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# 8 – Cooperation Across the Interface of Primary and Secondary Care

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## Battle Zone

Starting with a citation: "cultural interfaces are said to be like battle zones between the fronts of two armies facing each other: the situation creates uncertainty and fear, there are no rules, the one part trying to impose power to suppress the other part" (1).

The primary secondary care interface is a clearly defined demarcation zone, and it has changed very little during the last 20 years. It is similar in different European countries (2). The patient seems too often to be caught in a "no mans-land" where they suffer from care fragmentation, not knowing what to do, what is to happen next, or who is coordinating (3). These days, the patient has become more like a consumer and customer, a tendency that is boosted by social media spreading messages about which services to demand. Competition is turning health care services into suppliers of health care in a market, and the family doctors find themselves often in an unexpected role to shop secondary care services for their patients, based on expectations or needs. Increase of cost in health care is by many attributed to inappropriate use of care at the interface (4).

## Different Cultures

Primary care and secondary care represent different cultures, and their interface represents the biggest hindrance for smooth care processes in modern health care systems (5). One important reason is fragmentation of secondary care as result of higher professional specialization, technology and focus on pathology, with the risk that persons are more often seen as organs or diagnoses than individuals. At the same time, family doctors struggle to keep a broad and patient-centred perspective in a jungle of new knowledge, patients' increasing expectations and demands while coordinating complex diagnostics and treatment. Iona Heath has described the basis for these differences in an eloquent way: "In family medicine, patients stay and diseases come and go. In hospitals, diseases stay and patients come and go".

Working in separate medical realities may diminish understanding and even respect for the concerns of others. To be able to smooth patient journeys, professionals themselves must cross the interface to learn about the other side, share perspectives and seek mutual understanding and goals. However, little effort has still been devoted to bringing professional groups together to enable them to understand that their work is complementary with that of others in a single healthcare system. The probably best approach so far is a Danish model where family doctors act as advisers in hospitals (6).

Improving interface problems has gradually caught the interest of professionals and leaders of health care (7). We all agree that seamless care is an important goal for quality improvement, but when it comes to broaden our perspectives and changing behaviour, we resist and regress.

## *Important Perspectives*

Four important perspectives of the quality of care at the primary/secondary care interface:

1. The system perspective: A system approach to better co-ordinated care implies that we should understand and discuss division of tasks across boundaries within the health care system. This can improve process-flow, reduce waste of resources and diminish patient risk.
2. Perspective of medical quality: Patients must be given an interpretation of symptoms and findings within a holistic framework where biological, psychological and social aspects of health care are considered and weighted. They have the right to make choices for diagnostics and intervention (8). To achieve this, the professionals must cooperate. The alternative is obsolete: fragmented and uncoordinated care resulting in poly-investigations, poly-interventions and poly-pharmacy.
3. Patient perspective: Patients expect coordinated chains of investigation, treatment and follow up. It is important that professionals and leaders use patients' experiences to improve quality of care on a systematic basis. Understanding patient perspective is an assumption for narrowing the "expectation gap", where needs and expectations clash with offers.
4. Provider perspective: Modern health care systems are complex with multiprofessional providers. There needs to be capacity within the system to prevent and settle conflicts between specialities and professions. Competition should give way to mutual understanding of roles and skills.

## *Targets for Change*

Based on complexity and perspectives, in 2001 the EQuiP listed ten targets for quality improvement of the interface (2). They are still valid.

- Develop leadership with a defined responsibility for improving the interface
- Develop a shared care approach for patients treated in both primary and secondary care
- Create consensus on explicit task division and job sharing
- Develop guidelines that describe quality problems at the interface and seek solutions to such problems
- Develop an interface that contains the patient perspective
- Develop systems for appropriate information exchange to and from family medicine care
- Reinforce interface improvement through education
- Facilitate team building across the interface
- Establish quality monitoring systems at the interface
- Establish a broad understanding of the need for cost effectiveness at the interface

The work required in different countries must be based on national needs, resources and priorities. Improvement of leadership is probably the most important target. So is bringing family doctors and specialists together to develop personal and group relations and understanding. Bridging the expectation gap by informing and empowering patients will also be a strong drive to improve communication and cooperation across the interface. The ten targets can help redesign health care systems in order to deliver care that is perceived by patients as seamless.

Working towards these targets can help leaders to make care systems work as a whole. In Norwegian hospitals there is a new trend assigning family doctors with public health experience to the leadership. The Danish model for family doctors as advisers in hospitals is a multi-potential method to promote cooperation (6). Studies of patients' expectations and experiences can help professionals to act in accordance with guidelines for medical practice and

cooperation.

Improving care across the interface is a continuous process that must be based on principles for quality improvement. Shared perspectives and common goals can lead to behavioural and system change. Both carrots and sticks are needed to accomplish the task.

## Take Home Messages

- The interface primary/secondary care represents major obstacles for seamless care
- The culture gap between primary and secondary care needs closing by sharing perspectives and goals
- The subject must be addressed both by leaders, family doctors and specialists
- Improving care across the interface must be based on principles for quality improvement
- Patient experiences must be monitored and listened to

## Original Abstract

http://www.woncaeurope.org/content/24-interface-between-primary-and-secondary-care-continuity-shared-care

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