spectra 137

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Bringing the health service and social services closer together

One of the FOPH's aims is to build more bridges between the health service and social services in order to strengthen integrated health promotion, prevention and the provision of care.

Body, mind and social factors all affect our health and are all interconnected. A person is more than a complex biological machine. A person is a social being embedded in a network comprising family, friends, school, workplace and leisure activities. A good network is good for health.

A literature review carried out by the University of Freiburg shows, for example, the influence that material factors (e.g., working conditions) and psychosocial risk factors such as stress or social isolation (loneliness) have on the development of diseases. Stress increases the risk of developing cancer by 47 per cent and the risk of psychiatric disorders by as much as 85 per cent. Social isolation increases the risk of cardiovascular disorders developing by 26 per cent and the risk of dementia by 27 per cent. Stress and social isolation can also affect the use of alcohol and tobacco, both high-risk activities.

Conversely, these psychosocial factors can also have a positive effect. According to the literature review, social integration reduces the likelihood of developing musculoskeletal disorders and dementia.

Other studies show that a large proportion of people receiving welfare benefits in Switzerland have chronic illnesses, mental health issues and a poorer quality of life. There is a link between poverty and health.

Social support improves life expectancy

On the whole, then, it is not surprising that socially isolated individuals have a two to five times higher risk of dying prematurely (source: Obsan Dossier 27). A large number of studies show that social support has a major positive impact on life expectancy. This integrated approach to health is based on what is known as the biopsychosocial model, which combines body (bio), mind (psycho) and social milieu.

Let's take a typical example of an elderly woman who has a fall in her kitchen and requires surgery in hospital. She would like to return home as quickly as possible. However, her family members are overwhelmed by the task of caring for her, have fallen out with each other and are not sure that they can cope with the burden. A new setting now has to be established in which everyone is involved: the patient, her family, doctors, care providers, etc. Her discharge from hospital must be planned carefully and a supportive environment needs to be created and maintained. What is the best solution for the patient and for the family?

In cases like this, the health service and social services may be operating in two unconnected worlds: healthcare professionals in one and social workers in the other, with health insurance and accident insurance on one side, and invalidity insurance, supplementary benefits, welfare benefits, etc. on the other. The funding systems are separate, tasks are fragmented in a way that is no longer in keeping with modern life, and the legal provisions are largely uncoordinated.

Complementary networks and coordination

"What we need to do is open up these isolated worlds by building more and stronger bridges between them," says Simona De Berardinis, Head of National Addiction Strategy at the FOPH. "What we're aiming for are well-integrated therapies and services, and networks that complement and are coordinated with each other." It is important for specialists to have some understanding of how the other players within the overall system function and what they offer, and to seek to coordinate with them. In many cases it is also necessary to find a common language because the jargon and thought processes are so different.

Marianne Jossen, Head of National Strategy for Non-communicable Diseases, adds: "These bridges are also important in terms of cooperation between the different authorities, and more specifically between the FOPH and the Federal Social Insurance Office (FSIO) because integrated health promotion can only succeed on a foundation of cross-sector and interprofessional collaboration."

Health 2030, the Federal Council's health policy strategy which, among other things, defines greater emphasis on coordinated care as one of its objectives, forms the basis of this undertaking.

What the stakeholders are doing

The FOPH has initiated a number of measures designed to improve the situation, all based on the biopsychosocial model, which include promoting interprofessional collaboration in healthcare and integrating the E+E approach (early detection and early intervention). A study commissioned by the FOPH also looked at the conditions necessary for success when establishing interprofessional collaboration at the interface of the health service and social services.

Other measures include work related to forward health planning, the palliative care and dementia platforms, stakeholder networking and knowledge sharing, for example in the form of events such as this year's stakeholder conference or round tables offering specialists the opportunity to discuss psychosocial determinants of health.

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Links:
- Stakeholder Conference 2023 website https://tinyurl.com/jarcswy7
- University of Freiburg literature review https://tinyurl.com/2rhc2kch
- Obsan Dossier 27, Social Resources as Health Protection https://tinyurl.com/manwdyy5
- Study of the conditions required for the success of a health service / social services interface https://tinyurl.com/yck5rkfz
- FOPH link for coordinated care https://tinyurl.com/5n97cxhd
- FOPH examples from practice: www.bag-blueprint.ch

Rest and relaxation reduce the risk of developing many NCDs.

“The potential of education is underused”

5 questions for Markus Kaufmann. “As a society we should accept that some people need support for a certain length of time. And during this time we should offer them more assistance,” says the Managing Director of the Swiss Conference for Social Welfare (SKOS).

1 How many people who are receiving welfare benefits have health problems?

Currently some 265,000 people are receiving welfare benefits in Switzerland. One third of them only require financial assistance temporarily, for up to a year at most, and another third get back on their feet again within three years. But 63 per cent of people who receive long-term welfare benefits are known to have impaired health, according to a study carried out in 2014 by the Social Policy City Initiative. These individuals are often too ill to work, yet they generally have no entitlement to an invalidity pension. The figures demonstrate very clearly that people who receive welfare benefits for a long time are under tremendous psychological strain, and this stress can cause further illnesses. A vicious circle develops in which a person needs welfare benefits because they are ill. And a person becomes ill because they are poor.

Markus Kaufmann, Managing Director of SKOS

2 Is the connection between poverty and illness stronger today than it was 15 years ago?

Not necessarily. I think this problem has always existed. The Federal Statistical Office has been keeping detailed statistics on benefits since 2005. So we’ve had very good, accurate figures for nearly 20 years. They show that the number of people receiving benefits increased up to 2017 but has been decreasing again since then. We think this development came about because the invalidity and unemployment insurance systems took a stricter approach during the second decade of this century. This meant that many people who had previously obtained benefits from these insurance systems, which come into play first, became dependent on welfare benefits.

We had feared that the figures would rise during the COVID-19 pandemic, but in fact they declined, and this trend has continued after the crisis. One of the factors at play here is the economic situation and the current shortage of workers. It’s easier to find a job nowadays than it was ten years ago. Another factor is the expansion of the social insurance systems during the pandemic, with developments such as the expansion of short-time working and the extension of the daily benefits paid by the unemployment insurance system.

There was a change in society’s attitude during the COVID-19 crisis. Before then the generally held view was that anyone who was basically “normal” would manage on their own, and that we needed to apply maximum pressure on the others to get those who were thought to be lazy into work. The legislation was tightened in many places, and particularly the legislation applying to foreigners. This view changed during the pandemic. We realised that anyone can be affected.

3 What is the situation in other countries?

Switzerland is a prosperous country and can afford a relatively comprehensive social welfare system. That’s why there is no visible precariousness here. In the USA the welfare network is far less comprehensive and as a result the country has an enormous homeless problem. And compared with Switzerland, there are seven times more people in prison in the USA. For these reasons, too, welfare benefits are an efficient instrument in economic terms. Subsistence support is a cost-effective tool.

4 What is SKOS doing to mitigate the interactions between poverty and poor health?

Around half of all welfare benefit recipients have not completed vocational training, which makes it very difficult for them to find work in the short and medium term. In the past, many of these people were simply written off or forced back somehow into the labour market. In 2018 we worked with the Swiss Federation for Adult Learning to launch a training campaign, and we are now expanding this project to give all welfare benefit recipients the chance to receive basic or further training. The potential of education has been underused in the past. Yet it has been shown that education can promote health and help people to cope independently with everyday life.

5 What would you like to see going forward?

I would like society to stop ostracising people who are receiving welfare benefits. These benefits should be seen as something to which people are entitled when they’re not doing well. As a society we must accept that some people need support for a certain length of time – and during this time we must provide them with assistance so that their situation can stabilise and they can be reintegrated into the labour market and in social terms.

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Link:
Key indicator report by the Social Policy City Initiative, 2014 (in German)
https://tinyurl.com/28knb2zh

At first hand

Linda Nartey, Vice Director FOPH

What is the best way to achieve collaboration?

Christian is in his late forties and has been diagnosed with cancer. He is working in a low-wage job. His financial situation does not allow him to pay the deductible for his health insurance. And he will be facing further costs, for transport to and from hospital or if he needs care at home, for example. Will he have to get into debt? Where can he obtain help? What are his rights? The situation is too much for Christian. Luckily the staff at the medical practice he visits are supportive. They want to help him, but this raises further questions. Is this their responsibility? How can they charge this counselling to the health insurance provider? Do they even have the necessary expertise?

This case shows how difficult it is to achieve targeted collaboration at the interface between the healthcare system and the welfare system. Individuals who find themselves at this interface often face many different challenges. Physical diseases are often accompanied by psychological stress; individuals not only have too little money but also an inadequate social network or a lack of employment prospects. All these factors interact and potentiate each other. By the same token, decisions taken and implemented within the welfare system have an impact on the healthcare system and vice versa.

These two systems are largely separate in institutional terms, and the legal basis, responsibilities and funding mechanisms that operate in one bear little relationship to those that exist in the other. The individual should always be the focus of attention. If people like Christian are to be supported as effectively as possible, employees, institutions and organisations from both systems need to work together in a more coordinated and needs-based fashion. It is against this background that the FOPH and the Federal Social Insurance Office FSIO are jointly organising a conference on 20 June 2023 that will put the spotlight on this collaboration. Integrated health promotion can only succeed if it works across sectors.

“We need to stop thinking in sectors”

There is much to be said for integrating social workers into the provision of basic healthcare. General practitioner Michael Deppeler and René Rüegg, a social work expert, explain in an interview that this facilitates better management of complex cases.

Mr Rüegg, in your research project you evaluated the impact of social workers in doctors’ practices. What emerged from this evaluation?
René Rüegg: This type of cooperation model is fairly common in other countries, in Belgium for example, but still very rare in Switzerland. We studied and observed four pilot practices. The most important finding in my view was that all the doctors concerned said that the social workers in their practice enabled them to focus better on their medical work. They were very satisfied with the cooperation and felt that the counselling provided by the social workers made their jobs much easier. The patients also reported that their mental state improved in the course of social counselling, and that they didn’t need to see their doctor so often.

Mr Deppeler, your practice is one of the pilot models.
Michael Deppeler: Yes, although we’ve actually been working this way for over 20 years. One of the reasons for this is that my early professional experience in the 1990s was shaped by the medical approach taken by the Lory Hospital in Bern, where we lived and practised biopsychosocial medicine under Professor Rolf Adler. There we were also used to working in interprofessional teams. I then followed this approach when my colleagues and I set up our general practice. We worked with psychologists from the very start, mainly in sensitive areas such as determining an individual’s suicide risk, or when crisis intervention was necessary.

We have also been working with a social worker for nearly ten years. He advises our patients if they have acute financial problems or need to find a care home. And he knows how to apply for a helplessness allowance or a personal assistance allowance.

That sounds like an all-round success. So why are there so few medical practices with integrated social work in Switzerland? Because it costs more?
Michael Deppeler: I need more time in my practice to counsel patients with their complex life stories and medical histories. Because of this, every three years I have to discuss with santésuisse, the organisation that represents health insurers in Switzerland, whether or not what I do is economically efficient and effective. These are nerve-wracking negotiations during which I have to explain why I need 16 or 17 minutes for my patients instead of only 13. But if, within my network, I can avoid the need for somebody to go into hospital, I save thousands of francs.
René Rüegg: It’s difficult for a single practice to prove that costs were reduced further down the line. To do this, health insurance data from groups of individuals or risk groups would have to be evaluated and compared. Unfortunately it is still very difficult to get hold of such data. However, last year the federal government decided to promote coordinated care networks as part of its cost-containment measures. This means that the federal government acknowledges that these networks are economically efficient and offer added value. So that aspect is not really being contested. Yet it’s still difficult for a doctor to base their practice on an integrated care model because it takes a lot of effort to establish a network, particularly at the start.
Michael Deppeler: But I think it’s very important to integrate healthcare and social welfare with each other. At the moment we are putting a lot of effort into shuffling costs from one source of funding to the next. For example, take the many invalidity reports that I write for people who lose their jobs because of a chronic health condition. Often, their applications are rejected after months in the review process and they end up on welfare benefits. We need to stop thinking in sectors and rethink the whole funding issue.

To what extent do social problems – such as loneliness or poverty – have an impact on health?
René Rüegg: The theory teaches us that people generally become ill in response to a whole range of psychosocial determinants. And equally that an illness can have many social consequences. Somebody who is diagnosed with cancer, for example, is at risk of losing their job. This means that they suffer not only from loss of income but also from the lack of contact with former colleagues.
Michael Deppeler: This is why we take a salutogenic approach. The first thing we want to know is: how does the person sitting opposite me perceive the problem? And the second thing is: what resources does this person already have and what do I need to provide them with temporarily, in the form of a professional support network? The third aspect is then the person’s sense of purpose. In my practice I encounter so many people who have given up. It is known that a feeling of helplessness and powerlessness places a physiological strain on the cardiovascular system. Studies show that these feelings cause as many strokes and heart attacks as smoking. But the cardiologist does not take this psychosocial stress into account at all. They are always focused solely on cholesterol, blood glucose and blood pressure.

Administering an injection or a tablet is more in keeping with what society expects doctors to be doing than establishing a support network.
René Rüegg: Yes, in this country doctors are responsible for treating diseases. Textbook medicine has little time for maintaining or promoting health.
Michael Deppeler: Nor are these things items of service that can be reimbursed under the Health Insurance Act (HIA). But I have learned that the HIA does allow for a relatively large degree of freedom: you just have to make use of it. There are basically very few activities performed by a doctor that cannot be delegated, such as certifying death or carrying out post-mortem examinations. Everything else can be outsourced. In the same way that I delegate blood sampling or taking X-rays to my medical practice assistants, I can organise expert social counselling for my patients and invoice this counselling as a medically prescribed service.

Social workers in doctors’ offices bring benefits: thanks to social workers, doctors can better focus on their medical work. Patients also benefit.

Dr Michael Deppeler

Michael Deppeler is Medical Director of the Salutomed joint practice, which he set up together with four colleagues as a “centre for integrative healthcare” almost 20 years ago.

Dr René Rüegg

René Rüegg initially studied social work at the University of Applied Sciences and Arts Northwestern Switzerland, followed by social sciences at the University of Zurich, before obtaining a PhD in public health at the University of Bern.

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