

## INDEX OF HEALTH-SERVICES' EFFECTIVENESS IN HIV: A DISCUSSION-DOCUMENT

**Title:** Index of Health-Services' Effectiveness (IHSE) in HIV: Discussion-document

**Date:** 2013.01.10 (ISO 8601)

**Version:** 1.2

**Author:** Rupert Whitaker

This document is presented for the purposes of comment and feedback. Due to a failure of the WP commenting system at the moment, please provide comments via the [Contact Us \(www.tukeinstitute.org/contact-us\)](http://www.tukeinstitute.org/contact-us) page or via the mirrored page on the blog at <http://www.tukeinstitute.org/?p=1333>. We would be grateful for feedback on questions such as:

- what could be better in this Index and how?
- what should be removed and why?
- is this a good/helpful/necessary idea?
- how should this be promoted?
- which organisations should promote the use of this Index, if any?
- etc

### Overview

An index of the health-effectiveness of services is proposed as a measure of the degree to which such services are effective in helping people maintain or resume a normal, healthy, daily life. This is a universally relevant Index but we are looking to pilot it in the area of HIV, one of the chronic conditions most obviously influenced by a complex interaction of physical, mental, behavioural, and social issues. If HIV is not your field of interest, please consider it in the light of other chronic conditions.

Most health-services for HIV focus currently on treatment of the virus, where treatment-success is measured in terms of the amount of virus detectable in the blood and whether the T-cell count is within a normal range; assessment of illness is limited and primarily focused on bodily signs. Research shows that this approach is insufficient to ensure that people with HIV are able to lead full, healthy lives; people with undetectable viral load and 'normal' levels of T cells can still be unnecessarily ill, due to the interaction of complex physical, mental, and social — or "biopsychosocial" — issues.

Although the physician-dominated British government's Expert Advisory Group on AIDS called these issues "window-dressing", the clinical and public health evidence available shows strongly that it is these issues that are significantly responsible for the continuing transmission of the virus as well as the diverse co-morbidities of HIV infection related to poor health-outcomes among those already infected.

Scientific research has also identified various factors that contribute to services' effectiveness in creating good outcomes, defined in terms that are relevant to daily life and health. These factors include comprehensive/biopsychosocial services that are integrated, easily usable, of good quality, delivered by appropriately-trained professionals in a patient-centred manner, and — crucially — services that empower patients to take responsibility for their health and health-behaviours. Empowerment means that people with HIV are able to participate in, and have influence over, the emotional, occupational, social, political, and health-service contexts in which they move. Empowerment enables health and minimises disability; conversely, disempowerment — as with unresponsive, inadequate, or irrelevant services — promotes disablement and disability. The concept of empowerment in HIV-services stems from the Denver Principles and relates to work currently underway on the Denver Principles Empowerment Index, led by Sean Strub (cf. [www.seroproject.com](http://www.seroproject.com)).

The effectiveness of services can be measured, but the mediating factors that enable and promote health can also be measured. Their measurement can contribute significantly to the betterment of services and, thus, the betterment of the health of people with HIV. The Tuke Institute proposes measures for six central criteria, each with sub-criteria, which would form an index of the health-effectiveness of services for people with HIV.

### Criteria

1. effectiveness in terms of health-status, in which clinics must show:
  1. that they measure patients health-status on entry and at various stages of service, to measure the effectiveness of their services
  2. that the measures of health are comprehensive — i.e., embracing physical, mental, behavioural, and social health
  3. that the measures of health are patient-centred and meaningful to the patients in their own lives
2. empowerment and participation of patients
  1. clinics must show that they empower patients to participate in various levels of service, from clinical decision-making to complaints-handling, audit and governance, and planning and policy-development
  2. that participation is systemic rather than using unelected 'representatives'
  3. patients must be enabled to take responsibility for their health, addressing all aspects of their physical and mental health in social context
3. comprehensiveness of services
  1. clinics must show that they provide services that address all aspects of illness, including physical, mental, behavioural, and social
  2. that they integrate services addressing clinical prevention, treatment, and rehabilitation
    1. clinics must show that they have integrated biopsychosocial services
    2. they must demonstrate integration through various methods (e.g., nurse-leadership, case-conferencing, case-management, co-localisation, etc)
    3. they must show how they integrate therapeutic interventions with both primary and secondary preventive interventions
5. quality — clinics must show that their services are of good quality in terms of:
  1. the ready availability and variety of primarily evidential treatments and treatment-modalities (chemical, psychological, nutritional, surgical, etc)

2. clinicians' competence in reference to their role — clinicians working only within their areas of qualified expertise (e.g., physicians not providing psychotherapy/counselling unless they are also qualified as psychotherapists)
3. the clinic's physical quality (structures, aesthetics, cleanliness, etc)
4. the clinic's cultural health (staff morale, pro-patient attitudes, team-function, communication-skills of both clinical and non-clinical service-providers, positive responsiveness to complaints, etc)
6. usability — clinics must show that they provide services of good quality in a way that is most efficient and easy to use for the patients, particularly in terms of:
  1. geographical accessibility
  2. temporal accessibility (opening-hours, weekend and evening opening, waiting-times, etc)
  3. flexible communication-methods with patients

**Data-collection**

Data on each of these measures would be collected by a variety of respondents, including the Tuke Institute directly, service-users, service-providers. The data would be reported to the public as buyers of the services and to the commissioners of the services as guardians of public funds, to ensure effective commissioning.

**Reporting**

The performance of any given service would be reported based on weakest-link analysis, in which criteria are reported by the lowest score achieved in each sub-criterion, rather than the average of sub-criteria. The rationale behind this lies in the fact that, as services are systems, a break in the chain of delivery means that all elements in the system therefore are either reduced in effectiveness or fail. This Index brings with it a graded kitemark of quality from basic (bronze) to excellent (gold), with explanations as to areas in which a provider can better its services.

**Value**

The proposed Index is valuable for a number of reasons. As well as being a tool for promoting effectiveness in health-services in HIV, it is a resource for service-providers: it identifies standards to which all services should aspire while educating both service-users and service-providers about the ingredients and importance of health-effective services. Using this Index, clinics will be able to show their commitment to the well-being of people with HIV by meeting the criteria for optimal services, and ensuring that they are fully up-to-date with the best practices in serving the health-needs of people with HIV through appropriate training. It is a means also for service-providers, as leaders in quality, to achieve public recognition for their commitment to the health of their service-users. It can also provide a blue-print on which measures of services for other chronic-terminal conditions can be based, thus demonstrating leadership by the HIV-sector once again.

By educating service-users, it also raises reasonable and informed expectations as to the quality of services, and provides leverage with which to promote health-effective services. It is also a resource for people with HIV to identify those services that are committed to providing health-effective services and which, therefore, are committed to the well-being of people with HIV.