

## Keeping the faith in integration and primary care

The integration of care is a policy objective that unites most health care systems. It is universal in that it transcends differing system architectures that exist globally, such as those based on state funding and delivery, social-insurance-based systems or private-sector-led health care markets. Put another way, few if any health care systems claim to offer care that is sufficiently “joined up” and designed around the needs of patients and population. This is even the case for systems with developed and comprehensive primary health care—a sector that evidence tells us should support care integration. For example, Harvey *et al.* within this edition highlight that older people and their carers continue to experience difficult transitions between secondary and primary health care services. Such challenges remain despite significant research highlighting the frustration and anxiety related to such transitions (see e.g. Ellins *et al.*, 2012).

A brief review of the literature reveals numerous studies and systematic reviews that suggest that integrated care can often (though not always) deliver higher quality patient experience, better clinical outcomes and (sometimes) lower health care costs. Indeed, in this edition of the journal we present further examples of the potential for primary care led initiatives to deliver benefits. These papers fall into two broad types. First, are specific initiatives aimed at changing a model of care for specific patient cohorts, such as joint GP-specialist case conferencing for Type 2 diabetes in Australia (Meyerowitz-Katz *et al.*) and nurse interventions to support isolated elders in South East England (Longstaff *et al.*). Second, are broader attempts to construct models of inter-professional working based on defined communities such as the Primary Care Home in England (Lewis and Chana), the Health Care Home in New Zealand (Cumming *et al.*), community-governed primary care organisations in Ontario, Canada (Rayner *et al.*) and systemic attempts to deliver population health globally (Miller *et al.*).

Given the broad consensus around the aims and a body of evidence in support, it might be considered curious that the widespread adoption of integrated care has not already occurred and that the exhortations to deliver more integrated care continue. Diagnoses of the obstacles to care integration in practice are well established—financial incentive systems that reward “disintegrated care”, a political (and therefore resourcing) focus on hospitals as the symbols of health system virility, a lack of inter-professional training, shared information technology and so on. Less attention has been given to how whole health care systems reorient themselves from one dominant mode of working to another: we know very little about what is needed for those charged with the planning and delivery of care to make this shift.

The answer to this question is, of course, complex and multifactorial. Some elements (as we suggest above) have been comprehensively considered. However, there are others that we feel worthy of more attention. In particular, four factors stand out as important in supporting health care systems to make this reorientation:

- (1) A clear conceptualisation of the elements of an integrated care system (rather than taxonomies of integration types, which abound). In particular, how might an enhanced primary health care sector act as a component of such a system; currently primary health care development and care integration are often conflated.
- (2) An improvement and transformation process and resources that is truly multi-sectoral. Currently, it is often the case that the transformation skills and resources are predominantly located within hospital organisations (and less concentrated in primary health care).



- (3) An approach to evaluation that supports whole system change. The literature is strong in terms of the effectiveness of specific interventions in different care contexts and has many examples of evaluations focussing on how to successfully bring about change. However, the literature offers far less in terms of how interventions in combination or broader system-wide changes might affect patient experience, clinical effectiveness and cost. It is this perspective that is most needed by those planning transformative change.
- (4) A political or purchasing entity responsible for governing and funding of primary health care with the strength of character to allow the new approach to have sufficient time to be sufficiently implemented that its value can be properly assessed.

### Sharing the concept

Most people recognise the term “primary health care” in association with community (i.e. not hospital) based care. Beyond this affiliation with health, and being outside hospital, there is little consensus. Generalist medical practitioners will usually be central, and often accompanied by nurses and receptionists to configure a general practice. Dependant on the system, this is where many will draw the boundary around primary care. Pharmacy, dentistry, physiotherapy, counselling and community nursing are other health care professions are also commonly included, dependant on the individual and the health system with which they are familiar. Beyond which professionals are included in any conceptualisation of primary care, there is considerable diversity in how their work is organised and governed. Whilst this may seem of only academic concern, it does profoundly affect the way in which patients can access such services. A capitation-based model with no patient fees is a quite different arrangement to fee-for-service with patient charge. These characteristics also have a strong influence on what outcomes or activities the professionals will be rewarded for undertaking or achieving.

There already exists then a lack of clarity about what we mean by primary care. This is only going to intensify as we move into the enhanced models currently under development—health care homes, primary care homes and multi-speciality community provider labels will provide further opaqueness in an already muddled lexicon. The commitment within many of these models to expand or at least connect primary health care services into a wider set of community resources will add further confusion. Where for example, are the traditional boundaries between primary and social care, or between clinical care delivered by formal health bureaucracies and support provided by volunteer-led charities? In many ways, this loss of boundaries is to be welcomed if it is associated with a loss of barriers and a more seamless experience for patients (or should that be service users, customers, clients or people) and their families. If, however, it leads to a lack of certainty about who is responsible for what, and how these models can be best nourished, then it will detract rather than add to the vision of a more holistic model.

Language also has significance beyond the purely descriptive. How we describe something also reveals, and indeed influences, our perceptions. If we start to denote services such as befriending, exercise, education and personal support as primary health care services that can be prescribed, we are identifying these as belonging to the health sector. This is important as it could potentially disenfranchise those organisations best placed to deliver such services. It could also change how people relate to these interventions—for some the endorsement of their doctor will encourage them to consider something new but others may see community organisations as no longer independent. Furthermore, a more pessimistic perspective could be that extending the remit of primary care will extend the power of general practitioners. Such is the centrality of this profession within the functioning of primary care that they are the dominant force with whom even governments meddle with cautiously. This means that they

are often the instigators or the terminators of health care reform. For these new models to work, we do need doctors to be active participants but we also need a sharing of power so that communities and other professionals are able to also make a valued contribution. The language needs to reflect this position.

### **Making the change**

Many initiatives now take a quality improvement approach, emphasising the improvement in quality of care and benefits for patients that might be gained from reform. This approach is a key means of garnering the support of doctors (in particular) for change. It also often now embodies a range of principles and processes drawn from various change management theories and practices. The key factors required for successful change are increasingly well specified—a clear rationale (or impending crisis) requiring change; strong central and distributed leadership; attention to project management; good resourcing including ensuring those affected have time to learn, implement and adapt to change; ensuring new roles are not simply added to existing heavy workloads; and providing evidence along the way to demonstrate the effects of change, in relation to staff work, workloads, experience and satisfaction; clinical outcomes; patient experiences and outcomes; and health system effects (such as reductions in hospitalisations and use of emergency department services, and cost-effectiveness). There can, however, be tensions between the “ra-ra” approach needed to bring about support and change, and the reality that change can take time and that not all initiatives will be successful all of the time.

It is clear that in most health systems there is an imbalance in resources between hospital and primary care sectors, and between health and social care sectors. This pertains not just to service delivery but to organisational capacity and the infrastructure needed to create change. Moreover, primary care is a sector often dominated by relatively small, independent organisations that simply do not have the capacity to transform themselves, let alone take responsibility for wholesale system change. Similarly, much of social care is provided by community and voluntary organisations rather than the huge public institutions that often deliver acute services. Typically, too, it is hospitals that get new government infrastructure spending, with the primary and community care sectors having to rely on their own, limited resources for new investment.

It is tempting in this context to therefore see hospitals as the natural leaders of change. And with hospitals in many systems struggling to cope with the demands of ageing populations, perhaps now is the time when investment in “upstream” services might get universal approval. Yet this risks disabling rather than empowering primary care. Instead, a system-wide transformation capability and capacity is required, along with a strengthening of primary care organisations so that they may take a seat at the table. It is this principle that underpins approaches such as the primary care home that are explored in this edition of the journal.

### **Evaluating for improvement**

The challenges our health systems face are great and we face ever rising expenditure on health care and continued poor outcomes—especially for some populations—if we do not try to deliver a better mix of more integrated services. Yet not all key initiatives are evaluated, or they are not evaluated well, and too many evaluations are inadequately funded over too short a time period to tell us if our approaches to change and our new models of care are making the differences we want to see them make. Scarce research and evaluation funding and expertise is being wasted on too many small-scale and very time-limited pieces of work.

This approach has two obvious disadvantages. First these very specific evaluations often look at interventions in isolation and not in the context of any broader environmental factors (such as changes to financial incentives or local accountability). It is therefore

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difficult to understand how their impact may change if a particular intervention was introduced as part of a wider range of service reform (e.g. as part of a sustained effort to improve proactive community-based care). Second, the requirements of research funders often mean that study periods are relatively short before conclusions are reached. This can mean that results are judged at precisely the time when “implementation pains” are most acute. Rarely are interventions revisited to see if, in maturity, results have changed.

So those seeking to reform care have to rely on an imperfect literature that provides little of the guidance that they seek: what combinations of interventions might together change existing patterns of care; and what supportive environment is needed so that these interventions might succeed in the medium and long term?

Too many systematic reviews, for example, rule out too many papers on the grounds of poor quality research for us to be confident that our evaluation resources are being used well. This is not to say that the only approach is to use randomised controlled trials; on the contrary, these are expensive and focus on too high a degree of consistency in service delivery to always be useful for health services research, especially when we know that we need a degree of tailoring in our service delivery if we are to have health professionals engage with change and to have services meet local needs. But we do need more studies that match patients and study change before and after changes have been made; with the changes settled in. Therein lies a problem: how do we get changes introduced and settled in if we do not have the evidence to back them? Perhaps we need an approach with more rapid evaluations of many initiatives and more in-depth support for those that show initial promise.

### **Keeping the faith**

The models and improvements described in this edition are the latest in a long tradition of trying to improve and extend primary care. National or regional governments (depending on the system concerned) have often driven the more radical changes in particular. It is hard not to conclude though that governments are frequently better at suggesting new reforms than they are at implementing them. In particular, they appear to suffer from acute impatience that means that initiatives do not have time to embed so that their worth can be understood (see e.g. Ling *et al.*, 2012). England is a good (or should that be bad) exemplar. Primary care reforms in recent times include practice based commissioning, primary care groups/organisations/trusts and clinical commissioning groups (with the latter widely rumoured to be on the way out later this year). Care trusts were once promoted as the expected vehicle for health and social care integration but were scrapped to ensure purity in the purchaser-provider relationship (Miller *et al.*, 2011). This division is now being blurred through the introduction of sustainability and transformation plans and integrated care systems. This eagerness to reform also means that the results of evaluations are often not known before a policy is scrapped or extended (for example, the total purchasing pilots, integrated care pilots, integrated care and support pioneers). Australia is another serial reformer with recent vehicles including divisions of general practice, super clinics, medicare locals, and primary health networks. On the other hand, the community health centres in Ontario are an example of a model that has been allowed to develop over time. Whilst each centre has some uniqueness due to its connection with its population the model has evolved into a series of principles which are reflected by all. Another with a more stable approach was New Zealand, in which primary health organisations and district health boards have been in operation since 2001/2002. This stability may have been one factor that is enabling the local development of a health care home model of care that is currently slowly advancing across the general practice landscape. Interestingly, however, as this editorial goes to print, the New Zealand government has announced an 18-month review of the health system—seeking to identify what structures might support an increasing emphasis in particular on primary health care.

It is always easy to criticise governments. Whilst this is a legitimate and necessary activity, it must be balanced by an awareness of the complex and uncertain task faced in improving a population's health and well-being within available resources. Furthermore, politicians respond to the often impatient and unforgiving nature of the populace. Differences between national psyches and the democratic relationship will contribute to the patience that governments demonstrate. Put bluntly, if we are quick to believe the spin of opposition parties, then we can expect knee-jerk reactions. But politicians must also take some of the blame, as they find it easy to be as unforgiving in opposition as they were seeking of forgiveness when in government. The opportunity to damage their rivals generally outweighs the benefits for all of cross-party consensus for sustained effort on health reform. Beyond a change in political behaviour (which seems unlikely in the foreseeable future), there are other improvements to be made. More realistic aspirations in terms of scale and timing of impacts would be one, along with an honest appraisal of implementation and its connected challenges. Robust, independent and longer-term evaluation is a must, with a willingness to publish results and learning (however bad). More deliberative styles of government may also help, as this will provide legitimacy outside of elections and sophistication in understanding.

### Conclusion

There are many challenges that will hinder health care systems achieving a transformed primary care system which successfully integrates care around individuals, families and communities and which provides an informed context for improvement and innovation. Our experiences of past reforms mean that we can identify what these challenges will be, and more importantly, the ways in which they can be overcome. Doing so will require co-ordinated and collegiate action between politicians, managers, professions and communities. It will require a ceding of influence, resources and traditional certainties and perhaps this is the real challenge—how much do we want integration and are we willing to give up to ensure that it becomes a reality?

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