

AUSTRALIAN PRIMARY HEALTH CARE RESEARCH INSTITUTE

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WHAT IS THE PLACE OF GENERALISM IN THE 2020 PRIMARY HEALTH CARE TEAM?

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POLICY CONTEXT

Primary health care is a domain of reform and change as health care policy and strategies are designed to address growing health complexities. To maintain a cost-effective, equitable and accessible health care system, Australia must address issues like workforce shortages, technological advances, an ageing population, rising rates of chronic disease, increases in co-morbidity and growing multi-morbidities. A single-disease focussed approach will not address these complexities and issues. The place of generalism within the 2020 primary health care team needs to be understood and conceptualised.

We systematically reviewed the available evidence on the place of generalism within primary health care to document the essential dimensions of the generalist approach to develop sustainable options for primary health care in 2020.

KEY FINDINGS

- There is no agreement on a definition of generalism. Generalism in primary health care has not been formally conceptualised. Generalism is the result of the continual interaction of three essential dimensions: ways of being; ways of knowing; and ways of doing (see Fig. 1)
- A generalist approach delivers equitable, accessible, cost-effective care for patients
- Commentators signal alarm at the devaluation of and reduced emphasis on generalism. While there is strong support for generalism, there is also concern about the increasingly complex knowledge and skills required to practice as a generalist. This signals the need for high calibre graduates
- The three dimensions and their interaction combine to form a philosophy of practice. This philosophy is represented in a conceptual model of the essential dimensions (see Fig. 2)

Figure 1 [A Continuum of Generalism](#): the Foundation of a Philosophy of Practice

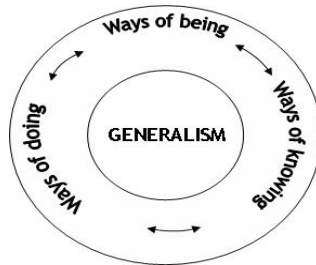


Figure 2 [Conceptual Model](#): The Essential Dimensions of Generalism

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 judgements 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. Context: community-based, uncertain, complex, deals with undifferentiated multiple problems of patients, acute and chronic care.

POLICY OPTIONS

Health care systems based on a generalist primary health care workforce underpinned by generalism will be well equipped to deliver cost-effective, equitable and accessible health care.

There are three areas of policy options

- Increase the importance and status of primary health care generalist workforce through career pathway development and remuneration, among other facilitators
- Enhance the educational content and settings that strengthen a generalist primary health care workforce
- Build and transfer evidence about strategies that strengthen generalism in the 2020 primary health care team.

INCREASING THE IMPORTANCE AND STATUS OF PRIMARY HEALTH CARE GENERALISTS

- Clear and attractive career pathways for generalists
- Scholarships for generalists to undertake further education and training

- Improved remuneration for generalists that recognises the increasing complexity of the work they do and funds models of generalist-led primary health care teams by developing finance models that reward care co-ordination, chronic disease management and evidence-based preventive health care
- Create a program of events that bring different groups together regularly to develop a blueprint to develop generalist-led primary health care teams in Australia

ENHANCING EDUCATIONAL CONTENT AND SETTINGS THAT STRENGTHEN A GENERALIST PRIMARY HEALTH CARE WORKFORCE

- Accredit health education and training programs that embed the essential dimensions of generalism at all levels (undergraduate through to postgraduate)
- Develop medical and nursing curricula content supporting generalism and enabling a generalist workforce
- Locally based dedicated 'training hubs' for generalist students on community placements. Practice-based infrastructure grants via the government could further support and strengthen existing training hubs
- Fund practice-based infrastructure grants to support technologies to improve generalist approaches

BUILDING AND TRANSFERRING EVIDENCE ABOUT STRATEGIES THAT STRENGTHEN GENERALISM IN THE 2020 PRIMARY HEALTH CARE TEAM

- Specify and fund generalist career pathways that attract high quality graduates
- Implement evidence-based models of generalist led primary health care teams
- Fund mechanisms that support effective models of generalist-led primary health care teams for people with multiple morbidities
- Increase the evidence base about the doctor and nurse generalist, their respective roles and place within Australian primary health care

METHODS

Evidence was analysed using a narrative review and synthesis approach. Evidence was accessed from electronic searches of databases and primary health care websites, and consultations with key stakeholders. Overall, 595 papers were identified, with 97 papers (74 commentaries, nine reviews, 14 empirical studies) reviewed. 35 papers: 17 reviews, 13 empirical studies and five commentary papers were identified as relevant to assessing cost-effectiveness. Key stakeholders were consulted via interviews at the start of the project and the responses informed the review and synthesis. Stakeholders were invited to provide feedback prior to the finalisation of the report.

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

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