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Health care reform

Can we maintain personal continuity?

Healthcare reform is high on the political agenda, and among the critical issues that have generated significant discussion are proposals for new models of general practice organisation.[1]

To help place these proposals in context, Bettering the Evaluation and Care of Health (BEACH) studies can be used to provide an overview of how Australian general practitioners structure their practices. Data from the 2008–2009 study indicated that the majority of participating GPs worked 6–10 sessions per week (78%) and most worked in practices of fewer than five full time equivalent GPs (60%).[2] More than half of the GPs' practices (55%) were involved in teaching students and/or registrars, 85% were accredited, and 68% employed a practice nurse.[2] Only 5% of GPs reported not using a computer for clinical purposes.[2] These figures demonstrate that while conscious of quality and teaching, Australian general practice tends to smaller scale models of service delivery and favours flexibility in working arrangements.

As Australian general practice is defined by a commitment to providing continuing, comprehensive, whole patient medical care,[3] it is worthwhile considering how new models of practice might impact on those qualities, in particular, continuity of care.

The comprehensive team model

There is concern in the policy arena that unless there are major structural reforms, our health system will be unable to meet the needs of an aging population and the increasing prevalence of chronic disease.[1,4] Hence the recent National Health and Hospitals Reform Commission (NHHRC) report emphasised strengthening primary care, particularly in the areas of preventive care and chronic disease management.[1] To achieve these aims, the NHHRC sees a far greater role for nursing and allied health worker involvement in primary care, and proposes the development of 'comprehensive primary health care centres' as vehicles for integrating general practice, nursing and allied health services.[1] Concurrently, a multidisciplinary clinic model has been promoted by the government itself, with the call for tenders to establish GP super clinics.[5]

The general assumptions underlying these approaches are that 'bigger is better',[6] and that by having workers from different disciplines under the one roof, multidisciplinary team care will eventuate. Co-location however does not necessarily create a team approach.[4] Experience from the United Kingdom suggests that there can be unintended consequences of large scale general practices including reduced patient satisfaction[7] and a reduction in personal continuity.[8] Personal continuity of care is known to have special value for vulnerable patient groups, including the elderly and those with chronic illnesses or psychological problems.[9–12] It would be counterproductive if, in trying to improve chronic disease management, the 'new general practice' caused alienation of these patients.

The personal team model

To enable multidisciplinary care while preserving personal continuity is challenging, however, a number of in-practice team models have been put forward. These models propose that large practices are organised around smaller teams,[8] at the core of which are a GP, practice nurse and receptionist.[13–16] Therefore it may be possible to retain personal continuity and recognition for patients within their personal team,[14] while achieving economies of scale and scope for multidisciplinary care. Integration with other health disciplines could occur as needed, either within the same facility or by external referral.

The personal team model may also promote vertically integrated medical education, where a team may include registrars as well as medical and nursing students. Cross discipline collaboration and training would be facilitated by this team structure. Cross referral of patients within the practice to teams with special expertise, or to vary clinical experiences for students and registrars, would add value to both patient care and teaching. Flexible working arrangements and a stimulating academic environment would encourage and support research activity. This model has been shown to have high long term patient acceptance in an academic teaching practice[13] and warrants further investigation in the Australian context.

Research is required to inform the size and structure of such teams, to balance needs for flexibility for the staff members, access for patients, and the preservation of personal continuity and recognition. A clinic based on this model would require thoughtfully designed architectural elements to enable it to work effectively. The appointment scheduling and medical records would need to be sophisticated and have robust IT support. Careful financial modelling would be required to ensure the financial viability of the practice.

In conclusion, striving for greater efficiency and effectiveness, it is vital that the interpersonal aspects of patient care are not neglected, and especially that vulnerable patient groups are protected from losing personal continuity with a GP. It is also important that the 'culture' of Australian general practice is taken into account in implementing new models of practice.[6] Adaptive solutions, such as the personal team model described, require consideration if Australia is to bring the best of traditional personalised general practice to modern multidisciplinary approaches.

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References

1. National Health and Hospitals Reform Commission. A healthier future for all Australians – final report of the National Health and Hospitals Reform Commission – June 2009. Canberra: Commonwealth of Australia, 2009. Available at www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/nhhrc-report [Accessed 30 September 2009].
2. Britt H, Miller GC, Charles J, et al. General practice activity in Australia, 2008–09. General practice series no. 25. Cat. No. GEP 25. Canberra: AIHW, 2009.
3. The Royal Australian College of General Practitioners. What is general practice? Melbourne, 2005. Available at www.racgp.org.au/whatisgeneralpractice [Accessed 12 August 2008].
4. Harris M, Kidd M, Snowdon T. New models of primary and community care to meet the challenges of chronic disease prevention and management: a discussion paper for NHHRC. Available at www.health.gov.au/internet/nhhrc/publishing.nsf/Content/16F7A93D8F578DB4CA2574D7001830E9/$File/New%20Models%20of%20Primary%20and%20Community%20Care%20Final%20(M%20Harris%20M%20Kidd%20T%20Snowden).pdf [Accessed 9 February 2010].
5. Department of Health and Ageing. GP superclinics. Canberra: Australian Government, 2008. Available at www.health.gov.au/internet/main/publishing.nsf/Content/pacd-gpsuperclinic-about [Accessed 12 November 2009].
6. Kidd MR. Bigger is not always better: what the National Health and Hospitals Reform Commission report means for general practice. Med J Aust 2009;191:448–9.
7. Baker R. Characteristics of practices, general practitioners and patients related to levels of patients' satisfaction with consultations. Br J Gen Pract 1996;46:601–5.
8. Guthrie B. Continuity in UK general practice: a multilevel model of patient, doctor and practice factors associated with patients seeing their usual doctor. Fam Pract 2002;19:496–9.
9. Nutting PA, Goodwin MA, Flocke SA, Zyzanski SJ, Stange KC. Continuity of primary care: to whom does it matter and when? Ann Fam Med 2003;1:149–55.
10. von Bultzingslowen I, Eliasson G, Sarvimaki A, Mattsson B, Hjortdahl P. Patients' views on interpersonal continuity in primary care: a sense of security based on four core foundations. Fam Pract 2006;23:210–9.
11. Ionescu-Ittu R, McCusker J, Ciampi A, et al. Continuity of primary care and emergency department utilization among elderly people. CMAJ 2007;177:1362–8.
12. Bayliss EA, Edwards AE, Steiner JF, Main DS. Processes of care desired by elderly patients with multimorbidities. Fam Pract 2008;25:287–93.
13. Brown JB, Dickie I, Brown L, Biehn J. Long-term attendance at a family practice teaching unit. Qualitative study of patients' views. Can Fam Physician 1997;43:901–6.
14. Baker R. Will the future GP remain a personal doctor? Br J Gen Pract 1997;47:831–3.
15. Australian General Practice Network. Primary health care position statement 2009. Canberra: AGPN, 2009. Available at www.agpn.com.au/__data/assets/pdf_file/0020/16274/20090402_pos_AGPN-PHC-Position-Statement-2009-FINAL-Graphic-Designed.pdf [Accessed 3 February 2009].
16. Waine C. The primary care team. Br J Gen Pract 1992;42:498–9.

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