

# From Integrated to Disembedded: Diachronic Analysis of Socio-Sanitary Integration

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**Abstract:** The increased utilization of new media technologies applied to health care and assistance (welfare, home care, psychological health) is determining the epistemological uprooting of their traditional meanings by introducing, on the contrary, a rise of applications that determines an increasingly active patient involvement in the implementation of care pathways and healing. In this sense, the patient must supervise the protocols, which characterize the hetero-direction of qualified personnel within the different social and health services in the previous era.

**Index Terms** - Disembedding, Homecare service, Integrated Home Care Service, The un-embedding

## INTRODUCTION

The increased utilization of new media technologies applied to health care and assistance (welfare, home care, psychological health) is determining the epistemological uprooting of their traditional meanings by introducing, on the contrary, a rise of applications that determines an increasingly active patient involvement in the implementation of care pathways and healing. In this sense, the patient must supervise the protocols, which characterize the hetero-direction of qualified personnel within the different social and health services in the previous era. The establishment and aggravation of tickets, difficulty in finding a bed (regardless of severity of illness), as well as the very long waiting lists for the performance of clinical and laboratory findings, are the figures of the crisis caused by the continuous spending review of the Health Department in Italy. Neither the amount of public spending (750 billion euros), nor the amount of public debt ( more than 2000 billion Euros ), or its relationship with the GDP for 2014 (132%), bode well, as well as maintain, the amount of current welfare: the reduction of the stock of public debt and tax burden (more than 45%) passes through the spending review in the "social spending."

## LITERATURE

### **Integrated Home Care Service**

The assistance share that we will analyze relates to the complexity and level of completeness: in fact, the difference between Homecare Service (hereinafter AD)<sup>1</sup>, the Domiciliary Hospitalization (hereafter OD)<sup>2</sup>, and Integrated Home Care Service (hereinafter ADI) consists precisely of finding a more evolved and complex care, which requires the coordination of different professional and well-structured skills. The ADI was defined by the WHO as "the possibility to provide at the patient's home services and instruments that contributes to maintain the highest level of well-being, health and function" and is characterized by the integration of services offered, including its multidisciplinary nature: participation and synergy of different professional profiles, related to the welfare of the user/patient (medical and paramedical personnel, social workers, psychologists, social workers, etc.).

In Italy, the AD began in 1970, with the personnel dedicated to carry out domestic activities and basic care. The early 1990s marked the increase of the senile population in Italy and the exponential growth of HIV infection. These factors "advised" home care, leading to substantial changes in response to acute illness and much more articulated needs than in the past, and thus, more structured and "integrated" performances.

In this perspective, the ADI was presented as an alternative to inappropriate hospitalization, and although untimely, may be preferred for the economic benefits it might offer.

<sup>1</sup> The Italian National Health Service guarantees assistance paths at their own residence or so-called "home care" to those who are not self-sufficient and are in weak conditions, with pathologies in progress or as result of them..

<sup>2</sup> The home hospitalization is a type of assistance that consents to guarantee the patient with all the health service normally provided in the hospital.

Ultimately, the diachronic analysis on home services in our Country can be fully carried out with the tripartite proposal from Gori and Casanova (2009):

- I. Pioneering phase - 1970s, 1980s - especially under the local aegis;
- II. **Consolidation phase** - 1990s - about 2% of the elderly enjoy AD;
- III. **Development stage** - 2000/2010 - about 5% of the elderly benefit from ADI.

*To which we believe it should be proposed a further phase, by reason of the changes to which we are seeing, in light of the changes to which the society is continually subjected in its entirety:*

- IV. **Unbundling phase** - current years - which does not want to be juxtaposed to the integrated home care, rather than stating its different characteristics.

From the point of view of those governing the endogenous and exogenous dynamics, which this integrated system has to face, for some time now, we have been witnessing in our country (and particularly in South Italy) the perpetuation of a paradoxical situation: on one hand, the increase of social demand for health services, and on the other hand, a fragmentation of the same, due to a deep and ongoing economic crisis.

Moreover, in the outlined scenario, the "simple" integrated system, whose epistemological roots are found in the multi-dimensionality of the Parsons (1995) AGIL scheme, related to the components of the "politics" of the "public," the "private," and the "private-social" sector, and is no longer in condition to guarantee the same welfare that has historically characterized the appearance of the *welfare state* and its evolution in the *welfare mix*<sup>3</sup>: the care for health is one of the duties assigned to the society, while to the structures remains a definitely residual role (Parsons, 1995).

### **The un-embedding**

The configuration of the era that best represents the current social peculiarities is the "late modernity," which Giddens (1990), mainly inspired by Beck (2008) and Bauman (2000), aims to highlight the radicalization of the modernity crisis. The changes that have occurred during the last decades, in fact, do not represent the passing of an era toward this next, but a radicalization of the main features of modernity: "we're not out of the modernity yet, but we have to look again to his nature because, instead of going toward a post-modern era, we are entering an era in which the consequences of modernity are becoming more radical and universal" (Giddens, 1990, p.16).

One of these consequences, perhaps the most important, is the un-embedding from the time and space. Modernity has produced an eradication of the social reality of time and space, which was developed traditionally. However, studies on the socio-economic impact of telemedicine remain superficial and not very numerous. According to Pushkin and Sanders (1995), this lack of studies is attributable to three factors: problems in technological infrastructure, telecommunication, and infrastructure organization. The divergence with respect to crucial issues has produced conflicting tendencies: Eco (2001) represents these alliances between "apocalyptic" and "integrated," identifying the median solution as solver of the controversy: the intellectual position. The relationship with the new technologies produces four categories, according to Minnini (2002), in which place individuals based on the use of new media: 1) *Techno-utopic*, who see new media as a tool of liberation and growth, in opposition to or in passing of the real communities; 2) *Techno-anti-topic*, who see new media as a tool of oppression and control, which is considered necessary for their control and their regulation; 3) *Techno-utilitarian*, which considers the new media instrumental to reach better or before a certain goal; *Techno-pluralist*, which seeks to enforce the moral autonomy and psychosocial experience of the new medium, but in the awareness that new media do not replace the experience of the face-to-face relationship, but are placed as a new space of exploration and relation. Thus, it is possible that while recognizing the magnitude, convenience, and results, we investigate on the effects of medium- to long-range clarification of an original type of interaction in the field of social and health care, based on the distance of the dyad doctor/patient - aka the proximity at distance (Severino, 2013)? And what will it be of the placebo (and nocebo) effect? Can we still benefit from its usefulness ?

### **The home care disaggregated**

The tele-medicine, in this sense, may be an integral part of the redesign of the organizational structure and service network in the country (Italy), whose original motivation certainly does not reside in the interest of replacing an established practice entrusted to the presence, but by the purely economic objective to obsessively track moderation, even if legitimate and justified. A typical example of the application of ICT is the field of tele-medicine, which allows us to offer counseling and medical treatment to patients, regardless of their physical location. This practice is particularly useful when you need to provide sophisticated medical care via satellite to patients located in remote rural areas or in areas affected by natural disasters. Thus, epiphanies heuristics services, in addition to the "simple" drop in the volume of care, are asserted in response to the chronic shortage of *welfare*.

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<sup>3</sup> It is an idea of Welfare Stare plurality in a restrictive way as a simple reference to the augmented variety of subjects involved in providing social services.

Distinguished by a *performance* of interventions and services offered to users at their residences, in view of the contemporary technological configuration, we become witness to the specular consonance between what happens in the late-modernity (disaggregation) and what is being structured within the basic level of health and social care, with particular relevance in the definition of the modality of care supply which supports innovative forms of home care. Some examples: tele-nursing, tele-medicine, tele-cardiology, tele-aid, virtual admit, tele-psychology, tele-social comfort, tele-electroencephalography, tele-dialysis, tele- ambulance governing, tele-diabetes, tele-radiology, tele-dermatology, and tele-perinatal monitoring. The significant aspects of psychological and sociological matrix, as well as the disaggregated form of assistance, meet the economic policies of practicing restraint, and do not longer support the formula *here and now* of performance – either institutionalized or at home - typical of face-to-face interaction, but rather focusing on the disaggregated type: clarify the social welfare and health services professional relationships, from local contexts and traditional aid relationship and their reorganization through procedures, therapies and protocols structured on indefinite arcs of space-time. *Therefore, the eradication manifested also in the social and health care integration creates a new kind of community and professional relatedness, separated from the site and the interpersonal presence: the disaggregated care, who, suffering from "sociological imagination" (Mills, 1959), we considered in identifying in the ADD.* Finally, it is important to keep in mind that the technology should be to be adapted to different user needs and not vice-versa. If the focus is on the assessment of technological processes, rather than on the eventual user's ability to use it, then the sin of incommunicability of the science which studies, paradoxically, the human-machine interaction, or better yet the degree of usability, is committed. The usability problem arises when the model of the designer (or the ideas of these with respect to the operation of the product, which transfers on *design*) does not coincide with the pattern of the end-user (the idea that the user conceives of the product and its operation). The degree of usability rises proportionally to the rapprochement of the two models (model designer and user model), which further depends on its degree of *affordance* (Gibson, 1979). "Tele-" is a prefix which is the first element of several scientific terms and means "distance" that hardly can refer to the meanings and feelings of inclusion. A group appointed by the EU developed the first definition of tele-health: *integration, monitoring, management and education of patients and health care personnel through systems that allow ready access to expert advice and information concerning the patient, regardless of where they physically reside.* The debate revolves around a barycenter question about the relevance of remote assistance; in other words, if the remote assistance provided through a telematics platform can really be considered as one that is present. We are convinced that there are no legal defects on the exercise of distance assistance, especially on the technical-professional aspect, as, indeed, we are aware of some research findings that demonstrate not only the efficiency of the procedure but also the effectiveness of the therapeutic method. However, scientific research requires repeated and rigorous validations. The reference is to the methods of sampling, the survey methodology, the various "conditioning effects," as well as the interpretation of the results, which should be devoid of the so-called self-fulfilling prophecy (Merton, 1948).

Each new medium produces the resistances that have, as a consequence, an imbalance, which in the case of ADD is linked to the possibility of access to technology: a division normally called *digital divide* (Warschauer, 2003, p. 1).

METODOLOGY

**The pilot-research methodology**

The pilot-research moves in analyzing the ADI and the ADD, in a town in the Sicilian hinterland (region of South Italy), with the aim of examining the dimension of the offer to the assisted and the innovative practices used to cope with new problems of home care. The methodology is qualitative: it avails oneself by the construction of a research *setting* based on a small "non-probabilistic" collective (Corbetta, 1999) of the chosen type (De Rose, 2003), characterized by individual cases emerged from six (3 +3) semi-structured interviews. Below (Table 1), we propose a scheme of the research participants:

*Table 1. Research participants broken down by type of home care received.*

Type of home care	ADI	ADD
Assisted	3	3
	Angela (76 years)	Carmelo (76 years)
	Girolamo (83 years)	Ada (70 years)
	Anna (79 years)	Antonietta (72 years)

The will to analyze the AD aspects, focusing either on the quality and the service supplied, has preferred an *insider* role, in order to conduct a thorough participatory analysis, even considering the possible degree of responsiveness due to the duration of the observation and our physical presence in the state of care needs of the user. Our participation allowed us to learn "to see something as something" (Wittgenstein, 1953, trans. It. 1967, p. 225) that, otherwise said, has allowed a partial form of socialization with the user and further attention to the study of the cases, so as to bring our body into play as an instrument of observation (Goffman, 1989, 2006,

p.109), while getting used to the contingencies we have observed. Therefore, it resulted in a "dialectical" relationship (Kemmis 1980) between observer and observed, such that the conceptual schemes of the first should have remained flexible and open in order to allow the researcher to reduce the complexity of the observed reality.

### Participant observation

The establishment of a relationship of trust with patients allowed, in the first phase of the "participant observation," to identify their specific approach to technology, based on a series of test questions regarding their relationship with technology, with the equipment and science in general, identifying (as shown in Table 2) their possible membership in the "Minnini classification" (2002). The newness of the ADD is considered by users to be both an advantage and a disadvantage: some of them deal with the news as a benevolent "relief," as the mode involves a correspondence - even if technological - that intrigues, being suited to the task of assistance provided.

*"I can keep quiet even if no one comes to see me...." (Antonietta, 72anni, ADD).*

From the observations emerge, however, other users' concerns that are related to the proper functioning of the equipment made available to the ADD:

*"I feel worried... if it does not work ?" (Ada, 70, ADD).*

In addition, receiving a daily operator's phone call does not allow them to be quiet about the dangers of their health risk, but considers it to be, at best, an opportunity to

*"tell a little of the lonely" (Ada, 70, ADD).*

In addition to the above, we must add the total disbelief, shown a few times, in considering the electronic methods that are scarcely efficient, as they do not guarantee a timely control of the situation of danger to the user or of additional remote services:

*"The science goes on, but I do not understand some things... how does a relative of mine to be alerted timely if I am sick?" (Girolamo, 83, ADI).*

*"they should consider when we are sick and when we need only company" (Angela, 76, ADI)*

Many of them live in the condition of assistance as though it were a *status* of absolute dependence, thus, in assessing the objective of the assistance, they believe that:

*"Home care is a cure for our sick condition (...) In fact, if we did not have it, our health would be much more precarious, better keep my ailments under control..." (Girolamo, 83, ADI).*

*"Nurses come at home without me going out, it is a situation that I like because I do not always have the strength to do it and I feel well assisted" (Angela, 76, ADI).*

*"My conditions, since I am old, do not improve, but at least I have the satisfaction that someone takes care of my health.." (Carmelo, 76, ADI).*

Therefore, an awareness by the users emerges, as the possibility to use assistance with special medical care directly at their own domiciles is seen to be greatly beneficial. Regarding the ADI, many users consider it to be more effective, because it is dispensing "live" for a specific user's necessity. The fact that professionals are personally met allows them to create a family relationship that borders with benevolence and allows to bridge social gaps and family.

*".. If it were not for the nurse to remember my duty.... How many times I would forget the pill" (Girolamo, 83, ADI).*

*"... These operators are like family now... we walked into the confidence... I also prepare the coffee for them!..." (Angela, 76, ADI).*

*"... Having a presence home it is a comfort for me..." (Anna, 79, ADI).*

The ADD raises curiosity among some interviewed, on both methods of completing the steps (use of equipment, technical assistance, etc.), both of uncertainty mixed with the discomfort, of not fully understanding the electronic novelties of which this formula consists of. In fact, they consider "being searched" as an important trait, while not accepting the presence of an operator:

*".. I am glad that every morning the phone rings to know about my conditions... it's beautiful!" (Carmelo, 76, ADD);*

*"... At least, I do a nice chat with the operator, so I spend the day!..." (Ada, 70, ADD).*

There remain, however, serious questions about the definition of safety and relief, which may be received from specific treatments, as well as from human contact; something that ADD can provide. In fact, the ADD interviewed responds not to have knowledge of the operators who provide the assistance service at distance, but that their job is related.

*"at the company on the phone in case of need" (Ada, 70, ADD).*

## RESULTS

The result of these observations has allowed us to consider how their positions could be defined conversely, according to the classification previously established, which allowed placing users depending on the use and consideration of the technology in the home environment. In this regard, it has become important to determine a clear categorization:

Table 2. Categorization based on the users' media utilization (Minnini, 2002).

	ADI	ADD	Classification
Ada (70 years)		✓	Techno-utopic
Carmelo (76 years)		✓	
Angela (76 years)	✓		Techno-anti-topic
Girolamo (83 years)	✓		Techno-utilitarian
Anna (79 years)	✓		
Antonietta (72 years)		✓	Techno-pluralist

What emerges is the conditioned confidence of ADD users in technology as flexible for times and modes, in the life of the individual, considering the improvement in quality and independency using satisfaction objectives as to that carried out in their presence. On the contrary, the ADI users show a general distrust toward the technological approach, putting them in a dystopian perspective, or averse to anything that is not implemented in the concrete and limiting the use to the usefulness restricted by circumstances. What emerges from the consideration of the comparison between ADI and ADD is a close correlation between the age of the users (slightly younger than the ADD) and the diversity of assistance provided to them. In fact, the assisted ADD has greater physical and personal autonomy, which allows him to make himself still sufficiently free to move, whereas for the ADI, assistance is no longer possible because they need continuous support in presence. In this regard, the diversity of their condition affects the relationship with the use of technology applied to everyday life, considering it in the first, emancipatory, while in the latter as oppressive and worthy of a limitation in use.

## CONCLUSION

The two modes of home care, while valid in their application and prosaic, are in need of an appropriate distinction, which allows to investigate and track down those "characters of effectiveness, efficiency and equity" (Donati, 2003, p.281) that can really differentiate each other and allow us to trace the ability to meet the minimum and absolute requirements of health protection, without forgetting to connect in a meaningful way the health needs and the size of the family and personal life. In fact, a serious disregard of all these prerogatives could fall into the risk of administering a service only when necessary, by losing sight of important considerations such as the relief to the patient, even in cases of extreme need. The technology, therefore, should be reconsidered in light of human needs, and the needs of users can be more quickly filled by a better integration between presence and distance.

What will be verified in the future is not only the manner in which the care and assistance will be provided, but also the quality of human relationships addicted to these, in order to verify and supplement the traditional "hospital practice", remote ways of support and assistance, providing a relational reconnection and a concrete combination of the different formulas, whose association could lead to satisfaction levels that are useful and necessary for the well-being of the user. It is believed that there may be much enlarged boundaries in the detection of diseases to which the placebo could find application and benefit with respect to an improvement of the health status of a patient, if not its complete healing, and these are related to mental, psychosomatic, and somatic diseases. The relevance of the effects of proxemics interdependence and in coexistence with the help relationship (doctor-patient) is enhanced further by the demonstration of a direct inverse effect (of opposite direction and reverse), when we were in the presence of an attitude and anxiety-inducing behavior (Ficarra et al., 2013) of the doctor (or perceived as such by the patient) or by the development of the same relationship set incorrectly: the nocebo effect.

However, the quota component of the placebo (and nocebo) in therapy may vanish in the absence of the deep structure of the interaction (in the ADD). Furthermore, "the most important role of the Internet in the structuring of social relations is its contribution to the new model of sociability based on individualism [...]. Thus, it is not Internet to create a model of individualism in the network, but its development that provides a material support suitable to spread the individualism in the network as the dominant form of sociability" (Castells, 2001, p. 129).

Thus, it is not so much the use of Internet potential, or much less the information technology that determines what we called ADD, as the use and abuse of the applicability of the network potential, in the absence of the deteriorating effects that any excessiveness determines. At un-embedding, which may be opposed to re-embedding, reconstruction of social and cultural ties and a re-connection of the actions to its traditional contexts of interaction and their time/space recombination, in order to re-establish a sense of continuity and order in the events, including the so-called ADD, occur. If this has happened, happens, or will happen, then we could say that the

goal set by the National Health Plans has been, is, or will be reached: *to treat at home means a substantial change of perspective*. It is to pass from the patient that revolves around the structures and supplying systems, the structures, to the systems and professions that take as center of gravity the person with its specific, unique and unrepeatable individual needs.

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