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Family Physician Corner

Working at the Interface between Primary and Secondary Care

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The relationship between primary and secondary care is not dichotomous. It's an extended spectrum relation, with no start and accordingly it never ends. Both settings contribute uniquely to the integrated delivery of health care. The type of interface, therefore, should not be colliding and the conflict seen in some health care settings are really arbitrary and artificial.

Nevertheless, different health systems around the world through history have experienced an everlasting conflicts and controversies. Ways to recover and repair the gap have been going ever since.

The vital role of primary care cannot be ignored or overlooked; it has become an integral part of all medical disciplines. Thus it is crucial to develop an understanding between primary and secondary care.

This paper outlines the causes of conflicts between the two disciplines and the probable ways for resolution.

Why the conflict?

The strong emergence of primary care, the change of vision of decision makers towards preventive planning and the transition from the very specific specialized focus on pathology towards the more global look to the illness process have augmented such difference and widened the gap[1]. Considering the primary care or family medicine as a relatively new medical discipline especially in our region has added a further step to this gap. Not to mention, even, the public unawareness of the importance of such discipline[2].

Secondary care has always been perceived from the public and decision makers as the ultimate reference of expertise and professionalism. The fact that the budget distribution falls very much in favor of secondary care is a real interpretation of the previous notion[3]. Primary care, therefore, are burdened with public demand and negatively charged with ministerial financial support.

What are the areas of conflict?

The interface between primary and secondary care is vast and complex. But there are certain enhanced areas of conflict, which have been stressed in the literature such as:

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Distrust between both partners at the level of management, knowledge and attitude. It is felt that there is a gap in knowledge across the two disciplines. In a study published in the Archives of internal medicine, there was an evidence that knowledge difference exist between generalists and specialists in some areas like myocardial infarction, depression and AIDS in favor of specialist[4]. But the difference in knowledge, nevertheless, did not affect management plan, or preventive care.

Family physicians are therefore well equipped with the necessary knowledge to implement an effective management and preventive plans[5].

The referral pathway between both systems has been a source of great deal of quality improvement initiatives with the aim of review and rectification[5]. The loss of communication between both parties seems to be another area of conflict. This was augmented by the inability to exchange medical information through scientific well-accredited channels[5]. Loss of exchange of medical information has created a gap in the professional as well as the public opinions.

Chronic disease management is growing to be another substantial area of conflict between both sides with unclear work distribution[6]. The concept of team work has mandated the divergence from subspecialty towards generality in chronic disease management.

Why Bother?

The complexity of the interface between primary and secondary care and the adoption of each system of its own tasks have left patients in confusion and dilemma and hence dissatisfaction. The quality of care therefore is jeopardized[6].

If the two systems are working separately and incoherently, the understanding and the respect will diminish, which will affect the performance of caregivers.

Can we bridge the gap?

The gap can be minimized and be bridged through different interventions. The European working party on Quality in family Practice (EQuiP) has proposed recommendations for improving the interface between primary and specialist care. These recommendations include the following[7]:

1. Develop leadership with a defined responsibility for improving the interface. This should be a combined leadership, sharing primary and secondary care with other relevant disciplines. The leadership should put plans and evaluate the process of flow through the disciplines. Any conflicts should be discussed and solved at that level. Leaders should build specialized and task-oriented teams and delegate authority and power in order to bridge the gap during the interface.

2. Develop a shared care approach for patients treated in both primary and secondary care. The current guidelines for chronic diseases focus on the roles of both primary and secondary care. Other disease guidelines should take into consideration the transition of patients through the disciplines in order to avoid unnecessary conflicts.

3. Create consensus on explicit task division and job sharing. Both disciplines should define their roles through the interface. The leadership should be the mentor of such role definition with inclination towards global look to the patient.

4. Develop guidelines that describe quality problems at the interface and seek solutions to such problems. The developed guidelines should be tailored to the local resources and meet the local needs of both disciplines. It also should be able to measure the quality of service through the interface.

5. Develop an interface that contains the patient perspective. The interface should be able to accommodate patients transfer through the disciplines and build their strategies and budgets upon such "journey". Patients also should be represented in the interface leadership in order to be acquainted with the problems and help in suggesting improvements[8].

6. Develop systems for appropriate information exchange to and from general practice care. This is a very important in developing trust and professional help across the interface. Exchanging information between both disciplines will certainly bridge the gap.

7. Reinforce interface improvement through education. The leadership through their subgroups have to spot areas of deficiency, the need for improvement and work upon them. Continuous education to familiarize both parties with the jobs and tasks of the other discipline should be planned for and implemented.

8. Establish quality monitoring systems which focus on quality at the interface. Certain quality indicators should be designed and monitored through the interface periodically. These indicators will evaluate the interface and help rectify problems. The indicators should be guideline-directed and evidence-based.

9. Establish broad understanding of the need for cost-effective use of the interface. The cost-effective use of the interface will be the result of the proper utilization and the monitored evaluation of the interface. Evaluation will be through quality indicators monitoring.

CONCLUSION

The interface between the primary care and the secondary care is a new area for both conflict and intervention. It is created because of changed needs and demands of both the public and the decision makers. The need to bridge this gap is overwhelming. The development of a shared leadership and conjoint

guidelines and teams will help create an atmosphere of professionalism and trust.

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