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Conference Abstract

Integrating formal and informal care: Who coordinates the coordinators?

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Abstract

Introduction: Background: In many countries, including England, increasing numbers of people survive into old age with multiple chronic health problems. This demographic pattern and financial pressures on health systems have stimulated a twofold substitution of care providers, namely of:

1. Primary for hospital care, where 'primary care' means home nursing services; physiotherapy and other 'allied' health professions; mental health services; and crisis-response services (out-of-hours care, ambulance, outreach etc.) besides general medical practice. Concomitantly, social care is often also required. Even when all these services are present a residual need for secondary care often remains.

2. Informal care (self-care and/or care by spouse, other family members, friends) for formal care.

In pursuit of marketisation policies, the UK government is simultaneously attempting to involve voluntary, 'social enterprise' and corporate providers.

Problem statement: These changes make it increasingly necessary for someone to actively 'integrate' the care of such patients - more exactly, to co-ordinate the care provided by a range of formal and informal providers so as to promote continuity of care. In theory the GP coordinates a person's health care, but in practice other organisations or individuals sometimes take on this role. That raises the question of how methods and patterns of care coordination differ, when different organisations or individuals fulfil the coordinating role.

Theory: Following Donabedian, we assume that health system organisational structures constrain the methods of care integration available to practitioners at local level, and the available methods of care integration constrain what health care outcomes (e.g. continuity of care) are achievable.

Methods: Design: Nested case studies tracing the methods and consequences of different care coordination methods from patient level to the organisational context and preconditions at provider level, and from provider to health system level.

Sample: Five English localities selected for maximum variety in the types of organisational structures available for integrating patient care. In each locality, a sample (n=68) of patients satisfying a set of clinical criteria for multiple chronic conditions was selected for study.

Analysis:

1. Categorisation of care coordination methods and their consequences at patient level, inducted from patient interviews and systematic data extraction from patient medical records
2. Categorisation of organisational factors impeding and assisting care coordination for each type of care coordination method, inducted from (1) and from interviews with healthcare professionals and managers.

Results: Provisionally (research continues), we found four main methods of care coordination at patient level:

1. GP as care coordinator (standard English model). GP input was uneven. Liaison and informational continuity with other health services was often problematic, but patients often looked to the GP as care coordinator.

Often one or more of the following arrangements coexisted with (1):

2. Other health professions as coordinator, including ad-hoc care coordinating bodies, although these were hard to sustain, and case-management schemes.
3. Patients self-coordinate their care. The more complex their health problems were, the less capable patients often became of coordinating their own care. Patients often under-estimated the severity of their condition and the range of services needed.
4. Third-party integrating organisations, for instance charities such as Age Concern. However, financial pressures made it increasingly hard for health services to support them financially.

Conclusions and discussion: These findings derive from small numbers of sites and patients in one country, so great caution is required in generalising empirically from them. They tend to confirm both that the structural separation of general practice from other primary and community care providers compounds the difficulties of care integration; and that it is practically difficult to substitute for the GP's coordinating role for this particular care group.

Keywords

England, care coordination, general practice, organisational structure

Powerpoint presentation:

<http://www.integratedcarefoundation.org/content/integrated-care-practice-care-coordination>
