New freedoms, new responsibilities
By General Practitioner Council Chair Dr Kate Baddock

[This article was originally published in NZ Doctor, April 2012]

When you have been around general practice for a few decades it is worth looking back and seeing whether we can recognise where we came from and see where we are heading. We began (in my memory at least) with a Section 51 – an agreement between each general practitioner and the Department of Health for services rendered to a third party i.e. patients. This was then superseded by Section 88, which was slightly more contractual in flavour but still agreed a patient subsidy for service given (fee for service). Section 88 remained in place until the development of the Primary Health Care Strategy and the shift to capitated funding through Primary Healthcare Organisations (PHOs).

At this stage the contractual environment changed. Not only did we move from a fee for service between the GP and the Dept of Health, but also to a contract between the PHO and the general practice that largely reflected (in back to back contracts) the PHO Contract between the PHO and the District Health Board (DHB). The direct monetary contract between the Dept of Health and the GP evolved into a service contract between General Practice and the PHO. General Practice now takes the risk and the responsibility of the contract – not the individual GP, and with increasing non-GP ownership of general practice and more salaried models of employment the GP has been freed from monetary concerns. This has enabled these GPs to focus on the clinical concerns of the patient.

Community pharmacy has traditionally been paid also for a fee for service – known as the dispensing fee. There are moves to consider a change to this funding model and develop a package of services that would then be funded through the Community Pharmacy Contract. The Pharmacy Guild has been negotiating this contract – this organisation advocates for the business owners of pharmacies. Sounds a bit like general practice doesn’t it? We – pharmacists and GPs – would be funded for care to identified groups of patients, negotiated by the business owners of pharmacies and general practices who may not be clinicians themselves.

Are we both in danger of losing control over what we do? Or have we been freed by the business constraints to act clinically in the patients’ best interests? And if that is so, how may we best do this? I think that it is absolutely vital that we (pharmacists and GPs) work together for the benefit of the patient.

But the patient needs a medical home – a place where they see themselves belonging and where they come for issues to do with their health. All members of the primary care team need to be linked into the medical home – either physically or by enabling technology that allows integration to be the lynchpin of care. We do ourselves, and our patients, no service by acting in isolation, thinking that in doing so we are serving their best interests. The patient needs us to work together and in doing so, develop the reality of the medical home.

Integrated Family Health Care Centres are one way of looking at the medical home, but integration is a way of working together that puts the patient at the centre. All of us who are clinicians, believe this is what we do every day and in every consultation, but it is more than that – it is the way we work with other clinicians that supersedes our own
designs. And those clinicians are not just the doctors who work in hospital settings, or in community clinics, and not just the nurses who work with us in our medical centres or in peoples’ homes or as nurse practitioners, but also the pharmacists - and the physiotherapists, the podiatrists, the social workers, the counselors, the podiatrists, the opticians and the audiologists (to name but a few). Together – linked by desire and backed by technology – we can put the patient at the centre of the medical home and provide the very best of integrated care.