Telecare: policy discourses, policy instruments and policy evidence

Andrew Eccles
School of Social Work & Social Policy
University of Strathclyde
andrew.eccles@strath.ac.uk
Background

Scottish Universities Insight Institute funding: four day symposium May/October 2013:

Design engineers, academics (Universities of Amsterdam, Brighton, Dundee, Lancaster, Maastricht & Strathclyde) Scottish Government, NHS 24, Local Authority telecare project managers, carers and end users.

Qualitative research across Telecare partnership sites in Scotland and discussion from ESRC *Making Research Count* programme
Policy underpinning


‘[It makes] economic sense wherever possible to substitute Assistive Technologies for human effort’
A view from abroad….

Pols, J & Willems, D. 2011 (Sociology of Health & Illness 33. 3)

‘The dubious status of promises and the unpredictable processes of domestication [of technologies] that are so hard to trap with standard research methods, make implementing telecare technologies on a large scale and on a top-down basis, as is done in the UK, a hazardous investment’ (p.496)
Current policy frameworks

In England the 3millionlives programme is set to extend telehealth and telecare to at least 3 million more people over five years from December 2011

David Cameron at the Financial Times Global Pharmaceutical and Biotechnology conference (December 2011):

‘We've trialled it, it's been a huge success and now we're on a drive to roll this out nationwide…. And this is not just a good healthcare story. It’s going to put us miles ahead of other countries commercially too’

FT Global Pharmaceutical and Biotechnology conference: ‘discussion between leading industry executives, government decision makers, investors, analysts and other specialist providers’
'The results of the [WSD] telecare trial were published in February 2013 and showed no statistically significant reduction in health or social care use between the telecare and non-telecare groups'.

'The results of the telehealth economic evaluation were published in March 2013 and showed that telehealth was not cost-effective at the scale implemented in the trial'.

'Headline findings of reductions in A&E visits, elective admissions and costs were not found to be statistically significant. Subsequently the largest single randomised control trial of telehealth for COPD also found no statistically significant difference in admissions between the telehealth and control groups'.
WSD on HRQoL

What this study adds
Compared with usual care, second generation telehealth had no effect on HRQoL, anxiety, or depressive symptoms for patients with chronic obstructive pulmonary disease, diabetes, or heart failure over 12 months.

The findings suggest that claims for potentially salutary or deleterious effects of telehealth are unfounded for most patients.

Telehealth should not be introduced with the aim of improving quality of life or psychological outcomes.

Effect of telehealth on quality of life and psychological outcomes over 12 months (Whole Systems Demonstrator telehealth questionnaire study): nested study of patient reported outcomes in a pragmatic, cluster randomised controlled trial

*BMJ* 2013;346:f653 doi: 10.1136/bmj.f653 (Published 26 February 2013)
[...] measuring QoL indicators and connecting these to specific technological interventions is fraught with methodological complexities. We would thus urge caution in the way that this term is employed. [...] if QoL has no agreed definition, and there are serious measurement issues, is it sensible to view improved QoL as an outcome of policy interventions involving ATs? We suggest a more nuanced enquiry might be: What are the predictors of QoL, and how might ATs connect to these?
Telecare evaluation in Scotland

‘The evaluation relied on Project Managers or other staff working with the telecare users (e.g. those undertaking telecare assessments) to identify what they thought would otherwise have happened to the client at and subsequent to the time of issue of their telecare equipment. This information was then used to estimate the resources that would have been used if the telecare equipment had not been provided’.

(Scottish Government, 2009)
Telecare evaluation in Scotland

The research notes that, of three possible methods that could have been used to evaluate the cost effectiveness of the policy, the least robust was used, given the complexities and uncertain variables inherent in the data under evaluation (Beale: 2012)
What did our SUII symposium discussions conclude?

• No straightforward ‘impact’ of technology: it works well for some people, at some stages of their lives, in some contexts

• Technology and the social dimension are intertwined and mutually shaped

• Users and use contexts are central

• Resistance to new technologies may reflect lack of ‘fit’ between technologies and care practices

• Performance regimes have the potential to skew good practice
What did our SUII symposium discussions conclude?

- The different – and sometimes in tension – discourses of technology companies (predictability of market growth) change managers (service delivery within fiscal constraints, interoperability) and end users (usability)

- The inadequacy (but persistence) of bio-medical ethical frameworks in viewing ethical challenges in telecare use. The need for contextual ethics and a pragmatic ethics to which practitioners can relate

- The false dichotomy of ‘warm care and cold technology’ (Pols & Moser, 2010); it’s about the social complexities of technology use
Complexity for front line practitioners

Information is not knowledge

– Need for interpretation and familiarity
– Shared decision and negotiation

Some concerns are relieved but new dilemmas are introduced: need to know or ought to know information?


‘With few exceptions, the current generation of ‘assisted living technologies’ does not assist people to live with illness….technology providers need to move beyond the goal of representing technology users informationally (eg as biometric data) to provide flexible components from which individuals and their carers can ‘think with things’ to improve the situated lived experience of multi-morbidity. A radical revision of assistive technology design policy may be needed’.

So what’s the issue here?

Mort, Roberts and Milligan (2009: 85)

“[there is an] ethical and democratic deficit in this field which has arisen due to a proliferation in research and development of advanced care technologies that has not been accompanied by sufficient consideration of their social context.”
The space for debate

As Callen et al (2009) note, public space for debate about the desirability of these technologies, their implications for care relationships and aspects of privacy, largely sits outside the realm of parameters set by ‘experts’.

These tensions tend to be muted by a mutually reinforcing discourse amongst technology companies, government and some academic research in which these wider social tensions are often not openly addressed.
Whose discourse?

Scottish Government (2008: 6): ‘telehealth will be widely recognised by service users and their carers as the route to greater independence and quality of life’

‘Telecare services [should] grow as quickly as possible’ (Scottish Government, 2008:6)

Tunstall: Telecare solutions to the ‘demographic timebomb’ (2009:3)

Tunstall is officially a ‘partner’ of the Scottish Government
Figure 1: % households taking up fixed broadband, by age group

Base: 62,669 GB, 594 Glasgow

Who is Offline in Glasgow?
Figure 2: % households taking up fixed broadband, by socio-economic group

Base: 62,669 GB, 594 Glasgow
Performance indicators

Reduce the Number of Avoidable Emergency Admissions and Readmissions to Hospital

Hospital bed days saved through telecare supported discharge

Reduce the use of care homes

Improve quality of life for users of telecare services

Reduce pressure on informal carers
Performance indicators

Acknowledged differences in methods of recording

Scottish Government categories of telecare partnership performance

The anomalies of performance regimes
The current telecare vision in Scotland: telecare & co-production - some points

- Telecare technologies market success will depend on *scale* not specifically on tailoring to individual, co-produced needs.

- End users of telecare technologies often lack capacity in decision making. Who then engages in the complexities of co-production with the end user: social work or technical support? Where co-production *is* acknowledged to be taking place it is often with *carers*, not end users. The interests of carers (who may also *be* users) and end users are *not necessarily* compatible.

- Telecare technologies *reconfigure* the meaning of care in new and unpredictable ways which may be problematic for front line care practitioners. These problems from reconfigured care are often specific to individual professions and may be impacted upon by job experience, gender and security of tenure.
References


• Cameron, D. (2011, December 6). *We've got to change the way we innovate, the way that we collaborate, and the way that we open up the NHS* (*transcript of speech, exactly as it was delivered*). Retrieved from https://www.gov.uk/government/speeches/pm-speech-on-life-sciences-and-opening-up-the-nhs.

References


References

• Eccles, A. (2010a). Ethical considerations around the implementation of telecare technologies. *Journal of Technology in Human Services, 28*(1-2). http://dx.doi.org/10.1080/15228831003770759

• Eccles, A. (2010b). Ethical issues in the implementation of telecare policy. *Gerontotechnology, 9*(2), 83-84. http://dx.doi.org/10.4017/gt.2010.09.02.034.00


References


References


References

• Pols, J. (2012). *Care at a distance*. Amsterdam: Amsterdam University Press.


References


• Scottish Government. (2012). *A National telehealth and telecare delivery plan for Scotland to 2015: Driving improvement, integration and innovation*. 