What is the place of general practice within primary health care – in the Aotearoa New Zealand context?

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To respond to the question *'What is the place of general practice within primary health care – in the Aotearoa New Zealand context?'* it is useful to make several essential distinctions. The first is the distinction between the general practitioner (GP) and general practice; a distinction that has evolved and then accelerated in the last 30 years.

In the early part of the last century, nearly all doctors were generalists.[1] The values of generalist medical practice, buried for a time in the burgeoning of specialist medical practice and secondary care, re-emerged mid-century as the vocational discipline of family medicine or general practice. In contrast to secondary care specialists, general practitioners deliver generalist medical care by purposefully engaging with patients as people over time,[2-4] and developing professional–patient relationships as an important framework for health care delivery.[1,3,5] This holistic approach places value on *'knowing the individual as a whole person,'*[5] and recognises the context of that individual within home, family, and community. Complex clinical problem-solving and decision-making skills are underpinned by principles of evidence-based practice wherever possible, but also depend on principles of values-based practice,[6] where patients' values, including family health beliefs and attitudes to life, are also an essential part of patient care. In the New Zealand context, this most importantly includes an appreciation and increasing understanding of complementary concepts of cultural awareness, safety and competence.[7]

In contrast, the general practice has become a place (both real and virtual) of comprehensive health service, where individual patients not only present for episodic care and ongoing clinical management, but also access preventive care, health education, and other services. A general practice must consider the health of its practice population, and many general practices have grown to become highly organised providers of primary care health services. Thirty years of extensive nursing contribution, larger group practices, the more recent but rapid evolution of information technology, and organisations such as Independent Practitioner Associations (IPAs), Primary Health Organisations (PHOs) and Management Service Organisations (MSOs), with new funding structures, have been key factors responsible for differentiating the vocational or clinical work of the general practitioner from the health care business of a general practice.

Whatever one thinks now about the original rationale for introducing the practice nurse subsidy in the 1970s,[8] it brought a nursing workforce and nursing perspectives into general practice in a way not previously seen, and today there are at least as many nurses working in general practices as there are doctors.[9-11] Experienced practice nurses have increasingly complex roles and skills as generalist nurses, not only undertaking a wide range of tasks such as vaccination, wound dressings and cervical smears, but also consulting with patients, making acute assessments and providing management of chronic conditions alongside general practitioners. Many have excellent telephone consulting skills and undertake triage duties on a daily basis.

Increasingly, comprehensive general practice health services are extending generalist nursing and medi-

cal care beyond the individual and immediate family to the wider community and small populations of people,[12,13] beyond individual health problems to health promotion and health maintenance at a community level. This level of 'organised general practice' requires a wide range of professional and managerial skills to deliver the comprehensive, co-ordinated, first-contact health care over time that is the hallmark of good primary care.[14]

The distinctions between 'organised general practice', primary care, and primary health care, now become important.

'Primary health care' aims to achieve much more than the 'absence of illness'. It was formally defined in 1978 in the Alma-Ata Declaration by the World Health Organization[15] to encapsulate the importance of accessibility, comprehensiveness, coordination and continuity of health care for all, underpinned by principles of social justice and equality, self-responsibility, international solidarity, and acceptance of a broad concept of health.[16] Health systems that incorporate all or most of these principles have come to be known internationally as primary care–led systems, and such systems have now been repeatedly shown to provide better care, and better health outcomes, at lower cost, than secondary care–dominated systems.[17]

The more focused term 'primary care' has come to mean the delivery of comprehensive health care services within a primary health care framework. Excellent, organised general practice in New Zealand ably delivers many primary care services. Within an effective PHO framework committed to reducing health inequalities, and engaging with the community, excellent general practice provides primary care that is consistent with, but not nearly as wide-ranging as, all of comprehensive primary health care. Comprehensive primary health care, with its continued emphasis on health for all citizens, is only achievable when primary care–led health systems are integrated with primary care–led housing, welfare, justice and economic policy.[18]

Achieving primary health care aims within primary care health services

Organised general practice can take many forms. General practitioners in New Zealand now work effectively in a variety of funding and business models; owning a practice is no longer the only way to work as a general practitioner. GPs now work in practices that may be all-staff-salaried, GP-owned, GP or nurse-owned, nurse-led, community-owned, trust-owned or even DHB-owned; new configurations continue to emerge. Regardless of ownership type, within a well-organised general practice with excellent practice management, striking the balance between the continuing demands of immediate individual episodic care and ongoing comprehensive care is a challenge, but possible to achieve if there is time set aside for development of an agreed strategic plan, involving all staff, regardless of their role. Such a strategic plan is a core requirement for successful practice accreditation via the College's CORNERSTONE process.[19]

The most frequently cited barrier to more easily achieving comprehensive care for a practice population is the complexity of current funding for primary care

The culture of the practice is the other vital ingredient for effective implementation of any comprehensive health care plan. When all ideas are valued, changes are evaluated, and leadership is inclusive and the principles of good teamwork followed,[20,21] best care for patients and practice populations can be achieved and good employees and employers will be recruited and retained.

The most frequently cited barrier to more easily achieving comprehensive care for a practice population is the complexity of current funding for primary care. Even though the population-based funding model introduced in 2001 as part of New Zealand's primary health care strategy[22] has assisted practices to make best use of their particular doctor–nurse–manager–other staff skill-mix, a significant proportion of funding is still fee-for-service and task-based, time consuming and complicated to access. The associated administrative burden does little to foster innovative thinking or encourage strategic planning at a local level.

Nevertheless, despite these limitations, there are excellent general practices in New Zealand today that can and do deliver many aspects of excellent primary care, drawing on the skills of a range of health professionals to provide first-contact care with the health system that is coordinated, comprehensive and continues over time, and consistent with the overarching principles of primary health care articulated at Alma-Ata.

Within good general practices, there are excellent general practitioners who have a unique skill-set to contribute to primary care. This skill-set is complementary to, but not the same as, those of excellent practice and primary care nurses, just as it is complementary to, but not the same as, that of pharmacists and other primary health care professionals also working in the community. When these skill-sets work seamlessly together, a patient-care team is created that is much more than the sum of the parts.[23]

As in the United Kingdom, the Netherlands, and the Scandinavian countries, the incorporation of the vocational work of GPs into well-organised primary care–led health teams and health systems has fostered a shift from primary medical care toward primary health care; a change in focus from illness and cure to health and illness-prevention; from episodic care of specific problems to health promotion and continuous, more comprehensive care.

But where to from here?

There is, however, a way to go to achieve fully collaborative practice that is universal in New Zealand primary care settings. Funding that is more flexible, simpler to administer and specifically supports the workforce as well as the clinical service, would do much to enable practices to use funding innovatively for their own local situation.

The work of practice nurses needs to be made much more visible, acknowledged and affirmed publically and professionally. The old practice nurse subsidy scheme has left a legacy of invisibility within and beyond the health professions; it is time practice nurses had due recognition, not only of their unique skill set but also of their undisputed and essential place in primary care teams in general practices, on clinical governance groups and in PHOs.

Well-trained practice managers also need to be recognised as fully-fledged health professionals in primary care. The practice management function is vital to the success of any health care business, and general practices are no exception.

Finally, continuing professional development (CPD) for all primary care professionals needs much more active support. Just as for secondary care health professionals, good quality CPD needs to be undertaken beyond the immediate workplace in an on-going basis. There is a recognised need to provide training to work in teams. Inter-professional education can do much to accomplish this, when health workers from different professional disciplines come together with a common goal and learn with, from and about each other.[24]

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