysis/>

modernization plan that provides and sets relevant standards with effective interventions under structured service models that define and addresses the immediate priorities of each individual patient.

Conclusion

The scope and complexity that comprises the field of coronary heart disease makes this a subject whereby the factors inherent in its causes as well as manifestations entail equating aspects of human behavior across the entire spectrum of demographic, cultural, social and psychological realms to codify commonalities and possible associative elements that tend to explain the reasons and causes for the world's most pervasive killer. As the field of examination represents healthcare, the core of understanding evolves an evolutionary process based upon decades of exposure, analysis and experience gained within the United Kingdom as well as on the world stage. The National Health Service has recognized the significance of the preceding and has crafted a program that seeks to build upon the known(s) within the subject field in a program that is flexible enough to improve upon itself to incorporate those aspects, considerations and new understandings that will inevitably will occur with new discoveries and as a result of the comprehensive data based system that will permit further modification and evolution.

Thus, user experience, along with quality of service, and fairness/justice with respect to the new National Service Framework has been addressed to exclude the existing inequities and shortcomings, yet understands that it is an evolutionary process that will continue to modify and improve upon itself using past experiences along with the new framework as the foundation from <https://assignbuster.com/uk-nhs-framework-for-coronary-heart-disease-analysis/>

which to accomplish this. The Secretary of State for Health, Alan Milburn (2000) firmly establishes the preceding in referring to the "... National Service Framework for Coronary Heart Disease..." as the nation's "... blueprint for tackling heart disease..." Mr. Milburn's statement goes on to add that the new ' Framework' is based upon the understanding and recognition of past inequities and shortcomings which this new initiative addresses, along with the understanding of "... the importance of modern prevention and primary care as well as the contribution of the more specialized services." The fact that the National Health Service has undertaken this modernization program clearly indicates that it understood and recognized the prior user experience, service quality and fairness/justice components needed considerable improvement. Regardless of how deeply one would delve into the inequities of the past, there could be an argument made for areas and points that were not covered, as the list is extensive. And no matter how comprehensive the present system is, it is an evolutionary framework that will have its own initial and ongoing issues and inequities to face as well as resolve. The difference between the two systems is that the present one was developed with the understanding that it will continue to improve upon itself as it learns from its base of past expertise.

In the complex and ever changing world of medical care, the preceding is all that can be asked from its healthcare agency, with the understanding that no matter how comprehensive the plan, modern changes and developments can and will render segments as obsolete, thus the need for a built in foundation that incorporates this as its framework. The very fact that past user experience, service quality and fairness/justice had shortcomings, along

with other points is the reason behind the new Framework initiative, and this in itself is a progressive view that is responsive to the needs of the populace, which is the rationale for the government's existence.

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