DOWNLOAD PDF RETHINKING THE MEDICAL MODEL

Chapter 1 : Rethinking the Health Care Access Model | Accenture

Effects of the medical model of disability. One result of the common medical understanding of disability is that people with disabilities often report feeling excluded, undervalued, pressured to fit a questionable norm, and/or treated as if they were globally incapacitated.

Rethinking the health care access model By: Ron Moody The great Canadian physician Sir William Osler, co-founder of the Johns Hopkins School of Medicine and a visionary in his field, strongly advocated providing medical care with the utmost efficiency. Osler made that observation in More than a century later, we continue to search for the best practices that broaden and improve access to health care. It takes on different forms in the 21st century than it did in the 19th, but healthcare remains in a constant state of change. Fee for service is being replaced by value-based strategies. Within Federal healthcare, we should be moving toward transforming how health care is conceived and delivered, leading to a future of care that is highly available and more easily accessible, satisfying to patients and medical professionals, and cost-effective. This will involve a change in strategy, policy and emphasis, requiring a cultural change supported today by new technologies, techniques, and processes that redefine the way services are provided. Access to healthcare is a critical issue at VA, DoD, and other healthcare organizations. Scheduling enough in-person visits to ensure proper care for a growing veteran population is a source of ongoing discussion and a challenge. Expanding access simply by adding staff or acquiring, building or opening new facilities is not a realistic solution. The solution lies in new methods and evolving the definition of healthcare access to include what is measured and how it is measured. This change is being fueled by access to health information technology and digital mobility. These tools are powerful engines of change. Transformative changes, through video engagement, advanced telehealth, secure messaging and other asynchronous options, are coming. They will be standard tools of healthcare delivery and clinical operations in the near future. To leverage the technology to achieve outcomes requires action today. Technology is an enabler of change, not the substance. Technology is no longer the primary rate limited factor to expand telehealth. You can talk to technology companies about their tech. Change management and leadership strategy drive the transformation, and AFS is the mechanism to reach that destination. The model for future generations of health care planners, participants and patients begins with redefining how the system currently works, and how it should work. Virtual care investment can lead to superior utilization, lower cost, and a reduction in strain on available personnel and resources. Implemented correctly, the results can be enhanced healthcare access across the full continuum of care, and the need for fewer healthcare professionals. The tripleâ€”and quadrupleâ€”aim can be achieved. Today is the start of an ongoing conversation about the future of health care access and delivery. I look forward to hearing your perspective on the changes ahead.

Chapter 2 : Blog | Rethinking Disability

In , Joanne Lynn and David DeGrazia wrote a brilliant paper about the "fix-it model" of medical decision making. In it, they posit that contemporary attitudes about medicine subscribe to a mental model whereby disease is defined by a deviation from normalcy and the role of health care is to provide an intervention that "fixes" or returns the patient to normalcy.

Capretta Spring Medicare was enacted a half-century ago and has been at the forefront of prominent political debates since the program first began paying hospital and physician bills for enrollees. Both the fiscal prospects of the program and its effects on our broader health-care economy now call for such fundamental rethinking. To do this, we would have to begin by considering just what the Medicare program actually consists of at the most basic level. At that level, Medicare is two things. First, it is a publicly run, community-rated insurance plan for persons age 65 and older and the disabled. Federal taxes and spending are not necessary to run this community-rated insurance plan. In theory, the full premium for this insurance could be collected from the enrollees during their time of eligibility for benefits. It is also, secondly, a social-insurance program. Like Social Security, it is designed to provide additional support to households with more modest incomes and to subsidize, to a degree, the health care provided to all elderly and disabled Americans. These features of Medicare require the imposition of taxes to pay for program spending and open the program up to the demographic and other pressures that have made financing Medicare such a challenge. An effective redesign of Medicare should begin by understanding that these two elements of the program are distinct. It could therefore be restructured to retain the protections associated with community-rated insurance while rethinking the tax-and-transfer elements associated with its current design. Disentangling these different facets would be complex programmatically, and would certainly be a very difficult political project. But it would also offer a way to modernize Medicare, make its finances sustainable, and enable it to help the larger health system work better for all Americans. In the long run, such a reform would cut a Gordian knot that otherwise threatens to debilitate our politics in the coming decades. In the United Kingdom, a newly elected Labor government pushed through the creation of the National Health Service, a single-payer program of universal, tax-financed health-care provision. President Harry Truman sought to do something similar in the U. Among his proposals was a plan for a voluntary, federally administered National Health Insurance plan. Truman faced strong opposition to his plan in Congress. A major impediment was the American Medical Association, which opposed "socialized medicine. When Democrats were next in a position to push for broader health-insurance enrollment in the U. Social Security was controversial when it was enacted in , but President Franklin Roosevelt was always confident that its design â€” a pay-as-you-go social-insurance program â€” would eventually prove to be very popular and would, in time, make the program politically untouchable. Workers pay the tax during their working years, and then receive a benefit in retirement based, in part, on the wages that were taxed while they were working. This connection between taxed earnings and benefits paid in retirement is the core of Social Security. Most Americans believe they have "earned" their Social Security benefits when they reach retirement because the federal government withdrew taxes out of their paychecks to pay for it. Proposals from politicians to adjust Social Security payouts are thus viewed by voters with extreme skepticism. The architects of Medicare borrowed liberally from the Social Security playbook. Medicare was built, in part, on an intergenerational social-insurance model. And the taxes they pay are deposited into a dedicated federal trust fund, from which the benefits for current retirees are paid. Much like Social Security, retirees believe they have earned their Medicare benefits with their payroll taxes, and thus also view attempts to alter those benefits as reneging on an implicit contractual agreement between citizens and the government. While politically clever, using the Social Security template â€” namely, collecting payroll taxes from current workers to finance benefits for current retirees â€” to design Medicare has meant importing into Medicare the same demographic pressures now pushing Social Security toward insolvency. As shown in Figure 1 below, the combination of falling birth rates and rising life expectancy has dramatically reduced the ratio of the working-age population to Medicare beneficiaries. In , there were 5. Today, there are

just 3. Medicare has a second component â€" often called Medicare Part B â€" which pays for physician and other outpatient services, and which exacerbates the fiscal problems associated with hospital coverage. As originally conceived, Medicare Part B expenditures were to be financed partially from premiums paid by the beneficiaries themselves and partially from the federal Treasury. Initially, the idea was to have the program financed in equal amounts from the beneficiaries and from the federal Treasury. That policy held until , when Congress, in response to rising costs and thus also rising premiums for the beneficiaries , limited the annual increases in beneficiary premiums to the percentage increase in their Social Security benefits. This policy had the result of rapidly reducing the proportion of the program paid for by the enrollees themselves. That policy, with some exceptions, has basically held for the past three decades. In , Congress added a new drug benefit to Medicare, and modeled its financing on the Part B program. The prescription-drug benefit is referred to as Part D of the Medicare program. Medicare beneficiaries also have the option to take their full entitlement in the form of enrollment in a private insurance option, called a Medicare Advantage plan. This feature of the program is often called Part C. Part D beneficiary premiums are required for enrollment, but do not cover the full cost of the benefit. Once again, federal taxpayers pay whatever drug-benefit costs are incurred that are not covered by beneficiary premiums. The burden on federal taxpayers from Medicare Parts B and D is enormous, largely hidden from view, and seldom noted in public debates. These amounts exceed what will be spent during that same period on all of the federal programs providing direct support to low-income households combined. With the enactment of the drug benefit in and the retirement of the baby-boom generation, taxpayer subsidies for Medicare are set to soar. And the net subsidy for such a couple will only go up in the years ahead. Both Parts B and D now charge higher-income seniors more for enrollment in the program. There was always an expectation that some funding would come from the general fund of the Treasury. Still, it is useful to consider how much program expenditures will exceed the resources specifically dedicated to paying its costs in coming years. That estimate assumes that a deep cut in hospital and other facility payments will occur without interruption for the next 75 years, which is unlikely. For Parts B and D of Medicare, the unfunded liabilities are essentially the cost of the program that is not covered by beneficiary premiums and thus must be paid from the federal Treasury. First, Medicare provides guaranteed inclusion in a nationwide, community-rated risk pool of all persons age 65 and older, plus eligible disabled workers. The program implicitly charges everyone in the risk pool the same premium for coverage, regardless of their health status. Moreover, no one can be denied access to the pool based on a prior history of illness. Second, Medicare is also a tax-and-transfer program. In a sense, the HI program can be thought of as a social-insurance program aimed at securing a type of annuity for health-insurance coverage in retirement. Workers pay the HI payroll tax while working and, in return, get an insurance benefit that has value equivalent to a monthly insurance premium, paid for by the government. While the implicit premium annuity is the same for all beneficiaries, higher-income workers pay much more in taxes to receive it. The combined employer-employee Medicare payroll-tax rate is 2. Above these income thresholds, the tax rate rises to a combined 3. As noted, Medicare also collects premiums from beneficiaries and taps into the federal Treasury to pay for additional health-insurance benefits for this population. Even if Medicare did not have its current tax-and-transfer features, it would still be a highly valued program for its beneficiaries. Conceptualizing Medicare in this way is useful because it immediately makes clear that a redesigned Medicare could de-emphasize its current tax-and-spending features, especially for those who could reasonably save enough to cover most of their health-insurance premiums in retirement on their own, while retaining and promoting its value as a source of guaranteed, affordable health insurance for the retired and disabled. Reworking the program in this way would reduce the financial risks to federal taxpayers while still providing an important safety net to retirees. The starting point for a fundamental and far-reaching reform of Medicare should be a vision for how the program would work after the reform is fully implemented and following a lengthy transition period. Such a reform would involve six key features. The first is a rationalized Medicare insurance product. Instead of separate insurance products for hospitalization, outpatient services, and drugs, Medicare would provide to enrollees a combined insurance product covering all of these essential medical services. A single premium would cover the cost of enrolling in Medicare insurance. Further, there would be a single, unified deductible; sensible

cost-sharing; and catastrophic protection providing an upper limit on annual enrollee costs. Second, Medicare would offer community-rated premiums for its beneficiaries. This simply means Medicare should treat everyone equally, regardless of their health status, just as is the case today. In practice, this means that insurance premiums for enrolling in Medicare would not vary based on the age or health status of enrollees. However, premiums should vary based on the lifetime earnings of enrollees, as well as on their own choices about the kind of coverage they prefer. Third, a reformed Medicare program would involve a smaller universal entitlement funded entirely by a Medicare payroll tax. Even if there were no such basic entitlement, Medicare would remain an attractive program because of the security of the insurance it would offer. All Medicare enrollees in the future would be entitled to receive a premium subsidy of this amount adjusted to reflect the value of the insurance plan at the time they are enrolled. However, because of the aging population, Medicare enrollment is projected to swell in coming years, as is Medicare spending. This new, smaller, universal entitlement should be paid from a single Medicare trust fund, and the long-term financing goal should be to cover program costs entirely from payroll-tax collections. In other words, when fully phased in, a redesign of Medicare should seek to eliminate entirely the general-fund subsidies that now dominate the program and impose an enormous financial burden on working-age Americans. Like Social Security, Medicare should provide a benefit that is self-sustaining over time with the payroll taxes dedicated to paying for it. There would be no need for two different trust funds under this kind of reform; Parts A and B could be merged together into a single Medicare trust fund. If Medicare were restructured in this way, the program would still lead to substantial redistribution of resources among Medicare participants because higher-wage workers would pay substantially more in payroll taxes than lower-wage workers for a benefit that provides the same insurance value for all enrollees. Retaining the payroll tax as the primary source of Medicare funding would also keep in place the strong political support that sustains the program today. Workers would continue to perceive that their payroll taxes were financing their benefits in retirement. In fact, under a restructured program, this prevailing perception would be more true than it is today, because there would be less general-fund subsidization of the premiums of workers who could afford to pay more of the total Medicare premium themselves out of their retirement savings. Fourth, a reformed program would offer additional financial support tied to lifetime earnings. Medicare should provide additional support to the elderly and disabled who lack the means to pay premiums on their own. This added benefit above the base level of entitlement would be calibrated to the lifetime earnings of the Medicare enrollee. Lifetime earnings is the appropriate measure because it avoids the disincentive effects and administrative complexity of measuring the actual savings and wealth of program enrollees. A means test of that nature would be intrusive and costly, and it would discourage enrollees from saving their earnings while working because of the resulting reduction in their Medicare benefits. Lifetime-earnings data are readily available from payroll-tax records and can be used to assess how much a person should have been able to set aside to pay premiums for health care in retirement, regardless of the actual state of their savings and wealth. As depicted in Figure 4 below, the enrollees in roughly the lowest quartile of lifetime earnings would be eligible for substantial additional support on a sliding scale. That support would then be phased out so that middle-class and upper-middle-class seniors would get only the universal entitlement benefit. That could be ascertained by looking at the average actuarial cost of providing such a product through the traditional, government-managed fee-for-service program as well as the privately run Medicare Advantage plans.

Chapter 3 : NPR Choice page

Rethinking acute medical care in smaller hospitals some general components of an improved model of acute medical care can still be identified from our research.

The Online Journal of Nonduality and Psychology. The mounting evidence for the abject failure of the medical model to treat psychosis is presented alongside six case studies of people who fully recovered despite psychiatric treatment and who felt more deeply in touch with hope, meaning, a sense of aliveness and the interconnectedness of life as a result of their difficult journeys. Rethinking Madness is an important and hopeful book. Current psychiatric treatment, while helpful for some, has proven inadequate for most psychotic patients. This book helps us to understand why. But beyond offering a critical appraisal of current methods, Williams also offers a powerfully hopeful vision of new possibilities for the treatment and transformation of this puzzling disorder. In Rethinking Madness, Dr. This book brings hope to many people who suffer from so-called mental illness and who struggle with the concept of illness, and opens up the dialogue in psychology beyond just the medical model. A spiritual component has seldom been used by the members of the medical establishment in treating the illness in any direct way, until now. Williams never trivializes the anguish and psychic and sometimes physical pain mentally ill people endure, he is never without hope for their relief. This book should be a part of the training of every physician, psychiatrist, and pastoral counselor, and owned by the family and friends of every mentally ill person as well as the sufferers themselves. It states boldly what many of us working in the field and following research based on lived experience have come to suspect: Backed by an extensive and engaging survey of historical and contemporary views of psychosis and its etiology, Williams presents an integrative, deep and ultimately humane body of theory and practice that will be of great use to anyone working in this intriguing and difficult area. And as the personal stories in his book reveal, for some, a bout of madness can be a transformative personal journey. Paris Williams presents a clearly written comprehensive treatise on madness. There have been a number of books published which have challenged the established verities in the social sciences It is written in easy to understand English, not postmodern jargon; it thoroughly examines and debunks the psychiatric model; and Williams is not afraid to make controversial affirmations. In order to buttress this contention, Williams gives readers a panoramic review of the existing literature and he presents six powerful case studies based on his interviews with 6 very articulate former patients who believe unequivocally that their psychotic episodes enriched their lives. There is an alternative. The Failure of Psychiatry and The Rise of the Mad Pride Movement With his new book, Rethinking Madness, Paris Williams adds significantly to the growing body of research literature that calls into stark question Western beliefs about the etiology, essential nature, and treatment of madness. Williams has a talent for synthesizing a vast array of research literature in a manner that is both elegantly written and accessible to a lay audience, and he uses those skills to deftly debunk myths about schizophrenia I highly recommend this book to all those who are touched by the psychotic experience, which really means all of us--and to find out why, just read this book! Williams explains how spiritual understandings, in the broadest sense, can help make sense of even the strangest of experiences and also help point the way toward recovery. These arguments are brought to life by moving accounts of the journeys of several people through and beyond psychosis. The case studies and the conclusions are novel and unique in their formulations. The insights and theoretical postulates derived from this research are important and likely to move the field forward in unexpected ways. For people who have experienced psychosis or altered states, it is a ray of hope in their struggle to thrive.

Chapter 4 : Rethinking Medicare | National Affairs

Rethinking the health care access model By: Dr. Ron Moody The great Canadian physician Sir William Osler, co-founder of the Johns Hopkins School of Medicine and a visionary in his field, strongly advocated providing medical care with the utmost efficiency.

Feature Radiology Business November 01, By Jeff Zagoudis Rethinking the Radiology Business Model As healthcare spending and the demand for imaging services continue to increase, radiology departments must assess the best way to maximize their investments to generate the most revenue Healthcare spending is on the rise. Further research shows that nearly half of the money 40 percent will be spent on equipment, an encompassing term that includes everything from beds to gurneys to imaging equipment. With so much money on the table, radiology departments are set up for a potential major windfall. Taking advantage of the investments, however, and capturing the largest possible portion of revenue will require strategic thinking and planning on the part of radiology administrators. An education session at the annual meeting of the Association for Medical Imaging Management AHRA in Nashville provided that group with a possible solution presented by an unlikely source â€" a pair of architects. Arch, co-founded RAD-Planning, an architecture and design firm in Kansas City that specializes in radiology, nuclear medicine and radiation therapy facilities. In the case of radiology and healthcare in general , this means maximizing the number of patients that can be seen in the course of a day. When evaluating their business model through this lens, radiology administrators must consider the pros and cons of generalized services versus specialized services. This approach is attractive because it offers benefits for both physicians and patients. For patients, who most often seek out specialized healthcare professionals when dealing with a specific medical issue, they can feel that they are being treated by an expert on that specific ailment. For physicians, specialization offers them the chance to maintain their credibility, even if they have to refer their patient to another doctor. While they may not have the skill set to treat the patient directly, they demonstrate that they still know where the patient can get the best treatment â€" knowledge that upholds their standing in the eyes of the patient. On the other end of the spectrum, radiology has traditionally taken on a more generalist role by nature, as all of its patients are referred from other physicians and departments. The skill set and expertise of general radiology covers a wide range of areas and modalities. The drawback, however, is that the skill set and expertise in any one area or modality may not be extensive. Specializing in a particular area of care can have significant impacts on the procedure and workflow of a department, the pair noted: This is not to say that specialization is the answer for all practices and departments. In the context of healthcare, specialization has two primary disadvantages: This type of setup can help patients better self-identify with what their needs are. The key, according to Junk, is identifying the areas where you specialize based on your demographics. This makes the model scalable to any size organization, and the facility appears more attuned to client expectations. Change is Coming Whether they implement this specific model or not, Junk and Gilk warned that radiology administrators will need to do something soon â€" pointing to factors such as the aging of the U. Not every hospital will be able to implement wholesale change immediately, but taking incremental steps is just as effective, they said.

Chapter 5 : Academy for the Psychoanalytic Arts | Rethinking psychoanalysis as being outside of a medica

Men's involvement in antenatal care and labour: Rethinking a medical model Author links open overlay panel Dr. Heather Draper BA, MA, PhD (Professor of Biomedical Ethics) Dr. Jonathan Ives BA, MPhil, PGCert LTHE, PhD (Lecturer in Behavioural Science).

Berend Mul This is the third post in a three-part series. The previous post of this blog series listed some of the points of critique that have been formulated by various scholars on the social model of disability. This account was by no means exhaustive, but it does serve to illustrate that in a changed intellectual context new limits of the social model have surfaced. The post concluded with a brief explanation of one alternative to the social model â€" the critical realist perspective or interactional model on disability proposed by Tom Shakespeare. Disease, Rosenberg starts out with in his article, is an elusive and complex entity. It is, quoting his words at length: In one way, obviously, disease is biological, i. Yet as the quote above makes clear, it is also a social phenomenon, and as a social phenomenon disease must be agreed upon and named through social process Rosenberg , pp. Rosenberg was not the first to recognise that disease is partly a socio-cultural phenomenon. In fact, his writing was not primarily a response to any medical model of disease, but instead was aimed at the social-constructionist approach of disease. According to Rosenberg, social-constructionist work had brought many valuable insights, but it also typically assumed a style of cultural criticism that had gone out of fashion in historiography. The social-constructionist approach overemphasised the extend of arbitrariness and the functionalist aims in the social processes of naming and agreeing on diseases. Whilst the social-constructionists are certainly right on the fact that disease is a social phenomenon and a social actor, it should be acknowledged that the social role of disease is limited by its biological character. According to Rosenberg, historians had not focussed enough on the connection between biological events, their perceptions by patients and practitioners, and collective efforts to make sense of these type of perceptions cognitively and in terms of policy. In addition to this. Finally, to say that disease is socially constructed is very close to tautology: The relationship between the medical profession and the state is an important topic in the social history of medicine. National Library of Medicine. How people make sense of disease depends on the intellectual repertoire available at the respective time and place. The biological characteristics of a disease too, shape, influence and put limits upon this social process of negotiating disease. Different diseases present different pictures to frame Rosenberg , Rosenberg and Golden p. They assume a role as social actors, becoming a factor in structuring social situations. This would require a more in-depth philosophical inquiry, which is not the purpose here nor is it within the scope of this website. This blog series should be seen as an attempt to bring both approaches from these different disciplines into one view, rather than as a systematic comparison. Generalizing, it is probably fair to say that historiography as an academic discipline is not particularly known for the extensive philosophical pondering. In that regard, the theoretical work on this philosophical underpinning of their field by Shakespeare, Williams and others in disability studies could serve as an inspiration for historians of medicine. London , although, of course, that is not to say that Framing Disease did not receive any critical reviews e. In contrast, Charles Rosenberg is considered an eminent historian within his discipline, and his work has been seminal to the history of medicine for decades Linker , pp. Of course, while the question what disability is goes directly to the heart of disability studies as a field of research, the relationship between disease and the broad discipline of medical history is not quite so close. Yet, although a direct comparison between both scholars is moot if only because of their generational difference , the immediate reception of their work is still noteworthy. Closing words Perhaps the different reactions in disability studies and the history of medicine to, respectively, the interactional model and the framing disease-approach might at least in part be explained by the different intellectual histories and academic identities of both disciplines. While the past has played a role in Western medicine in some shape virtually since its foundation in ancient Greece and Rome, the history of medicine as an independent academic discipline emerged in the first half of the twentieth century. From its inception, the discipline was closely aligned with medicine. They both approached the history of disease a crucial scientific part of medical

education, on par with subjects like pathology and anatomy Linker , pp. Indeed, their educational task lay primarily in teaching medical students â€" a task that is still a core component of the field Jones et al. In the decades after the Second World War successive generations of non-physician historians entered the field. But by and large, even these new social historians of medicine generally tried to balance social critique with academic objectivity, distancing themselves from a too overtly political or activist approach Kudlick p. As was noted, disability scholars typically hold a critical if not sometimes adversarial view of modern medicine and the medical profession. For obvious reasons, with exceptions medical history as an academic discipline maintains a different relation with medicine and the medical profession. It therefore remains to be seen if the distance between disability studies and the history of medicine can be closed see: Linker ; Kudlick makes the same point from her perspective as a disability scholar. Routledge handbook of disability studies New York, Handbook of disability studies Thousand Oaks, Bulletin of the History of Medicine Rosenberg and Janet Golden, Framing disease: Research in Social Science and Disability vol. Exploring Theories and Expanding Methodologies: Where we are and where we need to go Emerald Group Publishing Limited, Handbook of Disability Studies Thousand Oaks, In his introduction to Framing Disease Rosenberg himself does not associate his framing disease-approach to critical realism.

Chapter 6 : Reviews - Rethinking Madness

The film follows three subjects - Oryx, Jen, Dan - over nearly five years, and features interviews with notable international experts including: Robert Whitaker, Dr. Bruce Levine, Celia Brown, Will Hall, Dr. Marius Romme, and others, on the history of psychiatry and the rise of the 'medical model' of mental illness.

Chapter 7 : Rethinking the Radiology Business Model | Imaging Technology News

One of the central limitations of the bio-medical model in addressing war-affected children's distress is its little emphasis on refugees' own experiences and cultural explanations of symptoms, favouring instead a 'one size fits all' approach.