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Health care reform: can we maintain personal continuity?

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Abstract

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.

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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 satisfaction⁷ 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 practice¹³ 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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