Chapter 5
E-Health:
A Bridge to People-Centered Health Care

Anastasius Moumtzoglou
Hellenic Society for Quality & Safety in Healthcare & European Society for Quality in Healthcare, Greece

ABSTRACT

People-centered health care represents a structural change in thinking, which encapsulates before anything else the consideration of the patient. The development of people-centered care might include a partnership approach based on equal footing, capacity-building and the expansion of organizational care. Its central values encompass empowerment, participation, family, community, and the abolition of any kind of discrimination. As a result, they bestow people on shared decision-making not exclusively on issues of treatment but also for health care organization. On the other hand, a global e-health agreement is beginning to take shape on the engagement of stakeholders, the interoperability, and standards. Consequently, e-health can have a significant impact on people-centered care, despite the challenges of implementation and adoption.

INTRODUCTION

Health systems have reached a historic turning point. Changing population health patterns and outcomes shift the disease burden; higher levels of education, increased availability of information and access to goods and services alter expectations of health care delivery; patient satisfaction, patient safety, responsiveness of care are major issues, and patient-centeredness is a global issue.

DOI: 10.4018/978-1-61692-843-8.ch005

However, the current health care is becoming overly biomedical-oriented, technology-driven, doctor-dominated, and market-oriented. Changing health needs, community expectations, ageing populations, rise of chronic conditions; increased literacy and purchasing power, superior information technology and access to information lead to increasing consumerism. Weaknesses in medical education, which concentrates on body systems and disease conditions and pays less attention to social context, psychosocial and cultural issues, ethics, interpersonal communication and

relational skills fragments provision. Low health literacy means limited availability of pertinent information and weaknesses in quality systems less responsiveness. There are also gaps in health policy – financing incentives; workforce production, distribution and regulation; weaknesses in primary care and in continuity of care, and clamor for more responsible and accountable health care governance. Consequently, health systems provide insufficient opportunities for consumer input and feedback and little reporting to the community.

People-centered health care represents a substantial change in thinking, which encapsulates the foremost consideration of patient and covers patient-centered care (WHO, 2007). It stems its origin from the human rights campaign and has a protracted history in research, clinical practice and medical education. The fundamental values of people-centered care encompass empowerment, participation, family, community, and the abolition of any kind of discrimination. People have the right and duty to shared decision-making not only on issues of treatment but also for health care planning and implementation. Health systems should serve individuals, families and communities in humane and holistic ways in all settings and at every opportunity.

Nevertheless, we have not satisfactorily enunciated the concept at the health system level. Some of the reasons for the gap between vision and practice might include:

- The evidence demonstrates that there are significant gaps in what we know about how to raise standards of health literacy (Coulter & Ellins, 2006).
- Implementation of innovations, which improve shared decision-making (Coulter & Ellins, 2006).
- Barriers which include lack of knowledge and skills, concerns about time and negative attitudes among clinicians (Billings 2004, Graham et al., 2003).
- We need to understand how to enhance safety improvement through patient involvement, and we are not entirely aware of the effect of patient feedback, provider choice, complaints, and advocacy systems.
- 'Accountability' is a term of many nuances (Savage & Morre, 2004) and open to various interpretations (Mander 1995; Ferlie et al., 1996). Lewis and Batey (1982) make a practical distinction between structural accountability (disclosure) and accountability as an internalized predisposition (the willingness to assume responsibility for the outcomes of professional actions). Tingle (1995) argued that the various definitions of accountability are just starting points, while McSherry and Pearce (2002) state that accountability for health care professionals bears on changing practice. Therefore, to be truly accountable, practitioners need to check that their practice is evidence-based, efficient and effective.
- Quality improvement systems seem to be effective with regard to the implementation of selected patient-centeredness strategies, but they seem to be inadequate to ensure their widespread implementation (Groene et al., 2009).

On the other hand, empirical research has identified e-health behaviors, which include the decline in expert authority, pervasiveness of health information on the Internet and empowerment (Donelly et al., 2008). The findings demonstrate a decline in expert authority with ensuing implications for health management. Thus, the perspective of the chapter is to examine the prospects of e-health to the realization of people-centered care.

BACKGROUND

Eysenbach (2001) defined e-health as 'an emerging field in the intersection of medical informatics,