AUSTRALIAN PRIMARY HEALTH CARE
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ARRANGING GENERALISM IN THE 2020 PRIMARY CARE TEAM

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POLICY CONTEXT

The Australian Primary Health Care System is at a crossroad. We are faced with a burgeoning workforce crisis, a complicated model of private and public health care funding, and changes to the scope of practice of GPs, nurses and other allied health staff who comprise primary care teams in Australia. Both the Canadian and United States health care systems provide useful contrasts to consider as Australia builds a National Primary Health Care Strategy. One element of health care is shared universally: patients will increasingly present with complex, multiple problems rather than a single disease. New developments in the U.S. in the Patient-Centred Medical Home (PCMH) movement signify important directions for primary health care. Canadian efforts to build a Pan-Canadian strategy to resolve provincial differences are also of interest including the challenges of inter-professional collaboration faced within family health teams (FHTs). These developments signal that coordination of care across territorial and disciplinary boundaries is critical to the future of the health care system; they provide important international examples that can inform policy developments in Australia.

KEY FINDINGS

There is support for generalism and its essential dimensions as a guiding philosophy for primary medical care, whether this can be translated to broader primary care teams is open to further investigation and debate.

1. **No one site or setting has all of the answers**. We will need to use the strengths from different primary health care systems, including identifying those in our own, and create an evidence base of practice models that show how people can cooperate across disciplinary boundaries.

2. **Overall very positive response to the model**. People are using it and applying it to the primary medical care setting. Family physicians support the essential dimensions presented within the model. Experimental testing in Australian primary care settings of the essential dimensions of generalism and the development of measures for these are next important steps.

3. **Support for the diagrammatic representation of perspective**. People liked the way that the perspective diagram could assist to explain how concepts are fluid and expand and contract. While the conceptual model captures the essential dimensions of generalism it also represents these in a rather static way where their dynamic nature might be overlooked.

4. **Incentives do not assure that change happens in practice**. A key learning from these visits is that financial incentives will facilitate change but this does not always come with commitment to new values or better ways of practicing per se.

POLICY OPTIONS

Our findings from the linkage and exchange program suggest the following policy options from Stream 6 continue to be relevant for building and transferring evidence about strategies that strengthen generalism in the 2020 primary care team:

Develop evidence-based models of generalist led primary care teams. APHCRI, or its equivalent, could commission carefully evaluated pilot work in the practice setting to support the implementation and evaluation of such models. These could be tested using robust methods such as cluster randomised trials to assess cost-effectiveness.

Identify funding mechanisms that support effective models of generalist-led primary care teams for people with multiple morbidities. The NHMRC, APHCRI or the government could commission strategic research into such funding mechanisms. The government could also lead a review of Medicare items to ensure they support a generalist workforce though Council of Australian Governments (COAG). Research into the capital infrastructure that supports and sustains models of generalist-led primary care teams is also needed.

Increase the evidence base about the doctor and nurse generalist, their respective roles and place within Australian primary care. Commissioned research and evaluation of initiatives designed to support such working relationships within the Australian primary care setting are needed.

METHODS

This program examined the potential for ***building*** and ***transferring evidence*** about strategies that can strengthen generalism in the 2020 primary care team using Lomas' (2000) linkage and exchange model. The aim was to increase 'contextualisation (i.e. relevance and use) of evidence for policy-making'. To achieve this, ideas and evidence were transferred to Canadian and US settings from our research conducted and completed in Australia. We used the methods of dialogue, discussion and learning from our colleagues to think about preferred practice models for the Australian setting. We presented the devised conceptual model of the essential dimensions of generalism on which this program of research was based. The model appears in Table 1 and the notion of the dimensions occurring in continual interaction is shown in Figure 1. This culminated in the development of a visual representation of the model to emphasise the importance of perspective shown in Figure 2.

Table 1: Conceptual model: The essential dimensions of generalism as a philosophy of practice

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.

Figure 1: Continuum of interaction: dimensions underpinning a philosophy of practice

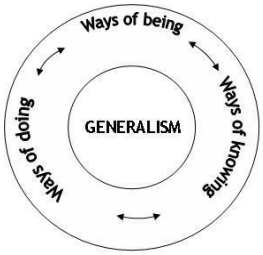
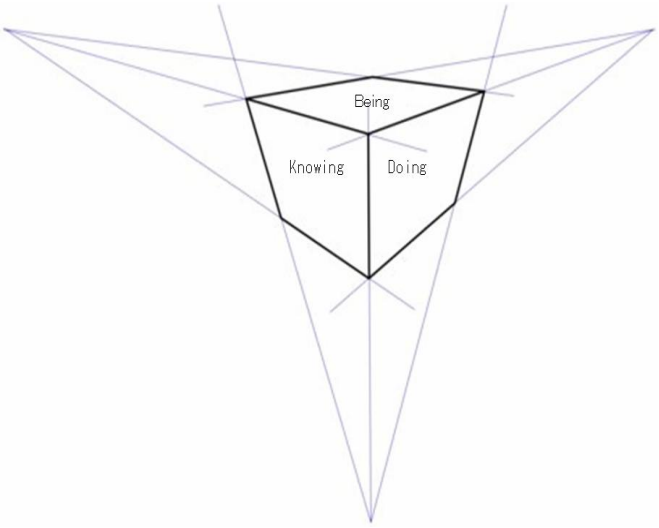


Figure 2: Perspective: an object will change dependent on where you stand in relation to it



For more details, please go to the full report

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