Editorial

It Medical Team
https://www.itmedicalteam.pl/

Health System and Policy Research
2254-9137

2023
Vol.10 No. 1: 169

Challenges in Implementing a Stroke Care Reform Acute Stroke Care and moving Care to the Community

Mannat Yadav*

Department of Psychiatry, Harvard University, United States

Corresponding author: Mannat Yadav

MannatYadav74@gmail.com

Department of Psychiatry, Harvard University, United States

Citation: Yadav M (2021) Challenges in Implementing a Stroke Care Reform Acute Stroke Care and moving Care to the Community. Health Sys Policy Res, Vol.10 No. 1: 169.

Abstract

A mandatory overhaul of stroke care was implemented in one of Denmark's five health care districts. The reform's dual goals were to reduce expenses and raise the standard of treatment. It involved moving from inpatient rehabilitation programmes to community-based rehabilitation programmes as well as centralising acute stroke care at specialised hospitals and shortening hospital stays. Patients would benefit from a more seamless care pathway between the hospital and the municipality, supported by hospital early discharge teams. The adjustments were made using a formal policy instrument, a health care agreement between the region and municipalities. Using a top-down approach, a committee carried out the implementation, with the hospital sector organised by regions being better represented than the primary sector. Municipalities organise the health care industry.

Keywords: Health care reform; Stroke care; Implementation Centralisation; Moving care to the community

Received: 02-Jan-2023, Manuscript No. IPHSPR-22-13389, **Editor assigned:** 05-Jan-2023, PreQC No. IPHSPR-22-13389; **Reviewed:** 19-Jan-2023, QC No. IPHSPR-22-13389; **Revised:** 23-Jan-2023, Manuscript No. IPHSPR- 22-13389 (R); **Published:** 31-Jan-2023, **DOI:** 10.36648/2254-9137.23.10.169

Introduction

All parties were in favour of centralising acute care, but municipalities opposed hospital-based early release teams because they believed it would interfere with their primary duties [1]. Municipalities would have preferred to have had greater say in how the reform was created [2]. Initial findings point to high acute care quality [3]. The area has experienced cost reductions as a result of bed closures and shorter hospital stays. Less success has been seen in realising the goal of integrating rehabilitation treatment between hospitals and towns [4]. It is possible that greater municipal engagement in the design process and stronger representation of healthcare experts throughout the process would have resulted in a more effective reform implementation. Municipalities organise the health care industry [5]. All parties were in favour of centralising acute care, but municipalities opposed hospital-based early release teams because they believed it would interfere with their primary duties. Municipalities would have preferred to have had greater say in how the reform was created [6]. Initial findings point to high acute care quality [7]. The area has experienced cost reductions as a result of bed closures and shorter hospital stays [8]. Less success has been seen in realising the goal of integrating rehabilitation treatment between hospitals and towns [9]. It is possible that greater municipal engagement in the design process and stronger representation of healthcare experts throughout the process would have resulted in a more effective reform implementation [10]. One way to describe the Danish healthcare system is as decentralised [11]. Three administrative levels national, regional, and local are organised for the planning and control of the health care system [12]. Hospital planning is the responsibility of the health authorities in each of the five regions [13]. The 98 municipalities are in charge of illness prevention, wellness promotion, and recovery. The general practitioners serve as the system's entry point and gatekeepers, sending patients to hospitals and specialists for care [14]. The regional level is supported by co-payments from the municipalities and state block funds. In order to reduce hospital admissions, the municipal co-payment was put in place as a financial incentive for towns to participate in health promotion and prevention [15].

Discussion

Denmark has a national policy that includes an Danish hospitals are now undergoing a process of specialisation and care centralization that has led to the creation of five mega hospitals. A global trend that many nations view as a way to make health care systems financially sustainable is the specialisation and centralization of hospital services, early release, and shifting treatment into the community. Effective care coordination across sectors is also necessary to address this tendency. Acute stroke treatment was specialised and centralised in the Central Denmark Region in May 2012, and inpatient rehabilitation services for patients with mild to moderate stroke symptoms were transferred to the municipality. The reform's primary justification was cost savings. Prior to the reform, there were five regional hospitals that provided acute treatment and inpatient rehabilitation for stroke patients; two these hospitals lacked a neurology department, and referral was mostly based on location. Because some patients were treated at a dedicated stroke unit while others weren't, the quality of acute stroke care varied across the area. Patients with the same need for specialised neurorehabilitation did not receive the same level of medical care at various hospital departments in the area, according to a group of leading neurologists in 2007.

Conclusion

A window of opportunity to change stroke treatment in the area opened up as a result of the Region's desire to reduce expenditures, with a focus on centralising acute stroke care and relocating rehabilitation care to the community. This article outlines the procedure for creating policies and carrying out this required modification. It's a shift that If the twin promise of reducing costs and raising care quality is to be delivered, there must be coordination of care across sectors. The primary goal of the stroke care reform was to reduce costs, but not by turning to quick fixes. The progressive closure of 30% of the acute care and rehabilitation hospital beds would result in cost savings. Moving rehabilitative treatment to the communities will shorten hospital stays and centralise acute care at two specialised facilities rather than five. With decreased death rates and better health upon release, centralising acute care served the combined goals of lowering costs and enhancing quality. A more integrated care route would also be advantageous to patients.

Acknowledgement

None

Conflict of Interest

None

References

1 Ahern J, Galea S, Hubbard A (2008) “Culture of drinking” and individual problems with alcohol use. Am J Epidemiol 167: 1041-1049.

2 Alaniz ML, Wilkes C (1998) Pro-drinking messages and message environments for young adults: The case of alcohol industry advertising in African American, Latino, and Native American communities. J Public Health Policy 19: 447-472.

3 Albers AB, DeJong W, Naimi TS (2014) The relationship between alcohol price and brand choice among underage drinkers: Are the most popular alcoholic brands consumed by youth the cheapest? Subst Use Misuse 49: 1833-1843.

4 Bahr SJ, Marcos AC, Maughan SL (1995) Family, educational and peer influences on the alcohol use of female and male adolescents. JSAD 56: 457-469.

5 Barry AE, Johnson E, Rabre A, (2015). Underage access to online alcohol marketing content: A YouTube case study. Alcohol and Alcoholism 50: 89-94.

6 Berkman LF, Glass T, Brissette I, Seeman TE (2000) From social integration to health: Durkheim in the new millennium. Soc Sci Med 51: 843-857.

7 Bernstein KT, Galea S, Ahern J (2007) The built environment and alcohol consumption in urban neighborhoods. Drug and Alcohol Dependence 91: 244-252.

8 Borrell LN, Jacobs DR, Williams DR (2007) Self-reported racial discrimination and substance use in the Coronary Artery Risk Development in Adults Study. Am J Epidemiol 166: 1068-1079.

9 Bouchery EE, Harwood HJ, Sacks JJ (2011) Economic costs of excessive alcohol consumption in the U.S., 2006. Am J Prev Med 41: 516-524.

10 Boynton MH, O’Hara RE, Covault J (2014) A mediational model of racial discrimination and alcohol-related problems among African American college students. 75: 228-234.

11 Brooks Russell A, Simons Morton B, Haynie D (2013) Longitudinal relationship between drinking with peers, descriptive norms, and adolescent alcohol use. Prevention Science 15: 497-505.

12 Bui HN (2012) Racial and ethnic differences in the immigrant paradox in substance use. JImmigr Minor Health 15: 866-881.

13 Caetano R (1987) Acculturation and drinking patterns among U. S. Hispanics. Br J Addict 82: 789-799.

14 Caetano R, Clark CL (1999) Trends in situational norms and attitudes toward drinking among whites, blacks, and Hispanics: 1984–1995. Drug Alcohol Depend 54: 45-56.

15 Caetano R, Ramisetty Milker S, Rodriguez LA (2008) The Hispanic Americans Baseline Alcohol Survey (HABLAS): Rates and predictors of alcohol abuse and dependence across Hispanic national groups. JSAD 69: 441-448.