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Changes to general practice

■ In September 2008, the Federal Minister for Health and Ageing, Nicola Roxon, announced plans to change delivery of primary health care in Australia. Ms Roxon suggested that general practitioners should 'relinquish some of the work that could be safely done by other health professionals'.¹ The New South Wales Australian Medical Association President immediately responded by saying 'any fragmentation of primary health care to other allied health workers will mean diminution of care for patients'.¹ Any suggestion of change to general practice service provision in Australia seems to be met with scepticism and negativity from the medical profession. Yet if we examine Ms Roxon's proposals in detail, we find they are neither revolutionary nor likely to compromise patient safety.

Ms Roxon believes GPs need to embrace complex care;¹ other health professionals can and should deal with minor illnesses and injuries, aspects of health promotion and disease prevention. Moreover, the simpler aspects of general practice could be managed by practice nurses (PNs) and/or nurse practitioners (NPs), who have more intensive training. This latter role appears to strike particular fear into the heart of doctors who worry that the patient-doctor relationship is at risk. Nurse practitioner only clinics have been suggested² but are unlikely to meet the needs of all patients. However, we believe from experience and research^{3,4} that the best new model of care is GPs, NPs, PNs and other health professionals working collaboratively, not in competition. After all, GPs have been referring to other colleagues, such as dietitians and physiotherapists, for decades.

The coming generations of doctors are unwilling to work in the way of their GP forebears. Interviews with medical students, registrars and GPs in Australia⁵ and Canada show they are looking for flexibility, lifestyle choice and team based care. Many do not want to manage the business side of general practice and are excited by the diversity in the health care services they are able to offer. Some feel a change from fee-for-service to alternative funding plans will allow them greater freedom to manage patients, delegate tasks and collaborate in team activities.⁵

Between us, the authors have worked in Britain, Australia and Canada; countries with a strong tradition of family medicine and a commitment to the provision of generalist care. Each has tackled

problems in primary health care delivery differently, and the three systems have advantages and disadvantages.

We recommend that Australian general practice looks at new models of care. Ontario is currently piloting family health teams (FHTs) as a new model of health care delivery. These teams are funded by the ministry which pays the doctors a salary with some bonus payments and remuneration for team collaboration time. The FHT usually includes a NP, PN, and perhaps a pharmacist and dietician. The team is usually co-located, with regular case discussions between all involved. Patients can choose to see a doctor or NP/PN, and the doctor and NP can refer to each other during consultations. Experience in the UK indicates that patients will choose a GP or NP depending on the problem and are able to discriminate between the roles.⁶

Our ongoing research and experience suggests that when medical students spend time both in practices staffed solely by doctors (sometimes single handed) and those where the team ethos is strong, they almost always state a preference for the team based model.

The discussion paper 'Towards a national primary health care strategy' published by the Department of Health and Ageing in October 2008, contains many references to what it refers to as 'multidisciplinary teams'.⁷ Team based care that draws on the skills and scope of other health professionals may be the way forward. It will allow GPs to have special interests while still offering a generalist service for a proportion of their work and most importantly, enhance patient care.

References

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