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**ARRANGING GENERALISM IN THE
2020 PRIMARY CARE TEAM?**

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POLICY CONTEXT

The National Health and Hospital Reform Commission (NHHRC) final report and the draft National Primary Health Care Strategy state a preference for multidisciplinary primary care to improve chronic disease management, promote prevention and help address workforce shortages. The patients most likely to require multidisciplinary care will be those with complex and multiple health conditions. Although team care arrangements have become a focus, less is known about what the future health care needs of patients with complex and multiple illnesses are. We also have little information about what these patients value in their primary care and how to arrange it to meet their needs. If multidisciplinary teams are to be implemented in the Australian primary care setting, how much of the holistic and fundamentally generalist values might be lost? Defining features of generalists are their knowledge of patients over time and use of patients' life stories and context balanced with technical information to provide holistic care. The study's aim was to explore patients' needs and to identify if the features of generalism have relevance for the development of multidisciplinary team care in the Australian primary care setting.

KEY FINDINGS

- Primary care professionals do not use a singular definition of the term 'team'.
- There is a lack of evidence about whether multidisciplinary team care improves patient health outcomes.
- At the organisational level, there is a need for the provision of physical and technological infrastructure support to facilitate team care. A greater need is present for developing shared ways of working together across different professions and the development of information sharing systems and processes.
- Patients we interviewed had between four and 10 health care providers, but still viewed the general practitioner (GP) as the central coordinator of their care. Patients value their longitudinal relationship with their GP.
- Primary health care professionals engaged in innovative research methods to think about team care arrangements and how to develop shared ways of working together.

POLICY OPTIONS

1. Reform of the primary care setting will require careful consideration of who is best placed to coordinate patient care. Data indicates that GPs are currently the main coordinators of patient care but there is no formal system or processes to facilitate this.
2. Team care arrangements as part of the Enhanced Primary Care (EPC) Medicare item numbers are used by GPs for patients with chronic diseases like diabetes, but plans are seen to place heavy time burdens on professionals and have not facilitated teamwork between allied health and GPs.
3. There is considerable work to be done with all primary care professionals about what they mean by the terms 'team', 'team care arrangements' and 'multidisciplinary teams'. This is imperative if team care is to be successful for patients.
4. Information systems and processes need to be developed and supported for primary care professionals to transition to working within multidisciplinary teams.
5. Funded research is needed from within primary health care settings to establish if team care improves patient health outcomes. There is little to no evidence available on this internationally or nationally.
6. Complex patients have complex life stories that impact on the patient's health and well being. Primary care professionals are uniquely placed to understand the patient story and its role in patient health care.
7. Patients value the essential elements and dimensions of generalism that were previously identified in our study 'What is the Place of Generalism in the 2020 Primary Care Team?', which was commissioned by the Australian Primary Health Research Institute. See Figure 1.

Figure 1 A Conceptual Model of the Essential Dimensions of Generalism

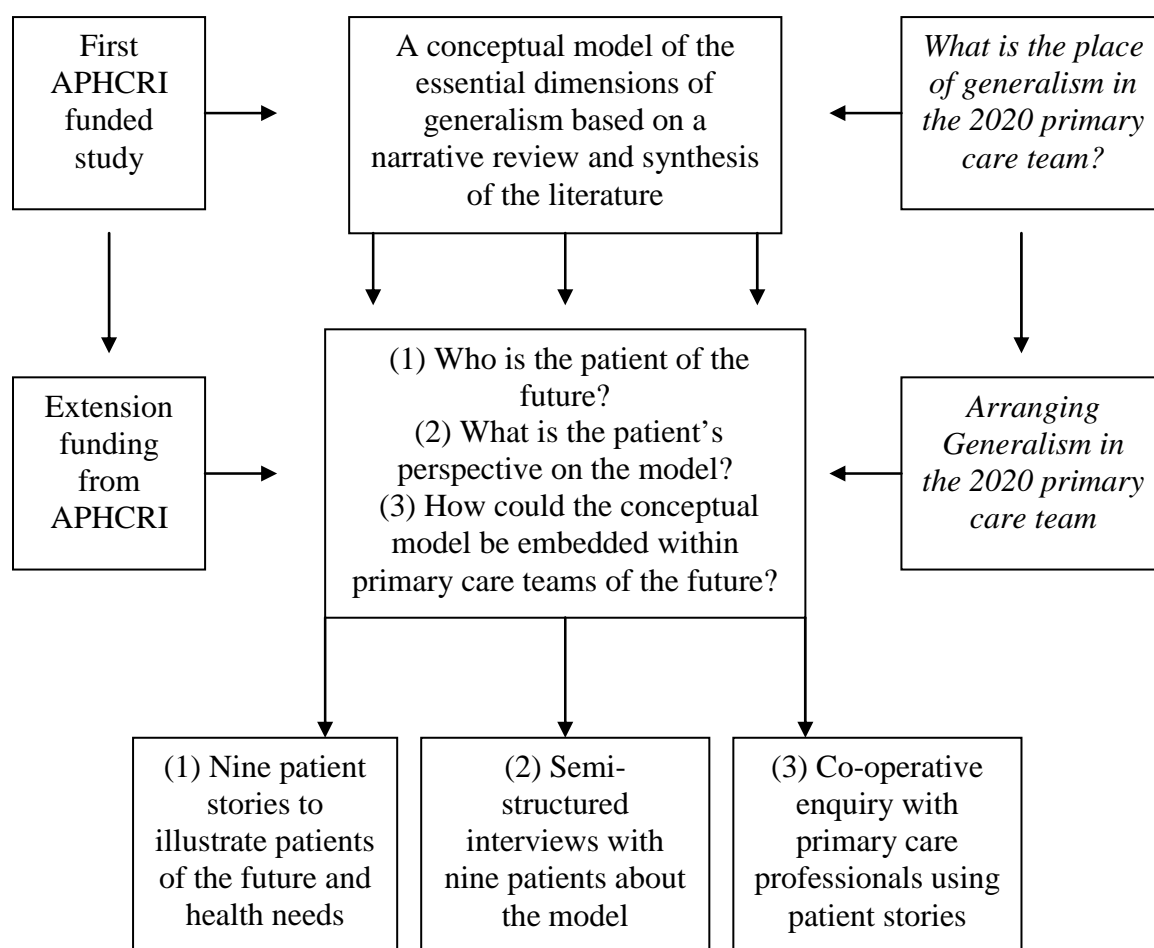
Dimensions of Generalism	Explanations: the key features
Ways of Being (Ontological Frame)	Virtuous character: holds ethical character traits of compassion, tolerance, trust, empathy and respect.
	Reflexive: interdependent, reflects on judgments and biases, lifelong learner.
	Interpretive: processes of interpretation are used to understand patient with an emphasis on the contextual factors, use of multiple health systems languages, active listener, autonomous decision-maker, good communication skills.
Ways of Knowing (Epistemological Frame)	Biotechnical: uses scientific and rational evidence, high index of suspicion, bio-medically driven, technically focussed, uses advanced information systems.
	Biographical: concentrates on lived-experience and life-story, family, carers, community and social knowledge all provide evidence.
Ways of Doing (Practical Frame)	Access: accessible, first-contact point, gatekeeper, provides referral.
	Approach: balances individual versus population needs, consultation-based, holistic, comprehensive, flexible, adaptable, acts across clinical boundaries, provides early diagnosis, interdisciplinary team approach, negotiates & coordinates services, integrates knowledge, promotes health through education, prevents disease, is culturally sensitive, provides patient-centred care, minimises service inequities, reduces service fragmentation.
	Time: provides continuity of care over whole of life cycle (longitudinal). Context: community-based, uncertain, complex, deals with undifferentiated multiple problems of patients, acute and chronic care.

POLICY OPTIONS (CONTINUED)

8. Further research is required into how to embed these elements and dimensions of care within primary care organisations and multidisciplinary team care in the future;
9. Our data indicates that patients highly value the relationship they have with their general practitioner (GP), the impact of proposed reforms in primary care on this relationship need to be considered.

METHODS

Figure 1 Diagram of the Arranging Generalism Study Design



For more details, please go to the [full report](#)

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