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Continuity of care in New Zealand primary health services

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In this issue of the *NZMJ* Santosh Jatrana, Peter Crampton and Ken Richardson present findings relating to their investigation into continuity of care in New Zealand.[1] Their research examines this in relation to individuals' experience and characteristics across a whole nation, which is relatively unique in the continuity of care literature. The article is part of a series of papers reporting from SoFIE-health, a set of national surveys conducted between 2002 and 2010, involving some 22,000 adult participants. Other papers in the series have dealt with affiliation with a primary care provider,[2] and access to primary health care in New Zealand.[3]

In this new paper, which uses survey data from 2004–5, the authors derive a measure of continuity of care from the strength of participant responses to the following four questions from the survey:

- Would the *same doctor* or nurse take care of you every time you go?
- If you called them, could you talk to the person that *knows you best*?
- Do you think they *know you very well as a person*?
- Do you think they *know what medical problems* are most important to you?

Somewhat reassuringly for general practice in this country, the authors find generally high scores on their measure of continuity of care, with an overall mean of 3.10 out of a possible 4. Furthermore, and also reassuringly, the data largely support the authors' hypothesis that those who have a greater need for care will have a higher mean continuity of care score.

Thus they have found that the elderly, those of Pacific and Asian ethnicities, those in lower income brackets and those with chronic diseases all experience greater degrees of continuity of care than their younger, wealthier, European-descended counterparts.

But why should we care?

As general practitioners and teachers of medical students, we see a number of implications arising from this work.

Continuity of care has long been regarded as one of the key features of successful primary care systems, and as a core value within General Practice/Family Medicine. Esteemed scholars of the discipline such as Ian McWhinney[4] and Barbara Starfield[5] include it in their definitions of what constitutes primary care, while the European Society of General Practice/Family Medicine (WONCA Europe) list "the provision of longitudinal continuity of care as determined by the needs of the patient" as one of the essential "characteristics of the discipline".[6] And while there is debate about how continuity of care might be most satisfactorily defined,[7] its benefits are readily experienced within the daily work of GPs.

Familiarity with one's patients saves time, reduces uncertainty, and contributes to more satisfying and nuanced consultations for both parties. In our teaching we place a great deal of emphasis on instilling in our students an appreciation of the patient in his or her context; a context which can readily be appreciated from both the cumulative knowledge of a patient and his or her history, circumstances and preferences, and also the trust built up in the long-term professional relationship between patient and GP.

There are both opportunities and threats to continuity of care arising from current trends in the health system. On the positive side some of the changes brought by the Primary Care Strategy would seem to support continuity, particularly the increased funding of patients enrolled with a primary care provider. The authors suggest continuing attention to the provision of incentives to support affiliation and continuity of care. It is encouraging to see continuity of care and personal service acknowledged as values which must be maintained in the move towards the current Government's model of larger Integrated Family Health Centres.[8]

On the other hand, emerging trends relating to providers and how they organise themselves may work against continuity. For example, after hours care is increasingly undertaken by organisations separate from the patient's practice, and GPs are less likely to become practice owners and work in one location for many years. Many practitioners prefer to work part-time, and increasing numbers of GPs develop sub-specialty practices (e.g. musculoskeletal or ENT GPSIs).[9] Larger medical centres and flexible hours of work make it harder to achieve continuity of care with a single doctor or nurse.

Jatrana et al comment that their model, which focuses on the individual receiving continuity of care, does not "account for much of the observed variation in continuity of care". We would suggest that perhaps at least some of that variability might be accounted for by provider factors, and that we should all think seriously about the implications for continuity of care of evolving models of health care provision.

The work of Jatrana, Crampton and Richardson provides a baseline for further investigation of the phenomenon of continuity of care in New Zealand. Questions which might be considered include those related to which aspects of continuity are the most crucial (e.g. continuity of information within a practice, versus continuity of the relationship with a single provider), an exploration of other settings in which it might be reasonable to try and improve continuity of care (e.g. secondary care provision of care to the chronically ill), and perhaps an examination of the relation of actual health outcomes to continuity of care measures in the New Zealand context.

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