Integration – what will it deliver?

Integration has to be the buzzword of 2012 and what it will look like - from the Ministry of Health's perspective, from DHBs and of course from providers. The drive for integration comes from the Government's Better, Sooner, More Convenient Health policy and from the twin drivers of cost containment and better health outcomes. But will it deliver?

Part of the problem is in seeing it from these different perspectives. Integration is often described in either vertical or horizontal terms. And then both vertical and horizontal integration can be seen from either a clinical or an organisational perspective.

Some parts of the sector look at vertical integration in a clinical sense - where clinicians from the community and clinicians in hospital settings work together more closely for the good of the patient. A good example of this is the Canterbury initiative.

But vertical integration could also be seen in an organisational sense - where primary care and secondary care organisations integrate to provide seamless care.

This may involve (in the future) primary care budget-holding for some secondary care services or it might look like South Canterbury where the PHO has been drawn into the provider arm of the DHB.

Or it could look like something entirely different such as the Integrated Delivery Systems (DHSs) as are present in some areas of the US.1 Looking for evidence of success in the literature has been a little harder, and illustrated - at least in one instance - that vertical integration will only be successful where organisational and clinical visions are aligned.2

Then there is horizontal integration and again this could be clinical or organisational. In clinical integration at a horizontal level this means - in a hospital setting - that the patient might only visit the hospital once to have their x-ray, their consultation and their biopsy.

It enhances the patient experience and is significantly more efficient for the patient (Better, Sooner, More Convenient). In a community setting this is reflected, for example, in the IFHCs that are able to provide a one-stop shop model of care. But it could also be brought about by the concept of virtual IFHCs (or provider hubs) where different providers are able to work together to provide integrated care but not all from the same site (here there is an imperative for enabling information technology).

Some examples where this has been happening (in a ministry-driven approach) are the long-term condition changes to the Community Pharmacy Service Agreement and the warfarin management rollout and giving of vaccinations through community pharmacies.

Horizontal integration at an organisational level has been happening over the past 12 months with the significant reduction in the number of PHOs throughout the country.

The number of PHOs now is only 35 (at last count). The number of NGOs are also reducing. There are conversations afoot all over the country to develop capable primary care organisations with the capacity to deliver on the BSMC policy: PHOs amalgamating with management services organisations, PHOs amalgamating with
other PHOs, and many organisations looking at alternative business ownership models with general practices.

Where does the GP sit in all of this? First of all, New Zealand tops the list of OECD countries for the percentage of population that considers itself in good health.\(^3\) Furthermore, we have one of the lowest hospital discharge rates among those same countries\(^4\) and we have the highest increase in life expectancy at birth.\(^5\) So, for the practising GP why should things change? The imperatives are for the future. Those of us in practice now may not need to change but the writing is on the wall.

General practice and primary care are going to change - the burden of chronic care and an ageing population, is going to require it.

But I quote from an article published by Martin and Sturmberg in 2005 "ignoring the historical highly developed role of GPs could lead to the irreversible decline of the unique contribution of general practice. GP non-participation may result in chaos".\(^6\) Notwithstanding the changes that are already being implemented or driven from the centre do we have any idea of what actually works in terms of integration? There appear to be any number of models in the literature\(^7,8,9\) but little in the way of either evidence of "working integration" and even less in the way of evaluation of these.

A study in Australia in 2011 looking at better collaboration between GPs and diabetic educators in terms of diabetes care reflects how good collaborative relationships enhance care.\(^10\)

The Diabetes Get Checked programme - with its links to diabetes education, retinopathy and podiatry screening - also enhanced care, but failed to reduce "health outcomes" in terms of significant lowering of the HbA1c.

A review written in New Zealand on integration comments "we know nothing about the range of mechanisms that are being used to integrate services nor how successful each is at effecting change".\(^11\)

It does not look further at whether any such integration will have the desired effect of improving health outcomes, reducing health spend or enhancing the patient experience.

Such is the state of integration in New Zealand. As with all reforms, there is both a threat to the way GPs have always worked and an opportunity to affect some real change in the health of our patients. But we have to be clear what we are trying to do - integrating (clinically and/or organisationally; vertically and/or horizontally) for its own sake is not the answer - it is merely a means to an end.

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