SHORT COMMUNICATION

Developing integration around primary care: new professional roles and emerging professions in integrated care delivery

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ABSTRACT

Continuity, comprehensiveness and coordination are key functions of primary care, as set out in the Declaration of Alma-Ata. Therefore, primary care systems must play a key role in integrating care not only within but also across health and social care systems. In addition, over the past decade, it has become apparent that primary care professionals must take on new roles and acquire new skills in order to tackle the challenges presented by the increase in the number of patients with chronic diseases and multimorbidity, and the associated need for coordinating services. In response, professional roles in primary care are expanding beyond their traditional boundaries, new types of education and job profiles combining health and social care as well as therapeutic skills have emerged to supplement traditional capacities in case and care management, and care navigation has emerged as a new function of primary care. Here, we argue that, in the future, an integrated health and social care workforce will have to draw as much on the emergence of these new professional profiles as on new roles for well-established primary care professions.

Keywords: INTEGRATED CARE, PRIMARY CARE, CARE WORKFORCE, CARE PROFESSIONS, SKILL MIX

THE NEED FOR INTEGRATED HEALTH AND SOCIAL CARE SERVICE DELIVERY

As set out in the Declaration of Alma-Ata, primary care systems must play a key role in integrating care not only within but also across health and social care systems *(1)*. In addition, over the past decade, it has become increasingly apparent that hospital-centred and disease-oriented health care systems need to find new ways to tackle the challenges presented by the ageing of populations worldwide, the concomitant increase in number of patients with chronic diseases and multimorbidity, and the associated need for coordinating services. These challenges have led to an intensification of efforts to reduce fragmentation within and between the health and social care systems and promote coordination between the numerous care settings and care professionals operating in these settings *(2)*.[1] Forty years after the Declaration of Alma-Ata, its postulation of continuity, comprehensiveness and coordination as key functions of primary care is thus more relevant than ever *(1)*.

Patients with complex long-term care needs interact with and require support from the formal networks provided by health care and social care professionals while drawing on informal networks for additional support.[2] Fig. 1 offers a helpful visualization of how the roles of different care providers can be conceptualized along two key dimensions: the "health–social care divide" – for example, between general practitioners (GPs) and home care providers – and the "formal–informal care divide" – for example,

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[1] Fragmentation in health care refers to the organization of health care systems in silos based on speciality or care settings, where different care professionals specialize in diagnosing and/or treating conditions related to a specific organ system without necessarily appreciating and considering the relation to the patient's general well-being and care process (that is, focusing on the parts without considering the whole).

[2] Informal networks are the social networks of each individual, on which they can draw for support and care when this is needed. These include family members as well as neighbours, friends, acquaintances and colleagues.

FIG. 1. THE ROLES OF DIFFERENT HEALTH AND SOCIAL CARE PROFESSIONS IN INTEGRATING CARE DELIVERY
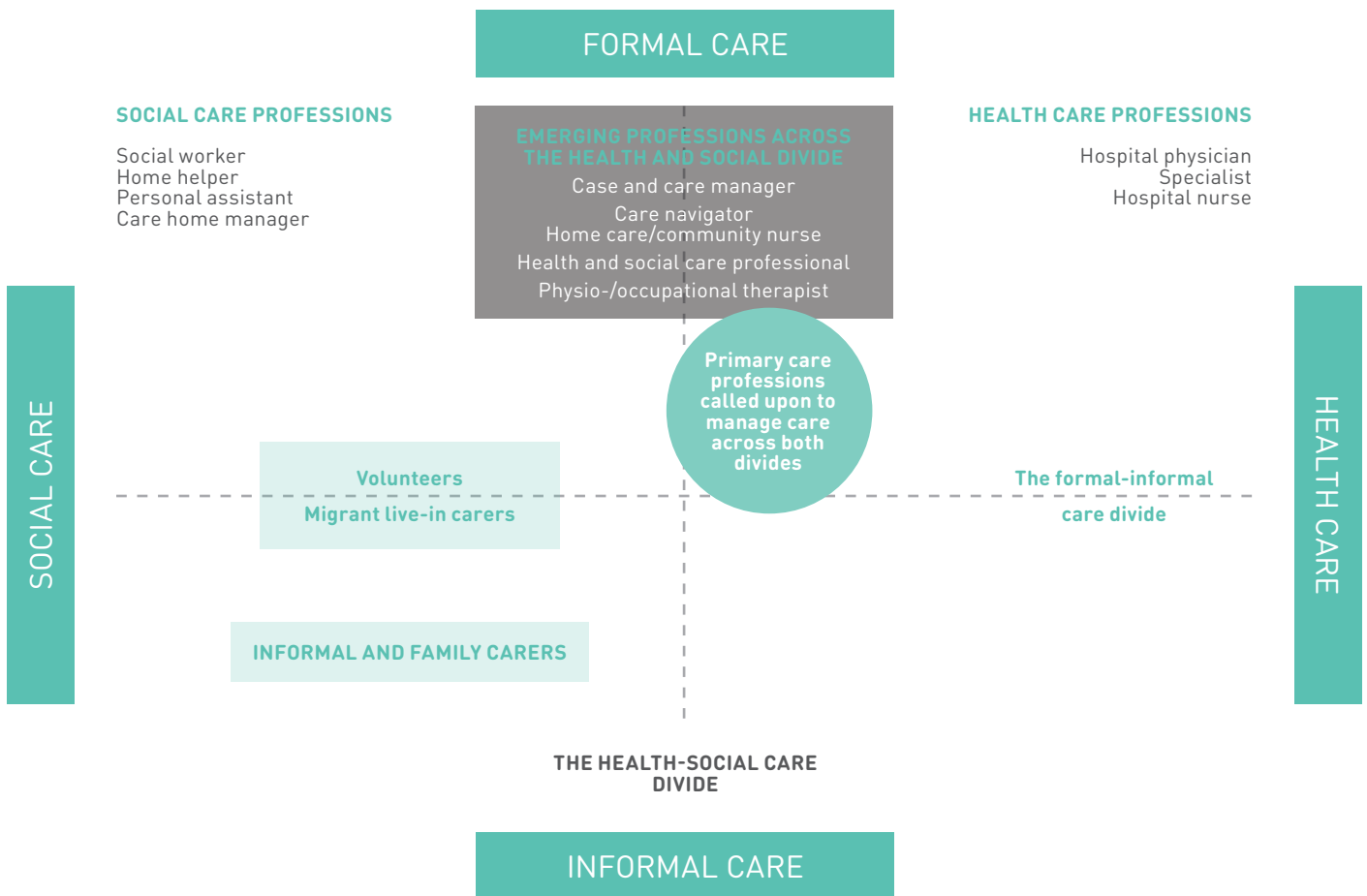
between home care providers and family carers. To successfully manage the care of patients with complex needs, communication and coordination are needed across both divides simultaneously. In order to do this, both emerging professions (for example, physio-/occupational therapists) and primary care professionals are increasingly called upon to play more complex, cross-sectoral roles and manage care across the divides in a person-centred manner. This is visually represented in Fig. 1, as, while the more traditional health care and social care professions are placed at the edges of the graph, both emerging professions and primary care professionals straddle the quadrants.

However, in the past, various attempts to overcome fragmentation in the health and social care systems via primary care have often failed to address both the health–social care and formal–informal divides. For example, in countries where primary care centres were promoted as drivers of integration between health professionals, collaborations were often limited to the interactions between GPs and nurses or pharmacists, leaving social care professionals out. Similarly, models such as the Chronic Care Model, which involved GPs or registered

nurses acting as case managers responsible for coordinating both health and social care, seldom took into consideration the fact that patients might be older people with multimorbidity or those in need of long-term care. As a result, patients needing treatment and support across the health and social care divide have frequently had to resort to using emergency departments, experiencing repeated hospitalization ("revolving-door effects") or having their needs unmet, all of which have a negative effect on their quality of life (3–5). Furthermore, initiatives to improve coordination within the health care system have often failed to recognize or support the essential role of informal carers of people with long-term conditions. Traditional primary care teams are ideally positioned to assist informal carers, but they often fall short in assessing needs and providing follow-up (6).

Among the factors that have contributed to limit progress in these areas are capacity limitations in primary care, a lack of communication and information-exchange structures, and the limited training of primary care professionals (2, 7, 8). Shortages of GPs and other primary care professionals, limited funding to promote integrated working, unclear definition

of responsibilities, and a lack of resources to follow-up with patients and their families, as well as an underdeveloped culture and infrastructure for interprofessional work and cross-sectoral communication, also hamper efforts at integration.

EXPANDING ROLES AND EVOLVING SKILL MIXES AT THE INTERFACE OF INTEGRATED CARE DELIVERY

The above-mentioned shortcomings in addressing coordination and providing integrated pathways of care have resulted in a broad range of interventions at various levels. For instance, building on the historic approaches of public health provided by community health nurses and family nurses or health counsellors, the old principles of case management have re-emerged in the public (health) discourse. A wide range of pilot projects and programmes in Australia, Europe and the United States, as well as several Asian countries, have re-established case management as a way to improve the responsive capacity of primary care, in particular in the context of nurse-led disease management (9), but also by physician-led initiatives, for example the multispecialty community providers in the United Kingdom (10).[3]

An important trend for primary care professionals is that their skill mix, that is, the combination of activities and skills needed within a given profession and generally covered by professional education, is changing, and their roles are now expanding to include tasks previously considered to be beyond traditional boundaries. A case in point is the emergence of specialist nurses in the Scottish health care system, NHS Scotland, both for disease management (for example, HIV nurse specialists) and for long-term care (for example, specialist residential home nurses), with their ability to work across organizational boundaries and in multidisciplinary teams as well as improve communication between professionals in the two sectors (11, 12). Similarly, the emergence of psychiatric mental health advance practice nurses in the United States, ambulatory emergency care nurses in the United Kingdom, and community nurses in several European countries as well as in Australia, Canada and the United States reflect the efforts of health professionals to develop new professional skills, work autonomously and facilitate cooperation. However, it should be emphasized that, in many cases, such developments are role extensions rather than

role redefinitions. In other words, primary care professionals are being asked to do these tasks in addition to their normal workload, and to pick up new professional skills in addition to the ones they are expected to have; for example, primary care providers often have to use new types of communication and information technologies in their professional practice, without having had appropriate training. This trend is leading to an overburdening of the primary care workforce (13).

In addition, members of non-traditional health professions are playing increasingly significant roles in care coordination. A notable example is the central role of occupational therapists and physiotherapists as coordinators of community-based care. In the wake of the re-ablement policy in Denmark (14), which emphasizes prevention and rehabilitation in care for older people, such non-traditional health professionals are filling the gap created by the low involvement of nurses in preventive functions and assignments. As the numbers of non-traditional health professionals in support roles in primary care teams is increasing (15), it is likely that the breadth and complexity of their tasks will continue to increase in the future.

Similarly, social workers have begun to act as coordinators of care in the community and as integral parts of discharge and care management teams in several European countries. In addition, in the United Kingdom, routine nursing and therapeutic tasks are often delegated to trained personal assistants and community support workers, indicating their considerably broader role in personal care (12). Likewise, in the Netherlands, guidelines for care coordination underline the necessity of higher professional education for case managers, who need, for instance, in the case of dementia care, good knowledge of how to manage the problems that can arise in informal care, as well as good sociopsychiatric skills (16).

EMERGENCE OF NEW ROLES AND PROFESSIONAL PROFILES

In a parallel development, several countries have taken critical steps towards establishing new professional profiles by proposing more integrated post-secondary education curricula, designed to overcome silo thinking in care. For instance, in Denmark, a highly professionalized social care workforce has emerged, with qualifications as "social and health helpers" and "social and health care assistants" requiring theoretical and practical training courses lasting

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[3]   See also General practice forward view. Redditch: NHS England; 2016 (https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf, accessed 12 November 2018).

14 and 34 months, respectively *(17)*. In Austria, a curriculum similar to the Danish one was put in place in an attempt to streamline the previously scattered and unregulated training programmes for care professionals in the areas of disability, care for older people and family care. The role of "specialist social carer in old-age care" requires a two-year training programme that includes education as a nursing assistant, with the option to become a "social carer with a diploma" by adding a third-year module. At this qualification level, social care professionals can take up team-leading and managerial positions, for example in nursing homes or day-care centres.

While there is no such curriculum in the United States, in 2013 an article analysing trends in health and health care suggested that new provisions for comprehensive geriatric education and training were needed in the United States, with specific consideration for both social work educators and aspiring geriatric social workers. It was proposed that such provisions should include the creation of geriatric education centres to offer short-term intensive courses focusing on geriatrics, chronic care management and long-term care, to be offered to all health professionals, including social workers *(18)*.

An innovative role emerging at the confluence of health and social care is that of the care navigator (found, for instance, in Australia, Canada, the United Kingdom and the United States). To reduce existing barriers in accessing health and social care, care navigators offer assistance to patients and their family carers in identifying appropriate services, within both the health and the social care sectors. They promote healthy, disease-specific lifestyles and address patient-specific issues such as self-management and adherence to treatment, as well as identifying patients' personal beliefs and fears *(19)*. In a parallel development, the roles of community navigator and link worker are emerging in the United Kingdom. They bridge the gap between care organizations and the communities they serve, by connecting professionals with support resources in the community, and proactively creating links between individuals and their care providers *(12)*.

It is important to emphasize, however, that the development of training programmes for new professional profiles, as well as their systemic integration, presents considerable regulatory and financial challenges and can be a lengthy process. Given the pace of technological innovation and changing needs structures, it is therefore necessary to increase the vigour of curricula and skills at the interface of health and social care education. For example, moving beyond the more traditional hospital-centred education, supplementary courses and modules could be offered to enable the proliferation of integrated job profiles for primary care professionals and professionals in emerging health–social care professions. Such new profiles may lead to a reallocation of the workload for more traditional health care professionals so that they can focus on tasks that better reflect their training, potentially providing efficiency gains.

CONCLUSIONS

Primary care will continue to face rising demand from an ever-increasing number of patients with complex needs. To respond to this challenge, integrating health and social care and coordinating formal and informal care will be essential *(20)*. Such integration will require primary care professionals to be able to carry out new tasks and acquire new skills, such as using new information and communication technologies. Such an approach has the potential to both improve coordination of care and allow for a more efficient allocation of staff to specific care tasks. This approach may also be a better fit for the places where care is increasingly being delivered: at people's homes and in their communities, rather than in inpatient settings (whether acute or residential care).However, the new types of roles and skills required for such an approach cannot be viewed simply as add-ons to existing job profiles; to avoid increasing the workload for an already overburdened workforce, it will be necessary to provide appropriate training and organizational development, both within and across health and social care professions. Therefore, it will be necessary to re-design workflows, redirect budgetary allocations to enable additional training and redistribute responsibilities among care workers.

In adopting this approach, it will be necessary to identify efficient ways to overcome factors that inhibit joint working between health and social care professionals and between formal and informal care providers. More emphasis needs to be put on the development of shared visions, by implementing appropriate job profiles and providing joint education and additional training to increase the skill mixes of health and social care professionals *(21)*. Primary care will experience a further extension of its role and importance in the health care system, and this will entail investment in a new identity for the "primary care professional".

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