The University of Manchester
Manchester Business School

Care coordination for people with multiple chronic conditions in general practice: An Oxymoron?

Background

Fragmentation

Specialisation and sub-specialisation of medicine has led to the fragmentation of provision in which the needs of people with chronic conditions are often not met (Boerma 2007). A growing body of evidence suggests that coordination and integration are essential mechanisms through which to re-design services to improve the outcomes for people with complex needs (Goodwin, 2010; Curry & Ham, 2010; Lewis et al, 2010). Whilst this has been a policy priority supported by successive governments since the 1990s, the widespread provision of integrated and responsive care for people with chronic conditions has largely failed to materialise (Goodwin, 2010a; NHS Alliance, 2011).

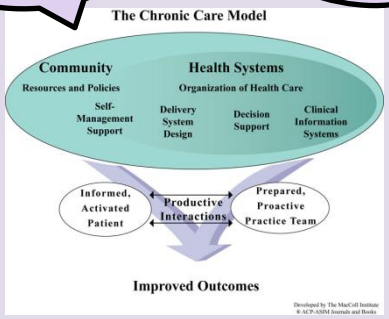
Role of general practice

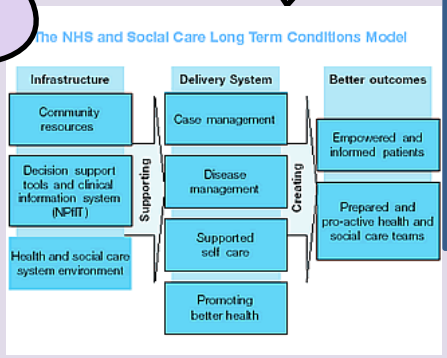
Within the NHS, general practitioners (GPs) are identified as having a central role in coordinating care for patients with complex needs and accept overall responsibility for ensuring patients are appropriately guided through the wider healthcare system (Lakhuni, 2007). In practice, the evidence in support of effective coordination is largely absent and GPs themselves recognise this as an area for improvement (Goodwin, 2010b). If patient outcomes can be greatly enhanced by improved coordination, and general practice consider this as part of their role, it is difficult to see why the issue of coordination as a barrier to high quality health care persists?

Coordination and Integration

Proactive community healthcare team

Supported self - management

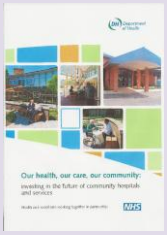


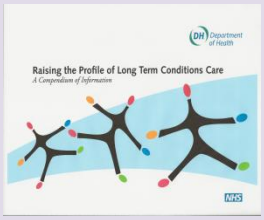


Aim

The purpose of this research is to understand how care is coordinated for people with chronic conditions in general practice. In particular, the extent to which the structure, context and funding of general practice inhibits or facilitates individual and collective agency in organising care.

Policy context





Preliminary propositions

Path dependency

- Entrenched physical and professional divide between primary/secondary care
- Power differential between GPs/hospital consultants, health and social care
- Marginalised role of generalists = reduction in holism and patient centred care
- Evidence of new forms of fragmentation

Context of primary care

- Structure of primary care undermines collaborative practices and collective agency
- Lack of ownership particularly at interface with secondary care
- Heterogeneity of general practice and independent status, difficult to influence as a whole

New forms of fragmentation

- QoF – disease specific organisation of care
- Downwards role substitution perpetuates fragmentation
- Authority to coordinate not conferred to non-medical staff

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