



AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

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APHCRI LINKAGE & EXCHANGE TRAVELLING FELLOWSHIP REPORT

Stream Four Report: Co-ordination of care within primary health care & with other sectors: a systematic review

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A COMPARISON OF THE RESULTS FROM THE STREAM FOUR PROJECT SET WITHIN THE INTERNATIONAL CONTEXT

The Stream Four review identified the strategies used to co-ordinate care at patient and provider level, and assessed their effectiveness. Two main types of strategy were found: those relating to communication and individual support for service providers and patients, and those which involved providing systematic support for co-ordinating care. The former were more closely associated with improved patient satisfaction, the latter with improved health outcomes. The report identified opportunities for strengthening support for care co-ordination within the Australian health care system.

Health care in the Netherlands has many similarities to Australia: it serves a similar size population (16.5m in 2006), involves similar levels of expenditure (9.2% of GDP in 2005, compared to 9.5%), has a strong primary health care sector, based largely on private general practice, with other providers operating from a wide range of different provider organisations, mostly of which are private not-for-profit organisations. Unlike Australia, patients register with a particular general practitioner, who is paid a small capitation fee and then by fee-for-service. General Practitioners act as gatekeepers to hospitals and specialist services, and provide medical care in nursing homes. Population satisfaction with core aspects of primary health care is generally higher than in Australia (Schoen 2007).

The Netherlands has a system that is funded through health insurance rather than direct Government funding. Health insurance has long been virtually universal and closely regulated. It has supported relatively equitable access to services, and this is underpinned by the strong value placed on social solidarity and mutual responsibility.

However, the lack of direct Government funding leaves the Government with a smaller direct role in health services than in Australia, although it is involved in monitoring and accrediting hospitals¹⁵.

However, major changes were introduced into the health insurance system in 2006 (Netherlands Ministry of Health Welfare and Sport 2005). These establish diagnosis and treatment related groups (DBC's) as the basis for funding and allow insurance companies to compete on price, and to choose which health services they will cover with their insurance rather than cover all providers. At the same time, competition law forbids collusion between insurance companies or between service providers. This introduces a strong element of competition that was previously absent.

Proponents of the new arrangements hope that it will lead to increased efficiency and encourage better quality care as insurers set the terms for covering services from particular providers. They note the tentative emergence of 'chain DBC's' which cover comprehensive care for complex conditions from a number of different providers. Detractors believe that the restrictions on collusion will undermine collaboration and lead to greater fragmentation, reducing the quality of care as insurers compete for business on price rather than quality of care. They see the reforms as a shift towards a more market driven health system dominated by for profit rather than not for profit organisations. It is too early to tell the impact of these changes on the health system, but there were many signs of service providers and provider organisations preparing themselves for a more organised approach to service provision.

Co-ordination of care has long been seen as a problem in the Netherlands (Smeenk, de Witte et al. 2000). As in Australia, but unlike the United Kingdom, there is no single authority with responsibility for co-ordinating primary health care services, either locally or nationally. One response to the problem of fragmentation has been the development of programs of transmural care. Transmural care is comparable to shared care in Australia, brings together providers who agree to co-ordinate elements of care within a framework of shared procedures and standards. This has been supported by the development of an extensive range of standards for care, many focusing on the roles of different providers. Transmural programs have arisen from a variety of sources, some in primary care, some hospital and some supported from universities or other external organisations. In some cities service providers have pooled funds to set up organisations to establish transmural care programs: for example the Foundation for Transmural Care in The Hague.

More recently, the language of 'integrated care' and 'chain care' has been adopted. Although usage varies, 'integrated care' suggests stronger integration and more complete care than 'transmural care': for example, there are proposals for developing integrated child health services in Amsterdam. However, much of the activity relating to developing 'integrated care' seems to be concerned with specifying the details of the care that is required rather than with developing the organisational infrastructure that allows the care to be provided across organisational boundaries¹⁶. The terminology of 'chain care' has been adopted widely in Europe, and is used more generally to describe approaches to linking elements of care across providers. In the Netherlands it appears that this will become the language for care coordination for the purposes of health insurance, through the 'chain DBC's' (diagnosis and treatment groups).

¹⁵ Indicators are currently being developed for co-ordinated care. These include the existence of agreed guidelines, written responsibilities, a single point for patient follow up and a single complaint authority.

¹⁶ This may in part reflect the very limited role of the government in health service provision. Funding for service providers comes largely through health insurance companies that, until recently, have had little incentive to influence the organisation of service delivery, and are provided in fragmented, largely private and not-for-profit sectors where there is little capacity for co-ordinated development.

Care co-ordination is supported in a number of ways.

In many places there are regional associations of health care providers who meet to support service development and co-ordination at local level. These are voluntary, usually without an external mandate, and so tend to operate rather like inter-agency groups in Australia. Their reach and impact varies, but some have long histories.

As noted, in some places service providers have pooled funding to establish organisations that will promote transmural or chain care across their organisations. This can include both vertical integration (between primary health care and hospitals) and horizontal integration (within primary health care). The Foundation for Transmural Care in The Hague had a staff of five, and programs in diabetes, dementia, bed sores and palliative care.

There are professional organisations devoted to promoting more integrated care: for example Sensor¹⁷. These tend to work through professional education and consultancy, and through seminars such as one on competition and cooperation that I attended in Utrecht.

Some 'integrated care' organisations have been set up that bring a range of health services into a single organisation. Two that I visited as part of the European Health Leaders' network were Almire, which brings together aged care, community health and general practice services, and Rivas, which includes hospital, aged care, community health and home care but not general practice. Both organisations had extensive systems for co-ordinating care and arrangements for comprehensive service development. These are private not-for-profit organisations which have identified an opportunity and developed a network of services that suits their local opportunities¹⁸. There is currently a move in Amsterdam to create integrated care organisations to provide health care for young people from six months to 16 years¹⁹. However, current competition policy would probably make it impossible now to set up integrated care groups like Rivas.

Some entrepreneurial clinicians are setting up more integrated approaches to care, taking advantage of opportunities arising from the new health insurance arrangements. I met a GP who had left 26 years of solo practice to form a group practice, with nursing and allied health staff, and a residential aged care medical specialist²⁰ who had formed a consortium to provide integrated health care under contract to residential aged care facilities.

The Institute for Health Care Improvement is developing guidelines for integrated or chain care

As noted above, some insurance companies are starting to contract with service providers for 'integrated care', particularly for people with chronic disease. It is too early to tell how service providers will respond in the relatively unstructured environment of health care, and in the face of strong competition laws²¹.

Some developments in integrated care have been funded as trials: for example the health research and development funding organisation Zon MW has funded trials of diabetes care and integrated chronic disease management.

¹⁷ www.integratedcare.nl

¹⁸ However I was told that current competition policy would preclude setting up such organisations now.

¹⁹ Interestingly, there appeared to have been little thought about the dis-integrating effect of such organisations as they take young people's health care out of the context of family health care through general practice.

²⁰ Medical care in residential aged care is a recognised specialty in the Netherlands

²¹ One prediction was that many services would amalgamate to permit coordination within a larger organisation, which is permitted by law.

There has been sustained support for integrated care from academic quarters, through champions such as Professor Guus Schrijvers and the Integrated Care Network²².

LESSONS FROM THE VISIT

I drew a number of lessons from the visit relating to integration and care co-ordination in Australia.

The visit reinforced the view that 'all integration is local': that is, to deliver better co-ordination of care, integration needs to work at the practitioner/patient and service organisation levels. Here local history and context are important, and external solutions need to be adapted to local circumstances. This was born out by the very different approaches to service integration between the two integrated care organisations that I visited, each with its own strengths. It means that system reform alone is unlikely to achieve good care co-ordination, although it will provide the framework for developments at the patient/provider and organisational levels.

The fact that similar problems of service integration and care co-ordination arise in such a different system reinforces the view that these reflect problems inherent in providing consistent care over time within complex and specialised health services. This suggests that on-going and significant investment is likely to be required to achieve good care co-ordination in the face of such difficulties, either at the patient level (through care co-ordination) or service level (through service development) or system level (through infrastructure development).

The Dutch experience highlights two issues which are also significant in Australia. One is the lack of infrastructure to support sharing of care – for example, shared health records, consistent assessments or standard referral forms. In both countries these limit opportunities for sharing care across providers and increase the cost and difficulty of doing so. The second is that there are frequently no clear lines of authority and responsibility for developing more co-ordinated systems of care and improving care co-ordination, particularly across different services and sectors. This has become evident in the Netherlands as services struggle to assemble groups that can develop programs of care that will meet the increasing demand for integrated care. Progress in these two areas would support the development of care co-ordination and co-ordinated service development.

The changes to health insurance in the Netherlands appear likely to create powerful new incentives for improving efficiency and effectiveness of health services. This highlights the lack of such levers in Australia, where there is little incentive for quality (including well co-ordinated) care, either in fee for service medicine or in direct state funded services or through private health insurance. This raises the question of where the drivers for effective care co-ordination will come from in Australia, particularly as the schedule of incentive payments for general practice becomes increasingly complex. At the same time, Australia would do well to note anxiety in the Netherlands about destroying collegial and collaborative arrangements for health care, and take care to 'first do no harm'.

In the Netherlands, health service arrangements are underpinned by a strong set of values, based on solidarity and consensus decision making. Some expect that these will help maintain co-operation and co-ordination in the more competitive environment that is emerging. It is not clear that there is such a strong set of shared values underpinning the Australian health care system. It may be worth actively exploring and developing the values underlying Australian health care, to create a firm foundation for any future shift to a more competitive or market driven system.

As noted earlier, there appears sometimes to be a disjunct in the Netherlands between developing the specifications for integrated care and planning the organisational infrastructure that can deliver this. This fits the Dutch health system, where specifications can be promoted through a number of channels, including health insurance, consumer organisations and

²² www.ijic.org

accreditation programs but where there is little direct external influence on service development. In Australia the role of the Government as funder or provider of health services and the work of meso level organisations such as Divisions of General Practice make it easier to address issues of organisational infrastructure more directly. However specifications have their value, especially as the basis of performance indicators for monitoring co-ordination of care and health system performance.

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