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Health Care in Challenging Times of Transition

Mari Carmen Portillo*

University of Southampton, Highfield Campus, SO17 1BJ, Southampton, United Kingdom

Health care is becoming a "rolling stone". The ongoing aging process of the society, the era of austerity, and the consequent increase of long term conditions and complex needs are making health agendas unstable and changeable to be able to deal with context and people complexities rather than with diseases [1].

Independently of the condition(s) a patient has, it is remarkable that health and social services are facing a new phenomenon of complexity for which they do not always seem prepared. Health agendas, health care professionals and also patients and families are being challenged by new imperatives globally. In this sense, patients and families are first hand witnesses of these changes and the cornerstone in the implementation in practice of these new "saving money" health care policies. More concretely, the rapid growth of long term conditions and their holistic impact are suffocating health systems especially in times of financial crisis nowadays. This is also causing a dilemma when it comes to counterbalance users' needs and health care costs [2].

Complex care plans have emerged as a response to the transition of care from acute hospitals to the community, which is paramount to promote independence and empowerment of patients and families when it comes to health promotion and symptom control. Therefore, complex care could be seen as a solution to tackle conditions that require continuous care and to bridge the gap between different health care professionals in different settings [3]. Nevertheless, more effective ways of communication between levels of care and partnerships to fill the gaps between hospitals and community services are needed. This poses a real challenge as health and social systems are quite fragmented and developing a more integrated system of support would need further assessment of contexts, risks and resources [4]. Moreover, a new concept of health team needs to exist so that patients and clients are put first and become change agents. This, although a common desire, could seem rhetoric if key health strategies and policies are not designed to reach and empower poor, vulnerable and deprived communities too.

In this regard, health inequalities and challenges within the community cannot be underestimated. Increasing pressure to achieve better patient outcomes and the shortages in the nursing workforce are a clear threat to sustainable community care, which is increasingly depending on the nursing staff, patients and their families, and the social sector [5]. However, are government agendas and education systems considering the importance of developing further posts, training and education for nurses regarding community care? Are health services prepared to promote a participatory model of care, evolving from paternalism to person centered care? Are health and non-health professionals aware of and prepared for this transition? Are nurses capable to lead this initiative? And even more importantly, are patients and families resilient enough and capable of taking over these new responsibilities?

While some answers and solutions are found for these gaps, new partnerships with the social sector could be established to strengthen an integrated care delivery. Governance and financial initiatives could be implemented based on the ideology of a parallel system. In other words, the complexity of patients and family's context and needs requires the synchronization of health care policies and services, and other alternatives agencies [5-7] Voluntary organizations and families are gaining major roles in health care delivery and a shared understanding of their experience in terms of management of resources and illness is essential for formal services moving on. A real commitment to excellence and shared decision making is the key to create a long standing health team which approaches the users' complex needs in the community, prevents complications and illness, and increases safety and autonomy for professionals and users and quality of life.

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***Corresponding author:** Dr. Mari Carmen Portillo, Faculty of Health Sciences, University of Southampton, Highfield Campus, SO17 1BJ, Southampton, United Kingdom, Tel: 0044 (0)238 059 7591; E-mail: M.C.Portillo-Vega@soton.ac.uk

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