

Integrated Family Health Centres

Revised statement approved July 2010

Background

In its “Better, Sooner, More Convenient” policies the government has specified its intention to introduce Integrated Family Health Centres (IFHCs). These would be developed within the wider context of improving access to services, including the devolution of some hospital based services to the community setting. It was intended that IFHCs would provide a full range of services, including specialist assessments by GPs, minor surgery, walk-in access, chronic care, increased nursing including nurse-led clinics, and allied health services, as well as selected social services.

The current EOI initiatives include a number of proposals for the development of IFHCs although the Government has made it clear that the capital for the development of these centres would need to come from the private sector¹.

This statement sets out the New Zealand Medical Association’s (NZMA’s) position on the proposed development of IFHCs.

Position statement

The starting point in respect of any health policy proposal is that patient care must be paramount. In particular, decisions should be based on evidence of efficacy wherever possible. Clinical independence is vital if patients are to be confident in the services they receive, the privacy they deserve and the health outcomes that we all desire.

Further, new policy initiatives must take care to support the existing public and private workforce, and current capital investment. New Zealand cannot afford to lose any of its already fragile existing health workforce. It would be unacceptable if creating such a centre in a particular area forced other local general practices – or indeed other health services – to close or reduce their services, as patient care could suffer.

It should be noted that some IFHCs already exist in the community with many general practices having on-site (or in close proximity) allied health professionals, laboratory collection services, radiology services, pharmacy services and access to other medical specialties. Most general practices already manage patients by use of multi disciplinary teams. While progress in these trends is inconsistent, there is a clear trend towards more collaborative models of care².

There is some evidence that the quality of care provided by general practitioners working in IFHCs may be affected, as there is a greater tendency to refer on³. In developing IFHCs, care needs to be

¹ Speech by the Honourable Tony Ryall to the New Zealand Private Surgical Hospitals Association 6 March 2009 <http://beehive.govt.nz/speech/speech+nz+private+surgical+hospitals+association>

² Change in Primary Care – New Zealand Experiences, Tom Love, DHBNZ, October 2008.

³ Imison, C et al “Under One Roof. Will Polyclinics Deliver Integrated Care?” King’s Fund, 5 June 2008, p 29. http://www.kingsfund.org.uk/publications/under_one_roof.html

taken that the possibility of inappropriately increased referral rates to other services within the IFHC do not occur.

IFHCs alone are unlikely to solve hospital demand pressures. What is required is a broad long-term policy agenda that encourages increased investment across the primary health care sector, particularly general practice, which will continue as the core service within primary care. The development of IFHCs will also require a renewed emphasis on collective governance, the alignment of funding systems and the establishment of collaborative contracting arrangements.

There is a risk that shifting hospital based services into the community may result in increased costs, as a result of duplication of infrastructure and resources. Further, while some previously hospital-based services may be co-located with other primary care services in a community setting, this on its own may not necessarily lead to shorter waiting times. It is also important that continuity of care is not lost in the drive towards a time efficient “one stop shop” approach.

Having said the above, the NZMA believes that the development of IFHCs may be beneficial, if they are created with full local general practice input and support, as well as the support of hospital based clinicians. The NZMA believes the following guidelines must be applied:

- Efforts to bring primary and secondary care services together should aim for integration rather than a devolution of hospital based services into primary care.
- Before the decision to co-locate services is made, some thought must be given to the effect that this will have on access for patients. For example, concentrating a number of general practices in one centre may lead to reduced access for many patients, and/or may threaten the viability of those practices not co-located. Patients must not be made more vulnerable through IFHC decisions, and this is particularly the case for patients who, for whatever reason, already have inequitable access to community services.
- IFHCs must foster a long term relationship between general practice, other health services and their patients – which promotes high quality continuity of care;
- There needs to be meaningful local support for the development of a multi disciplinary IFHC, including local general practices and other relevant providers;
- Hospital based specialists must be involved early in the development of any proposed new community service. Consideration also needs to be given as to how IFHCs/general practice will interact with private & public non-GP specialists in that community.
- Transfer of current hospital based services must recognise current and future resource levels and be appropriately resourced - including associated management and infrastructure costs.
- The areas where the IFHCs are developed must have a sufficient health workforce to support them so that other areas do not lose services as a result of health practitioners moving into these new centres.
- Plans for IFHCs must make provision for capacity and funding in education and training of the future workforce.

- The introduction of an IFHC must contribute to, and enhance, local health infrastructure, not undermine or compete unfairly with it;
- There needs to be strong, direct general practice involvement in the management and operation of the IFHC at the local level;
- IFHCs should be clinically led and engage the team based approach to care – with the general practitioner and/or specialist usually leading the patient management in this team;
- IFHCs should continue to provide the full range of high quality care services, including home and residential aged care visits, and longer more complex consultations;
- An information technology platform must be put in place that fully supports service integration.
- Legislative roadblocks such as those found in the Commerce Act 1986, which have prevented small general practices in remote rural areas from merging, must be removed.
- The IFHC model should be able to contemplate arrangements where local health providers who are not co-located can still work together to improve their service delivery. Practices should be encouraged to upgrade their infrastructure and introduce IT systems that allow better coordination of patient care. There should be no need to be physically co-located with the IFHC to enjoy the benefits of better IT services available in the IFHC and local practices should also be able to refer to allied health services available in the IFHCs.

It is noted that the Government does not intend to provide funding for the establishment of such centres. Given that, in many cases, the development of these centres will require considerable financial outlay, the Government should provide some form of incentive. This may be direct such as an interest free loan for the building of the infrastructure, or indirect such as the provision of longer term contracts (i.e. at least six years and preferably at least 10), where hospital based services are shifted into the community.