DIVISIONS OF GENERAL PRACTICE:

FUTURE DIRECTIONS

Government Response to the Report of the review of the role of Divisions of General Practice

April 2004

Foreword by the Minister for Health and Ageing

The Divisions of General Practice are "doctors working with doctors" to promote a "wellness culture" over an illness culture. The Divisions fill the gap between the Royal Australian College of General Practice (which sets standards of professional competence) and individual GPs (who make decisions about what's best for each patient). Divisions are involved in programs to enhance the quality of general practice and to promote community health (such as immunisation, optimal use of drugs and the provision of after hours care).

The Government believes that the development of the Divisions network has been one of the most important health innovations of the last decade. The Divisions, by and large, have done a very good job. But they're not perfect and even the best of them can learn from the experience of other Divisions. Hence the Review of Divisions of General Practice (The Phillips Review), and this Government Response.

The Phillips Review identified significant variation between Divisions, including differences in philosophy, resource capacities and a different approach to addressing local primary care needs. To ensure the community gains the maximum possible benefit from the Government's spending on the Divisions it is important to provide a response that clearly outlines the Government's objectives, priorities and expectations for the Divisions Network.

This Response to the Phillips Review is part of the Government's primary health care policy framework. It addresses the Division's primary care focus, role, membership, accountability and governance.

The Divisions network is a national infrastructure providing a mechanism to integrate various elements of the primary care system. As a local resource, the Government looks to Divisions to provide leadership, generate partnerships and build an organising framework that will maximise the community benefit from available health funding.

The Government's $2.8 billion *MedicarePlus* package is already yielding benefits for many Australians but is merely the latest in a series of steps that are helping to improve primary care across our country. It complements other initiatives that support the Government's strategic goals of: -

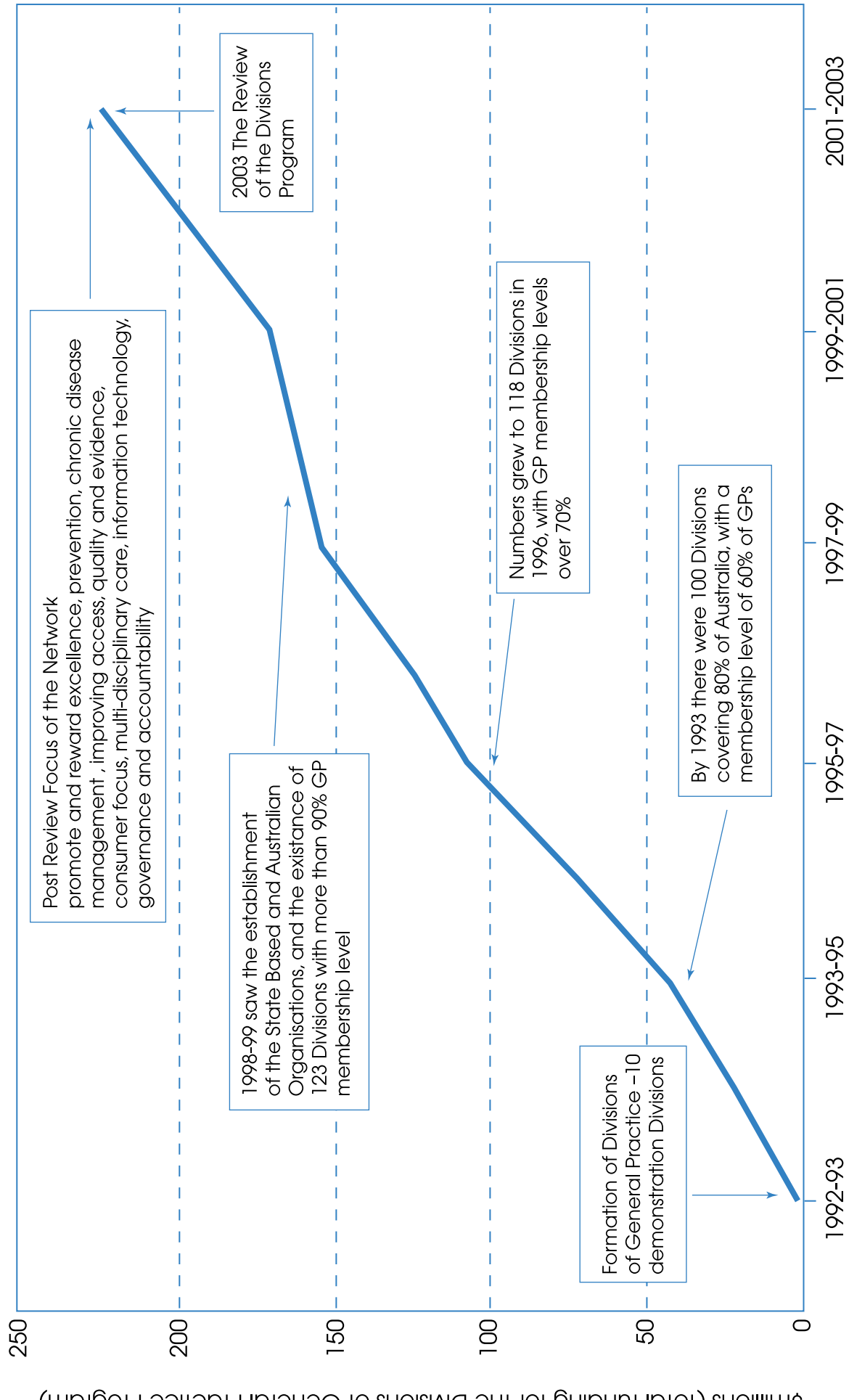
- making care more accessible;
- focusing on prevention and early intervention;
- encouraging better management of chronic disease;
- supporting integration and multi-disciplinary care;
- building the evidence base for effective, quality primary care;
- using technology to support best practice; and
- recognising and respecting the variety of practice styles.

The Phillips Review provides a platform to shape the role of the Divisions network in improving the health outcomes of the community. I invite Divisions and the ADGP to engage with the Government on the Review's recommendations and the Government Response.

I look forward to a continued productive engagement with the Divisions network to strive to develop a strong and sustainable primary care sector for all Australians.

The Hon Tony Abbott MP

EVOLUTION OF THE DIVISIONS



The Report at a glance

The Australian Government will work with the Divisions network and build on its existing strengths and achievements in order to advance primary care in Australia.

The Divisions network, with its local knowledge and connections, is positioned to play a vital role in strengthening our primary care system.

Divisions will be funded to:

- *Support GPs and general practices with a changing primary care environment*
  Divisions have a core role in working with GPs and their practices
- *Improve access*
  Divisions have a key role in improving access to health services for their communities, especially for high need population groups
- *Encourage integration and multi-disciplinary care*
  Divisions have a key role in encouraging team based approaches, building partnerships at the local level
- *Focus on prevention and early intervention*
  Divisions should look to encourage wellness, including identifying particular issues and risks for their local communities
- *Better manage chronic conditions*
  A priority for Divisions must be those with the greatest health need
- *Support quality and evidence based care*
  Divisions have a key role in encouraging quality and the adoption of evidence- based best practice in their local communities
- *Ensure a growing consumer focus*
  Divisions will be encouraged to work closely with consumers and local community organisations

Government will:

- Be clear in its expectations of Divisions, the State Based Organisations and the Australian Division of General Practice
- Reduce red tape by simplifying and streamlining contracts and reporting arrangements
- Provide greater financial certainty through four year funding contracts
- Provide high performing Divisions with performance funding, through a new funding pool as well as opportunities for greater flexibility in planning and reporting
- Expect and assist under performing Divisions to improve
- Support amalgamation and realignment of boundaries

Other features of the Report:

- New quality and performance system
- Core funding levels to be maintained
- New innovative funding pool building to $4m in 2006-07
- Improved governance and accountability arrangements

This report provides a strong foundation for the future growth of the Network. The various elements provide clarity of expectations and provide opportunities for Divisions to better meet the health needs of their community.

Chapter 1

Primary Care in Australia

Primary care is at the heart of Australia's health system. It is usually the first point of contact that people have with the health system and every year millions of Australians use primary care services. Good primary care can help people stay healthy, speed their recovery when they are sick, and ensure they get access to more specialised services if and when they need them. Good primary care is good for our people and good for our country.

Australia's primary care system works well, but there is always room for improvement. The Government's priorities are to strengthen primary care by:

- making care more accessible;
- focusing on prevention and early intervention;
- encouraging better management of chronic disease;
- supporting integration and multi-disciplinary care;
- building the evidence base for effective, quality primary care;
- using technology to support best practice; and
- recognising and respecting the variety of practice styles.

This section looks briefly at what the main challenges are, outlines some examples of the Government's achievements and sets out plans for the future, under each of the above headings.

1.1 Making Care More Accessible

Why is this a priority?

The Government is committed to ensuring that all Australians can access affordable, high quality primary care where and when they need it.

What's been achieved?

A significant investment in rural health services has seen growth in the numbers of GPs working in rural and remote areas. Initiatives to bolster GP numbers in under-serviced outer metropolitan areas have exceeded expectations. *MedicarePlus* is making it easier for GPs to choose to bulk bill children and concession card holders and is increasing our medical workforce.

Where next?

The Government is firmly committed to making further improvements in accessibility. The Government will continue to explore ways to allow nurses and allied health professionals to contribute to the delivery of specific services where they can appropriately do so. We will pursue opportunities to use information technology to overcome the tyranny of distance and isolation in remote communities. And we will maintain our efforts to work with both mainstream and indigenous service providers to address the health disparities that impact so negatively on Aboriginal and Torres Strait Islander people.

1.2 Focussing on prevention and early intervention

Why is this a priority?

Few people would argue with the view that prevention is better than cure. Prevention means helping people avoid illness. Early intervention means ensuring that signs and symptoms of disease are detected and treated early to avoid conditions deteriorating.

What's been achieved?

In the 2002-03 budget, the Government launched its F*ocus on Prevention* package. By doing so, it added a new fundamental pillar to Medicare which will ensure that prevention is better integrated into the health system as a whole and, in particular, that it is strongly embedded in primary health care. Data indicates GPs are undertaking more prevention for children and less treatment for 'traditional' childhood conditions.[1] Last year the Government also established a National Obesity Taskforce to look at ways of tackling the growing epidemic of overweight in our society. Through the National Health and Medical Research Council (NHMRC), we have developed clinical practice guidelines to support clinicians in their efforts to better mange overweight and obesity in adults and children. Divisions played a central role in raising immunisation rates for children at 12 months from shamefully low levels of 53 per cent to more than 90 per cent. Through initiatives such as Health*Insite* and Sharing Health Care we are supporting people to engage actively in managing their health and wellbeing.

Where next?

In encouraging prevention and early intervention, we need to find better ways to promote healthy lifestyles. We must remove any barriers that prevent people seeking medical assistance when they first need it. We must develop incentives that support GPs to keep their patients healthy rather than merely to see them when they are sick. We need to harness the energy and imagination of community groups to support and promote healthy lifestyles.

1.3 Encouraging better management of chronic disease

Why is this a priority?

It has been estimated that as much as 80 per cent of Australia's burden of disease can be attributed to chronic conditions. And that proportion will grow as our population ages.

People who live with a chronic disease cannot expect to be 'cured'. But a great deal can be done to minimise the impact of their disease and to prevent or delay its deterioration. Effective chronic disease management relies on regular and careful monitoring of the patient's condition and responses to treatment. That means people who have a chronic disease need to stay in contact with the health professionals who are looking after them.

1 Charles J, Pan Y, Britt H: Trends in childhood illness and treatment in Australian general practice, 1971-2001, *Medical Journal of Australia* 2004; 180(5): 216-219

What's been achieved?

The introduction of the Practice Incentives Program (PIP) chronic disease initiatives, Enhanced Primary Care (EPC) items, the aged care initiatives under *MedicarePlus* and other measures have encouraged GPs to better manage patients' chronic conditions. Such benefits are designed to complement the standard fee-for-service payments for general practice. The recently announced program of primary care collaboratives, with the Sharing Health Care initiative, will tap into the rich experience and ingenuity of our primary care professionals and community groups to devise new ways of supporting people with chronic diseases.

Where next?

The management of chronic disease needs to be further improved, and so we will continue to monitor the effectiveness of PIP, EPC and other measures as aids to better chronic disease management; and we will build on their strengths together with learnings from overseas to devise even more effective approaches in the years ahead.

1.4 Supporting integration and multi-disciplinary care

Why is this a priority?

Primary care has never been the exclusive preserve of GPs. Good primary care treats the whole person and takes account of the broader determinants of health. To do so, it needs to draw on the skills, knowledge and expertise of a wide range of professional disciplines.

What's been achieved?

The Government recognises that primary care is multi-faceted and values the contributions that health professionals other than GPs can make.

It has introduced grants to rural GPs who wish to employ a practice nurse or an allied health professional. It also pays pharmacists to carry out home medicines reviews and offers a great many Australians a rebate on private health insurance cover for services delivered by dentists, opticians and physiotherapists. Enhanced Primary Care items have been added to the Medicare schedule to reward team-based care.

Under *MedicarePlus* we have also provided new MBS items to cover wound management and immunisation services provided by a practice nurse 'for and on behalf of a GP'. This recognises the important role that nurses can play in GP practices and will free up valuable doctor time. The MBS will be extended to cover allied health practitioners, such as speech pathologists, podiatrists and physiotherapists, where GPs refer patients.

Where next?

We will continue to look for ways to encourage multi-disciplinary care wherever it can be shown to offer an appropriate and cost-effective way to meet patients' needs. People are looking for more variety and flexibility in how they access health services; and by encouraging multi-disciplinary care we will be doing more to improve services for people with chronic diseases. We need to work closely in partnership with states and territories and with health care professionals to improve the integration and coordination of care for those needing access to multiple providers and moving between different parts of the health system.

1.5 Building the evidence base for effective, quality primary care

Why is this a priority?

We place our trust in GPs and other primary care providers. We need to have confidence that the services they provide for us are safe, effective and reflect contemporary best practice. And yet we know that isn't always the case.

The need for action in this area is clear. For example:-

- There is compelling evidence that patients who receive antibiotics for a common cold do no better than those taking a placebo and have significantly more side effects and yet the common cold is still the second most common problem managed with antibiotics in Australian general practice.

- Cigarette smoking is the largest preventable cause of death and disease in Australia. About two out of three Australians who smoke let their GP know that they do so. But GPs only provide cessation advice or counselling to about half of them. What is more, these figures have remained virtually unchanged for the past 10 years.[2]

What's been achieved?

The Government has devoted significant sums of money in recent years to encourage evidence-based practice in primary care. Resources have been used both to build the evidence base on what works best and help turn evidence into practice. The results will be safer, more effective and more efficient services for us all.

To encourage evidence-based practice in primary care, the Government has invested over $12 million to set up and run the National Institute of Clinical Studies. A further investment of $15 million is going towards the establishment of the new Australian Primary Health Care Research Institute.

2 National Institute of Clinical Studies (2003), *Evidence-Practice GAPS Report Volume 1*, pages 2 & 16

Where next?

We will maintain our commitment to building knowledge about best practice in primary care, helping GPs and other professionals to access that knowledge, and devising new and more effective ways to ensure that evidence is translated into everyday practice. Promoting quality is equally important. While the work of the Safety and Quality Council has to date focussed primarily in the acute sector, it has also identified the need to broaden its focus to general practice. We will work with the Council to address issues of safety and quality in the primary care sector.

1.6 Using technology to support best practice

Why is this a priority?

New technologies mean that today's GP can access and share information, communicate with patients and colleagues, and work across time and distance to a degree that was once unimaginable. As a result of advances in diagnostic and treatment technologies, it is now possible to deliver services in a GP's surgery that previously required access to a hospital or pathology laboratory.

What's been achieved?

The Government's investment in *HealthConnect* and *MediConnect* is helping to chart the path for future developments in e-health. New spending in the *MedicarePlus* package will help more GPs to access the Health Insurance Commission's *HIC Online* service as well as supporting the roll-out of broadband access to more communities.

Where next?

We are committed to maintaining Australia's world-leading role in the use of technology to support effective and accessible primary care. In doing so, however, we will continue to emphasise the need for confidentiality, security and informed consent in the storage and handling of sensitive clinical information. We recognise that modern information technology offers exciting opportunities to improve the continuity of care for patients as well as ensuring that all health professionals can have access to comprehensive and up-to-date details of a patient's condition (with the patient's agreement of course).

We will work to define and deliver a clear and compelling vision for a truly modern primary health system that combines the benefits of new technology with the human face of highly skilled health professionals.

1.7 Recognising and respecting the variety of practice styles

Why is this a priority?

Australia's GPs and other primary care practitioners are rightly a treasured national asset. Many choose to operate as self-employed practitioners, often in partnership with professional colleagues. Others prefer the added security that comes with salaried employment. Some work full-time while others opt for part-time work so they can spend more time with their families or pursue other interests. Some choose to specialise in caring for children or elderly people, or to work to tackle the special needs of Aboriginal and Torres Strait Island people. Styles of practice differ, as do income expectations and approaches to practice management.

What's been achieved?

There is great diversity in primary care in Australia and that diversity is a source of strength. It fosters innovation and increases patient choice. It enables services to evolve in a host of different ways to reflect the social, cultural and geographic diversity of our nation. Australians would not accept a 'one size fits all' approach to primary care and the Government would never seek to impose it on them.

An immediate priority for the Government is to ensure that GPs, whatever their preferred approach to practice, are able to devote as much of their working day as possible to the delivery of care to patients. To that end, we set up a Red Tape Taskforce last year to look at ways of minimising unnecessary administrative burdens on GPs. The Government will ensure that efforts to minimise compliance costs and improve the communication flow to GPs are both continued and strengthened. Any opportunities to reduce or eliminate red tape will be pursued vigorously as they emerge.

Where next?

In looking to the future the Government is committed to maintaining a variety of general practice styles and to encouraging further innovation where it can deliver additional benefits. At the heart of the Government's thinking is the view that those GPs who wish to do so must be free to choose who they treat and to decide what they charge for their professional services. In such cases, access to bulk-billed services remains a matter to be decided between the doctor and his or her patient.

At the same time, there is a growing number of GPs who are keen to explore other approaches to the business of delivering primary care. Ideas such as salaried practice, capitation payments and limited fund holding for pharmaceuticals or diagnostic services, while by no means universally popular, appeal to some GPs. The Government will remain open to considering well formulated proposals for local innovation, possibly put forward by high performing Divisions, where they can be shown to benefit the community and are financially sustainable.

Chapter 2

Roles for Divisions

2.1 The changing nature of the Divisions Network

From a small start in 1991, the Divisions network now spans 120 regionally based Divisions across Australia, State-Based Organisations (SBOs) and the Australian Divisions of General Practice (ADGP). Ninety-five per cent of general practitioners are now members of Divisions; and there is one Division staff member for every 12 GPs[3]. SBOs and the ADGP support Divisions, at the state and territory, and national levels respectively.

Total Australian Government funding across the network in 2003-04 is $132 million, or about $9,400 per FTE GP. This demonstrates the Government's commitment to strengthening and securing the role of the general practitioner in the broad health system. However, taxpayers require the Government to be able to demonstrate a strong return on investment.

Divisions are diverse, partly reflecting the way they started, with significant local variations continuing today. They also vary according to their size, GP numbers, populations and funding. For example, the number of people served by each Division is between 17,051 and 583,486; and the number of full-time equivalent GPs in each Division is between 8 and 455[4].

The review of the role of Divisions undertaken by a panel chaired by the Honourable Ron Phillips found that there were significant differences in Divisions' focus and performance across Australia. The review identified areas where action is needed to ensure the Divisions network is well placed to make a significant contribution to the health of the Australian community. These action areas include the need for clearer goals, clarity of roles, increased accountability for outcomes and taxpayers funding, improved consistency of performance and governance across the network, greater alignment with state and territory health boundaries and an increased focus on the delivery of services.

The review provides a strong platform to help shape the role of the Divisions network for the foreseeable future.

2.2 Funding for outcomes

The Government provides substantial funding to Divisions as a means of achieving outcomes that are difficult to obtain through individual general practices operating in isolation. The focus of this funding is to assist general practice to provide services to the community within the context of a broader primary care system. The Government recognises the changing nature of the primary care system and has outlined the key priorities that need to be addressed to further improve health outcomes within the changing health environment.

The Divisions network has a key role in achieving important outcomes in each of the priority areas. Core funding should be used to advance these goals. In regions where the Division does not accept the platform, we will work with Divisions to explore alternate ways to achieve key priorities and ensure the community gains the best possible health outcomes as result of the work of the Division network.

3 Modra et al (2003) *Ten Years On: Results of the 2001-02 Annual Survey of Divisions of General Practice*, Primary Health Care Research and Information Service, page xx

4 Modra et al (2003) *Ten Years On: Results of the 2001-02 Annual Survey of Divisions of General Practice*, Primary Health Care Research and Information Service, pages 8 & 10

The Government agrees with the ADGP's identified priorities in the areas of Indigenous health, aged care, information management and information technology, workforce and governance.

2.3 Supporting general practice in a changing environment

Like all institutions, medicine is changing in a changing environment. This will continue. New health problems and risks emerge all the time. The health system has become more complex. There is an increasing concern with quality and safety. There are stronger expectations about corporate governance. Information technology is increasing in power and complexity. Consumers' expectations are also increasing.

Divisions can work with GPs and their practices to keep them attractive, viable, and rewarding through the changes now and those still to come. This support is about making general practice accessible for all so that health can be maintained and improved, and the job of the GP remains manageable and a worthwhile career. The Government recognises there will be many ways of making this happen that are dependent upon local conditions and needs.

Information management and technology is essential for modern general practice. Divisions are expected to help GPs and general practice manage change and keep up to date. They can play a key role in the provision of information to all practices and GPs. Many Divisions have already made huge gains in helping practices get computerised and computer literate. This effort needs to be sustained to build the capacity of general practice, assist in making general practice rewarding and sustainable, build linkages with other parts of the health system and contribute to improved chronic disease management.

Specific performance measures will be developed, but will include a means to report on action in the following areas:

— the use of data to assist to determine and address local health priorities;

— the identification of GP IT needs and development of strategies to address these needs; and

— number of practices that utilise IT systems for specific high value activities.

2.4 Improving access

The Divisions network is expected to play a key role in improving access to primary care services and in particular, general practice services. This is a critical role for those groups of the population where evidence shows access is not at appropriate levels: Indigenous peoples and older people living in residential care.

Indigenous health has received significant attention recently. The Government recognises that the effort must continue to ensure health gains are sustained. Some Divisions have done excellent work in this area. It is also pleasing that the ADGP has entered a Memorandum of Understanding with the National Aboriginal Community Controlled Health Organisation. This must now translate into making a difference in the delivery of general practice services.

Care for older people in our society is a major priority and should also be a core priority for Divisions. In particular, frail, older people in residential care often have complex and multiple

health conditions, especially in high level care. Coordination of care for these residents is essential and it is important for the GP to get involved as part of the care team. The Government will provide new funding under *MedicarePlus* to support Divisions to get better access to medical care for residents of aged care homes.

Australians need ready access to general practice and primary care more broadly. Therefore workforce planning and strategies are essential. Divisions should help recruit or retain doctors in areas of workforce shortage. Divisions need to be clear about where shortages are and how they can be addressed. They will be able to tell why their regions are attractive for general practice. They will be able to work with others to make general practice attractive, viable and rewarding.

The review notes there is a risk of duplication in workforce support (see recommendation 7). The Government notes this concern and will review the workforce activities of Rural Workforce Agencies and the Divisions network in 2004--05.

Specific measures will be developed, but will include a means to report on action such as:

- number of new health workers attracted to the region;
- workforce development with Overseas Trained Doctors;
- specific strategies to assist retention of doctors;
- succession strategies which demonstrate forward planning;
- strategies targeting the health needs of older people;
- the nature and extent of linkages with residential aged care facilities;
- the number of GPs participating in initiatives relating to the care of older people;
- strategies targeting the health needs of Indigenous people; and
- information and education to enable more appropriate models of care for Indigenous people and communities.

2.5 Encouraging integration and multi-disciplinary care

There is recognition that current health care practice at times focuses on episodic or transactional care, whereby a doctor deals with the specific most pressing concern of the next patient. This needs to be supplemented by strategies to promote a focus on the patient's entire health need, including the impacts of lifestyle factors.

Divisions need to work to better integrate GPs with other health services and professions to get better health results. This includes working with state and territory Governments to ensure greater integration across the health care system. It will also mean planning and implementing strategies for particular illnesses, such as chronic disease.

Through support for allied health workers and practice nurses, multidisciplinary teams can assist in this regard. Divisions are well placed to take a leadership role and identify and implement local strategies to enable a more comprehensive approach to health care.

Through development of strategic partnerships between general practice and community services, acute care and aged care, there will be more comprehensive care provided.

Specific measures will be developed, but will include a means to report on action in the following areas:

— the impact of linkages with other parts of the health systems, including hospitals, community care and aged care; and

— support for multidisciplinary care models.

2.6 Focus on prevention and early intervention

As local leaders, Divisions are increasingly helping improve the focus on wellness. They can identify risks to health and help people and the health system prevent illness. They can help local services identify disease early to help its treatment. They can encourage health assessments for those groups in the community most at risk and for which this Government has put in place new Medicare items. They can work with other local services to raise awareness of risk factors and promote prevention. Good Divisions are already getting involved in population health, using data and information to plan delivery and improve health. They are working on healthy ageing and on healthy families. They are also contributing to healthy schools and workplaces.

Specific measures will be developed, but will include a means to report on action such as:

— immunisation rates;

— prevention strategies that have been put in place; and

— use of data to promote forward planning and monitoring of progress on population health.

2.7 Improved chronic disease management

A priority for Divisions of General Practice should be helping those in the community with the greatest need. Those with a chronic illness fall into this group. Divisions are in a key position to undertake activities to support general practice to improve chronic disease management, such as:

- helping practices with information management systems that support better chronic disease care, such as register and recall/reminder systems and electronic patient records;
- linking GPs with allied health professionals and community organisations to provide self-management support for people with chronic conditions;
- helping GPs to keep up to date with latest evidence on chronic disease through continuing professional development activities;
- promoting quality in general practice through helping practices to gain and maintain accreditation, and assist GPs with clinical audits to improve the care provided for people with chronic conditions; and
- helping GPs, nurses and practice staff to work effectively as a team.

Specific measures will be developed, but will include a means to report on action in the following areas:

— specific strategies to promote comprehensive care for patients with chronic conditions, co-morbidities or with risk factors, and the impact of these strategies; and
— strategies to promote chronic condition self-management activities.

2.8 Supporting quality and evidence based care

It is essential that care practice be informed by evidence, and focussed on the needs of the individual patient and the broader communities that Divisions serve.

The Government supports evidence-based clinical care being identified as a priority by the network. Divisions are well placed to promote care that reflects changes in our understanding of best practice. This means assisting GPs and other professionals and services to improve their clinical care, updating it as new techniques and standards become available.

In addition to promoting clinical support systems and the promulgation of evidence-based best practice, Divisions have a strong role in assisting in the provision of quality health care.

Specific measures will be developed, but will include a means to report on action in the following areas:

— the promotion of evidence-based best practice in health care;
— use of clinical support systems by GPs;
— education opportunities provided to health professionals; and
— support for general practice accreditation.

2.9 Growing consumer focus

Divisions need to ensure they concentrate on the needs of their community and their patients. In planning where best to target their work and energies, Divisions need to have good consultative mechanisms in place to identify community needs and priorities and the best solutions to meet these. If the Divisions network is to have a more significant impact in primary care it will need to broaden its scope and integrate the views of consumers and their representatives and other primary care providers in the way it does business.

Specific measures will be developed, but will include a means to report on action in the following areas:

— the extent to which Divisional activity reflects demonstrated community priorities;
— community education and information strategies; and
— how the governance structures reflect the important role of consumers.

Many of the Divisions network are already undertaking excellent work within the identified Government priorities to strengthen primary care. Divisions are playing a key role to improve health outcomes within the changing primary care environment.

Mallee Division of General Practice

The Mallee Division of General Practice has demonstrated a sustained approach to increase consumer involvement in the work of the Division through a division-wide system of community focus groups. The community groups are solution focused when considering health issues facing their communities.

The groups elect a representative to a community reference group and the Division's board. This provides a supporting structure for the board representative with a path for community input.

In meeting the challenge to integrate consumer viewpoints at both strategic and operational levels, the Division has produced clear evidence of outcomes achieved by increased consumer involvement.

The Top End Division of General Practice

Sustainable outcomes are being achieved by the collaboration between GPs, Aboriginal elders and mental health workers, in the improved service delivery of mental health care in remote Aboriginal communities.

The Division's Aboriginal Mental Health Worker Program creates a close relationship between GPs and mental health workers through a 'ground up' approach to dealing with mental health problems. Qualified and supported indigenous health workers are placed in local mental health teams that are community-based and controlled, located in as many remote communities as possible. The Top End Division also employs two dedicated indigenous support staff to provide ongoing visits to GPs, clinic staff, community councils, Aboriginal elders and the mental health workers.

The cooperation has helped to improve mental health outcomes for indigenous people living in remote communities with indigenous workers providing early intervention and breaking down the stigma associated with mental health issues.

Riverina Division of General Practice

The establishment of the Primary Health Care Nurse program improves the access of local residents to a GP and improves the continuity of care provided.

The Division has appointed three full-time nurses to cover 12 small rural communities with populations of less than 1000 people. GP services have increased in these communities due to the guarantee of follow-up services and for the opportunity for another health worker to care for patients and be a point of contact for the doctor.

This 'healthy communities' model is an evidence-based approach which allows residents to have a major say in the provision of their needs and required support and has drawn praise from local councils and communities.

Chapter 3

What the Government will do to support this

The Government needs to change its relationship with the network. It needs to better set out its expectations. It needs to recognise the high performing Divisions and give them more flexibility to get on with the job. It also needs to work with Divisions who require improvement. It needs to continue encouraging high standards of the network, but also seek to streamline and improve its own requirements.

3.1 Clarity in its expectations

The review calls for the Government to be clear about its primary health care policy and the Divisions role in it. The Australian Government makes clear its objectives and priority areas for Divisions through this document.

The Government is clear in its expectations of the network: its role is to deliver services to general practice and local communities. However, the Government will continue to seek the views of the Divisions network on important policy areas.

The Government's vision for the network supports the themes of:

- changing approaches to health service delivery – improving primary care;
- providing new long term opportunities for Divisions; and
- promoting and supporting a culture of high performance, good governance and accountability.

3.2 Simplify contracts and reporting arrangements

The Government wants to reduce unnecessary red tape for Divisions. This means less monitoring of inputs and control of processes, and more measuring of outcomes, assessing value for money and rewarding performance. However, it is important that this is based on the highest standards of reporting and accountability.

It is acknowledged that the Department of Health and Ageing should be responsive to the needs of Divisions. To this end, the department will institute a more coordinated approach to contracts with members of the Divisions network. At present Divisions are required to report in different formats and to different timetables across a number of areas of the department. A single comprehensive reporting system will be developed, with a consolidated timetable for reporting.

There is now an opportunity for a fundamental shift in the relationship between the Australian Government and the Divisions network. For the network to operate more autonomously with simpler, broader funding streams, Divisions must ensure there is greater accountability for improved outcomes and stronger self-governance. The Government will work with Divisions of General Practice to focus on defining the outcomes expected from the funding provided rather than on detailed management of the funding and delivery of programs.

3.3 Provide greater financial certainty

The Government's vision for the future of Divisions must be realised within the current budget. Divisions will be expected to reconsider their business plans against the issues raised in this report.

The review recommended changes in funding, such as more funding certainty for Divisions and on how funding is distributed (see recommendations 29-34).

When thinking about funding, we must recognise as health needs change, the health system, the Government's approach and Divisions will also need to adapt. Divisions may need to consider re-directing existing resources to work on new problems.

Funding for Divisions will largely be determined by emerging priorities and the capacity of Divisions to meet these needs. While in the short-term core funding for the Divisions network will remain the same, this needs to be considered in light of new streams of additional funding for areas such as *MedicarePlus* aged care panels, mental health initiatives and nursing support.

To provide certainty, draft three-year agreements will be issued immediately. Under these agreements, funding for 2004-05 will remain at the same level as 2003-04.

These draft agreements will allow time to develop and consult on implementing the new arrangements. These new arrangements will be reflected in new funding agreements to be offered before July 2005. When accepted, they will replace the original agreements operating from 1 July 2004.

The review found the existing three-year funding agreements limit a Division in retaining expert staff and planning appropriately. The Government agrees that the Divisions network needs greater funding certainty before the current agreements end.

In the new funding agreements, a four-year contract cycle is proposed. Agreements can be considered for renewal after the third year. This will ensure that Divisions have 12 months warning of any changes so they can plan for the future more effectively and better manage their resources to achieve their plans.

The total amount of funding to the network will not change. However, as new activity will need to be supported and an innovations fund created, indexation on core grants will be shared – with half going to the recipients and half used to fund the high performance funding pool. Full annual indexation for organisations will start again in 2007-08.

The Government also agrees with the review that as further information becomes available on the burden of disease locally, this should be examined to see whether it should guide funding allocations.

In principle, the Government agrees with the review's argument and recommendations in this area. However, it is also recognised that this is complex and requires consultation and staged implementation. For example, using the Accessibility/Remoteness Index of Australia (ARIA) rather than the Rural, Remote & Metropolitan Areas (RRMA) classification means significant change. The changes however will be phased in over a period of time so that Divisions (both those gaining and losing) have time to plan and adjust.

3.4 Opportunities for high performing Divisions

Not all members of the network will be treated the same. Excellence will be rewarded with access to extra funding and greater flexibility, while assistance will be available to those with less capacity.

For Divisions that accept the challenge and demonstrate results, there will be new long-term opportunities. Greater flexibility, including the option for high performing Divisions to put fund holding options to Government. This will enable these Divisions to take a more strategic and long-term view to supporting general practice and to addressing the health needs of their communities.

In practical terms this means that high performing Divisions may have the opportunity to bid for additional funding to implement innovative options for service delivery in areas such as new models of care, multidisciplinary working approaches, innovations in information technology or community development.

A strong focus of evidence, evaluation and measurement will be required, and to assist in this regard, links with universities or other research bodies will be encouraged.

Further details on this are contained at Attachment B.

3.5 Dealing with underperformance

The Government is concerned to ensure all Divisions become high performers and that the communities they serve can expect a consistently high standard of service.

High performing Divisions that receive additional funding will be expected to undertake a developmental role within the Network. This may include a formal peer or mentor support mechanism. A key expectation of SBOs and the ADGP is that they will work with Divisions to lift overall performance.

The review recommended a rolling audit program. To ensure that such an arrangement assists with improving performance the Government will introduce a rolling review program. This will not only look to see that public funding has been utilised appropriately, but that it has been used effectively to improve health outcomes in the community.

3.6 Size and boundary alignment of Divisions

The Government also supports the review's view that each Division's size should be based on whether it can effectively and efficiently operate. Divisions need a 'critical mass' of population and general practitioner numbers for what is expected of them. The review also argues that Divisions' boundaries should be aligned with state or territory health boundaries (see recommendation 17-19), thus helping planning and integration across the health system and across lines of Government.

The Government will introduce the following measures to facilitate appropriate amalgamations and alignment of boundaries to state/territory health regions:

- funding will become available for business case development to amalgamate or re-align boundaries;
- where Divisions amalgamate, the second flagfall component of funding will be available for several years for associated amalgamation costs;
- SBOs will be asked to help and support amalgamations, realignments and other means to improve the effectiveness of individual Divisions; and
- meetings will be organised between state and territory health departments, SBOs, relevant Divisions and the Department of Health and Ageing to discuss how the Divisions network can better be aligned to join up the primary care programs of the Australian Government and state and territory Governments.

It is possible that Divisions which face challenges because of size or non-alignment with state health regional boundaries may overcome these challenges through linkages, co-location and partnership arrangements with other Divisions. However, where this does not occur and the performance of the Division is compromised, its assessment against the performance system will be affected.

3.7 Role of SBOs and ADGP

Funding for the SBOs and the ADGP is provided to achieve outcomes beyond the scope of individual Divisions and to increase the effectiveness of the network overall.

The Government is clear in its expectations of the network: its primary role is to deliver services to general practice and the community within established policy settings. Roles and responsibilities of different parts of the network should be clear. Divisions are at the front line of the network, the actual deliverers. They need to be effectively supported, both by the relevant peak organisations within the network and by Government. The roles the Government expects each of the parts of the network to play is outlined at Attachment A.

Chapter 4

Accountability for the public funding provided

4.1 Performance management

The review found that while most Divisions are delivering appropriate services to their communities, Divisions' performance is not consistent. The review also recommends the Australian Government establish a new, national performance system for the Divisions network (see recommendation 11). The Government agrees that a new system is needed.

The performance system now in place is sound, but needs improvement. For example, it has only limited capacity to work out which Divisions are performing well and which are struggling. There is also little information to show that Divisions are giving value for money for public funding. Therefore, to improve performance, we need better information.

The new quality and performance system will be made up of:

- national performance indicators;
- a rolling review process;
- financial accountability;
- a quality system with standards;
- peer review;
- rewarding high performers (including through a performance funding pool); and
- promoting best practice and peer support.

The performance indicators need to cover the objectives of the network. Indicators should answer the following questions:

How has the Division, SBO or ADGP ensured their work reflects the needs of their community and encouraged a greater consumer focus?

How has the Division, SBO or ADGP improved the capacity of general practice?

How has the Division, SBO or ADGP made general practice services more accessible?

Has the Division, SBO or ADGP linked different parts of the health system to get improvements?

How has the Division, SBO or ADGP improved population health?

How has the Division, SBO or ADGP improved chronic disease management?

How has the Division, SBO or ADGP assisted general practice with quality programs and evidence-based practice?

The new system will be introduced progressively, and the Government will consult in its development.

This new system means we can reward high performers and work on under performance, with the aim of getting all Divisions up to a high standard. It will also mean there is better information on how Divisions are making a difference in the health system.

4.2 Strong governance and accountability

Good governance arrangements are desirable for all organisations, public or private. The Government will support Divisions in strengthening their governance arrangements, including organisational structures, clarity over roles and responsibilities, lines of accountability and authority, legislative and financial compliance.

A Division that purports to represent its community needs a governance structure and vision that reflects its community needs and interests.

Divisions need a complete primary care focus – one that acknowledges the role of the consumer and takes into consideration comprehensive health care from prevention through to treatment. This means broadening their membership if they are to be local leaders in primary care.

The Review recommended that a position be mandated for at least one community representative with full voting rights on every Division board (see recommendation 23). The Government supports the need for Divisions to establish models of community engagement that may include broader membership on Division Boards. It means Divisions can:

- open themselves to community view and accountability; and
- improve how their board manages their responsibilities.

Boards also need business expertise – including those with legal or accounting knowledge. This will increase the skills of the board officers. Representatives from state and territory health services will also help Divisions and SBOs link up with the broader health system.

With stronger governance, along with an effective strategic, business and operational planning framework in place, the Government (and other funders) can have greater confidence in the capacity of Divisions in the development of new and innovative programs.

The Government acknowledges that Divisions are independent bodies, and the GP's they serve are also independent. However, the amount of funding provided to the Divisions Network is considerable. We will work closely with Divisions to ensure the appropriate administrative arrangements are in place to ensure efficient, effective and ethical use of taxpayer's funds.

The Government will take the following steps to improve governance and accountability:

- provide the Divisions network with governance and financial management protocols;
- expect adherence to protocols, once they are established, as a condition of funding; and
- implement a performance system with indicators on governance and good financial and program management.

Chapter 5

Conclusion

The Australian health system is the envy of many nations. If we get sick, we have a high quality health care system to care for us. But more can be done. We must always seek to improve and update our structures and systems of care. We need innovation and partnerships between all levels of Government, industry, health professionals and the Australian people.

Divisions can be local leaders and champions of change. Many Divisions have already demonstrated their ability to meet the needs of their communities. The Government aims to help Divisions to broaden their expertise through sharing of good practice and successful innovative programs. In this way, excellence can be spread throughout the Network, and the benefits of good practice applied across communities.

By giving the Government confidence in the network, Divisions can improve their position as means of first choice in implementing new programs and major changes.

Where we can the Government will co-operate with Divisions to lessen the administrative red tape. It will look to streamline and simplify contractual and reporting processes.

To take this Response forward, the Government will establish and chair an Implementation Reference Group to guide future strategies. This group will have a broad membership from both the Divisions network and the wider primary care system. Consultation and responsiveness will be a key part of this process.

Divisions of General Practice: Future Directions sets out a vision for the future. It also sets out future strategies for both the network and Government in working together to implement this vision.

Attachments

A - Specific roles for each member of the network

B - Performance and Quality System for Divisions

C – The Way Forward: Implementation

D – Government Response to Review Recommendations

Attachment A: The specific roles for each member of the network

(a) Divisions

The focus of the Divisions should be to assist general practice to provide services to the community in a primary care system. They are funded to achieve improved health outcomes in the key priority areas identified by Government in this document. They will do this through a range of activities, including:

- supporting general practices with information, improving capacity (for example, workforce support, and IT and management systems), getting a better focus on population health (for example, reducing health inequalities), and improving quality (for example, through education and accreditation);
- planning and working across the Divisions network on workforce issues and improving access, and getting better integration across professions and services;
- providing a regional infrastructure for the roll-out of specific or targeted initiatives;
- collecting local data for policy, program and service development, as well as supporting research and evaluation; and
- helping local communities to understand what services are available and how best to access them.

(b) State Based Organisations

The SBOs dual roles are to build the capacity of Divisions to achieve expected outcomes and to link with State Governments and other agencies to achieve health integration at the state level. These roles will involve a range of activities, including:

- identifying and promoting best practice and knowledge sharing at the state and territory level (for example, by encouraging a stronger evidence-base for Divisions' work, or using population health data);
- supporting individual Divisions in performance and quality improvement; and
- encouraging amalgamations and realignment of Division boundaries where this means Divisions can become more effective.

(c) Australian Divisions of General Practice

The Australian Divisions of General Practice (ADGP) is funded to provide national leadership and governance to generate a strong and effective Divisions network and to link with the Australian Government and national organisations to strengthen the Australian primary care system.

This includes the key activities around oversight of quality management systems and governance.

Attachment B – Quality and Performance System for Divisions

This document outlines the concepts of the new quality and performance system for the Divisions network. Further development and implementation of the system will involve broad consultation with the network.

There are several reasons for a new quality and performance system. There has been a lack of clarity regarding Government expectations of members of the Divisions network. A quality and performance system will enable Divisions to measure their progress and guide decision making about future programs.

One of the major problems with current arrangements for funding and support of the network is the diversity of roles and functions performed by Divisions. A quality and performance system will assist to differentiate between high performing Divisions and those who are less effective. It will signpost those Divisions that require additional support, or encouragement to change.

Performance indicators

The review recommended that there needed to be a set of national key performance indicators that the entire Divisions network be required to meet (see page 41).

The performance system, including national indicators, will be included in the new four year contracts to be offered before July 2005.

At first, indicators may need to be more about processes and outputs, but over time the Government will work with Divisions in developing indicators that focus more on health outcomes.

National indicators will be supplemented with extra indicators on local priorities, developed by Divisions.

Rolling reviews

The review recommended the establishment of a new performance framework, underpinned by a process of rolling audits (see recommendation 11). While the Government accepts the general thrust of this recommendation, it is proposed to conduct reviews to consider performance more broadly, such as whether an organisation is efficient, effective, appropriate or responsive.

For example, general practice education is the most used method for Divisions' health programs. A review can explain why this is most used and whether other approaches are more effective.

Reviews will be done by an independent organisation and start in 2005-06. Early reviews will be available upon request. All Divisions should be reviewed within a two-three year period, with future reviews completed in a regular cycle. Those Divisions found to have the most or more pressing issues will be reviewed again sooner.

The first reviews will look at existing planning, reporting, contractual and service delivery arrangements and how these arrangements meet primary care needs. Results from these first reviews will help develop the quality and performance system over time.

SBOs will be expected to share findings and knowledge from reviews with Divisions in their state and territory and with the interested public. The department will monitor how review findings are being implemented. If needed, SBOs may need to work with individual Divisions to improve their performance.

Financial accountability and reporting

The review notes that fund providers need to be confident that funds are managed well (see page 53). Financial accountability is an essential part of any performance system.

The network now has significant flexibility in how funding is used. This means Divisions can get on with the job and meet local needs. However, the Australian Government also needs to understand better how much funding is used for different purposes. For this reason, Divisions, SBOs and ADGP will be asked about expenditure details in their reporting.

The Government requires separate, transparent holding of the funds it provides. This must be shown through audited statements. The department also needs to retain its right to undertake an independent financial audit where there are financial concerns.

A quality system with standards

A quality system, with standards, is essential. The review notes that ADGP is developing a quality system with standards (see pages 42-43). The Government has asked the ADGP to treat this with priority. Its implementation will be covered by future funding contracts with ADGP.

Standards need to cover financial management, human resources, community consultation, leadership and continuous improvement.

Accreditation with the quality system is not required for funding until the system is fully implemented (expected by 2008). In the meantime, each member of the network is expected to use continuous quality improvement, starting with self-assessment, then using peer assessment, before finally moving to external accreditation.

Divisions which want to be recognised as high performers (with access to extra funding - see below) may want to be externally accredited before it becomes a requirement of funding.

Peer review

Peer review is a good way to develop a culture of quality. By getting involved in peer review, a service can learn not only about its own organisation, but also about others.

A panel will undertake a peer review. The panel will consist of people experienced in the Divisions network. Government will resource this activity. The panel will:

- work with the department to develop the method of assessment;
- consider review findings, reports of performance, financial reports and quality improvement or accreditation status to determine the relative performance of each Division; and
- undertake an overall analysis of the review findings for the network and Government.

Rewarding high performers, promoting best practice and peer support

The review recommends introducing 'earned autonomy' to reward strong performance (see page 42).

The network and its members now already enjoy significant autonomy, as independent organisations. Reporting for core funding (Outcomes Based Funding) is a minimum for Government requirements. However, because Divisions get multiple funding streams, reporting can become burdensome. Therefore, the Government will streamline its reporting arrangements across its programs.

In addition, for Divisions assessed as high performing, there will be access to increased flexibility in planning and reporting requirements.

The Government wants to reward high performers and promote best practice. The Government also wants to lift the standard of Divisions generally. Therefore, the Government will create a high performance fund for evidence-based excellence in primary care. Divisions can access the fund on a competitive basis, and only if they are assessed as high-performers by peer review.

These high performers would need to take a developmental role. For example, a strong Division might mentor a struggling Division. Funding will also be targeted at high priority areas in primary care. New approaches to service delivery could also be tested. Alternatively, approaches that already work could be developed or promoted.

Applicants to the funding pool must show:

- evidence for their proposal (from research or experience);
- a partnership approach, involving those players who need to be involved;
- a plan for evaluation;
- how they can share knowledge within the network;
- how they can mentor other Divisions on best practice; and
- how the proposal can be taken forward by the Division and the network.

The fund, starting in 2005-06, will have a discrete budget drawn from partially redirecting indexation. The peer review panel will assess applications and make recommendations to the Government. The review argued more work is needed in best practice in working with the Aboriginal community controlled health sector to improve health services and outcomes (see recommendation 13). This will be a priority for the fund's first year.

High performing Divisions may also have access to other program funding.

Divisions, depending on their performance, will be managed differently by the department. This applies across planning, funding, reporting, and monitoring. Table 1 shows how.

Table 1: Treatment according to performance

Assessed performance	Planning	Reporting	Monitoring and Support	Funding
High	Yearly advice of strategic directions and annual plans	Annual report, including requirements of all DoHA funding	Regular independent review as part of the rolling review process By invitation, participate as a member of or provide advice to the peer review panel Provide support to other Divisions	Access to additional funds for evidence-based excellence in primary care, including guiding low-performing Divisions in best practice
Medium	Strategic and annual plans submitted to the department for approval	Annual report including reporting requirements for all DoHA funding, submitted to the department for approval	Regular independent review as part of the rolling review process	Work in partnership with high performing Divisions to implement best practice
Low	Strategic and annual plans submitted to the department for approval	Six-month and 12 month reports, submitted to the department for approval. Annual update to Peer Review Panel on progress made to address performance concerns	More frequent independent reviews Regular monitoring by department state/territory staff Case management by SBO Guided by high performing Divisions to implement best practice	Funding contracts may contain additional conditions Where necessary, specific purpose audits to address any concerns about financial management

Some Divisions use research, evaluation and review. However, the review found this is not true of all Divisions. Good intentions are not enough; an evidence-base is also required, wherever possible.

The Primary Health Care Research and Information Service helps the network with evidence and research, providing information on the whole network, and primary care research.

The Government also wants more links between Divisions and university departments of general practice and rural health. The Government expects each network member to have a major evaluation partner to help with planning, assessing health needs, continuous improvement and an evidence-base for Divisions' work.

Finally, the new Australian Primary Health Care Research Institute has yet to establish its priorities for research. The Government would expect, however, some of its future work to involve the Divisions network and the evaluation and research of its innovative service delivery models.

Attachment C – The Way Forward: Implementation

Table 2 sets out a proposed timeframe. Projected times may be subject to change following consultation with the Divisions network.

Table 2: Implementation Timeframe

Activity	Timeframe
Review Implementation Reference Group	
Reference Group formed	May 2004
Duration of Reference Group	May 2004 – March 2005
Funding Arrangements and Contracts	
Advice of funding and contracts for 2004-2005 to 2006-07	April 2004
Consultation for future years funding; for example, transition arrangements to new funding formula	May -November 2004
New contracts offered	By early 2005
Performance Framework	
Development of framework including outcomes and indicators	May – November 2004
Advice of framework, outcomes and indicators	Within the new contracts to be offered by early 2005
Peer Review Panel	
Establishment of Peer Review Panel	2005
Commencement of peer performance assessments	2005-2006
Quality System	
Development of system and standards	2004-2005
Self – assessment against standards	2005-2006
Peer Assessment	2006-2008
Accreditation	2008-2009
Review program	
Establishment and consultation on system	2004-2005
Pilot reviews commence	2005
Full program of Rolling Reviews commence	July 2006
High Performance Fund	
Mechanism, guidelines and funding established in consultation	2004-2005
Funding available for specific proposals	2005-06
Applications to performance fund linked to performance assessment	2006-07
Reporting System	
Detail for new contracts developed in consultation	May – November 2004
Final requirements	Within the new contracts to be offered by early 2005
Encouraging amalgamations and alignment of boundaries	
Guidelines for funding for developing a business case	Consultation May – June 2004
Final guidelines disseminated	July 2004
Applications for funding for business case	July 2004- June 2006

Attachment D – Government Response to Review Recommendations

	Recommendation	Action
Chapter 5 – Primary Health Care		
1	That the Commonwealth gives priority to the development of a national primary health care policy and implementation framework and that the Divisions network be centrally involved in its development.	The Australian Government reaffirms its policy directions around primary care. The Government's expectations of the Divisions network as part of this have been outlined clearly in *Divisions of General Practice: Future Directions.*
2	That the national primary health care policy and implementation framework form the basis for discussions between the Commonwealth and the states and territories in order to achieve a more seamless national approach to primary health care.	As above
3	That the national primary health care policy and implementation framework allow Divisions to tailor strategies to meet local and regional health needs and priorities.	The performance system will include clear objectives but will allow each member of the Divisions network some flexibility in how these objectives are met to suit local conditions.
4	That Divisions of General Practice be required to undertake a stronger and more consistent role in primary health care, leading to better health status for all Australians, and that they do this by focusing on general practitioners and general practices in a whole-of-practice context.	Government expectations have been outlined clearly in *Divisions of General Practice: Future Directions*. Divisions will remain principally about general practice, but include a stronger focus on primary care.
Chapter 6 – Core Roles of Divisions		
5	That the scope of consultations on Primary Health Care Research, Evaluation and Development (PHC RED) research priorities be expanded to ensure the meaningful involvement of both the Divisions network and Indigenous health representatives in time for its use in determining PHC RED research priorities for the next National Health and Medical Research Council (NHMRC) research grants funding round.	The research activities of the NHMRC are researcher driven. However, the department will ensure the views of the Divisions network and Indigenous health representatives are sought in future priority-setting processes under PHC RED.

	Recommendation	Action
6	That formal collaboration be required between the new Primary Health Care Research Institute (PHCRI) and members of the Divisions network in order to improve the level of evidence-based rigour in reviews of Divisions' activities, and to find ways of ensuring that the review results are used to monitor and develop the role of Divisions.	The Government expects more rigorous evaluation of Divisional activity. The Government would expect some of the future work of the new Australian Primary Health Care Research Institute would involve the Divisions network and the evaluation and research of their innovative service delivery models.
7	That the roles of Rural Workforce Agencies and the Divisions network in relation to workforce activities be reviewed, including consideration of amalgamations between the Divisions network and Rural Workforce Agencies.	The Government will review the workforce activities of Rural Workforce Agencies and the Divisions network in 2004-05.
8	That to assist in the further and future identification of general practitioner workforce issues, a formal collaboration be established between the Divisions network and the Australian Medical Workforce Advisory Committee (AMWAC).	The Government supports more work between the Divisions network and AMWAC. The Government also supports the network, led by ADGP with SBOs, collecting and transmitting relevant information to AMWAC.
9	That all Divisions be required to undertake activities in relation to their core roles, focusing in particular on: • population health including the reduction of health inequalities • accreditation of general practices • education • research, evaluation and development • workforce support, and • information management and information technology. Specific national key performance indicators should monitor these activities.	The Government's expectations of Divisions for the public funding provided have been outlined in this document. The department will develop national performance indicators, in consultation. Indicators will become more sophisticated over time with experience and improved data availability and changes in the broader primary care system.
10	That the current stated aim of the Divisions of General Practice Program be reviewed to reflect the recommendations in this report. The aims of the Divisions of General Practice Program and the Divisions network should be consistent.	The aim of the program has been reviewed to more adequately reflect the Government's expectations and is covered in *Divisions of General Practice: Future Directions.*

	Recommendation	Action
Chapter 7 – In Pursuit of Quality and Performance		
11	That a national performance system be established by the Commonwealth, in consultation with the Divisions network, to include: • national key performance indicators for all organisations in the Divisions network • the flexibility to add additional performance indicators for local priorities • a system of rolling audits for all organisations in the Divisions network • the 'earned autonomy' concept to reward strong performance • arrangements for managing under-performance, and • if appropriate, the quality framework of the Australian Divisions of General Practice (ADGP), including standards, and an accreditation system based on those standards.	A new performance system will be developed and covered in contracts for the Divisions network. The system includes rolling reviews. Strong performance will be rewarded, with access to extra funding on a competitive basis and increased flexibility in reporting and planning. Poor performance will result in restricted flexibility in reporting and planning. The ADGP and SBOs also have a role in increasing the consistency and performance across the network. The ADGP will be expected to develop and implement a quality system.
12	That the national performance system for the Divisions network be developed and implemented as a high priority, and in time to be included in new funding agreements from 1 July 2004.	The new performance system will be incorporated in new contracts to be offered by early 2005.
Chapter 8 - The Role of Divisions in Improving Indigenous Health		
13	That the Commonwealth fund a consortium to identify models of best practice for ways in which the Divisions network and the Aboriginal community controlled health sector can engage and work together in order to improve health services and health outcomes for Aboriginal and Torres Strait Islander peoples. That the consortium includes appropriate Divisions of General Practice and Aboriginal Community Controlled Health Services.	As part of the performance system, extra funding will be available to high performing Divisions for specific projects. Best practice to improve health outcomes for Aboriginal and Torres Strait Islander peoples will be a priority for this additional funding. The ADGP and SBOs have a role in identifying good practice and encouraging wider adoption.

	Recommendation	Action
14	That the Department of Health and Ageing agree with the Divisions network and the Aboriginal community controlled health sector to a set of expectations for effective engagement between the two sectors, at each of the national, state and territory, and local levels. This set of expectations should be expressed as a common performance indicator in the Department's respective funding agreements with organisations in each sector.	The Government expects all levels of the Divisions network to be working effectively with the Aboriginal community controlled health sector. A specific indicator will be included in the performance system.
15	That a national framework be developed that defines and promotes culturally sensitive and safe 'mainstream' general practices and includes resource materials for Divisions. There must be active Indigenous engagement in the development, local delivery and evaluation of this framework.	Improving access to mainstream GP services for Aboriginal and Torres Strait Islanders will be a performance measure. Divisions will also need to demonstrate they are directing adequate resources to this area consistent with local demographics.
16	That Divisions support the provision of quality multi-disciplinary approaches to care for Aboriginal and Torres Strait Islander peoples by 'mainstream' general practices.	As above.
Chapter 10 – Size and Boundary Alignment of Divisions		
17	That each Division urgently review its size and its alignment to state and territory health region boundaries, with the following criteria in mind: • its capacity to develop the key characteristics and core roles of a well functioning Division and a stronger focus on Indigenous health (see Chapters 4, 5, 6 and 8) • its capacity to achieve the national key performance indicators (when available) (see Chapter 7), and • its demonstrated ability to work effectively with state and territory health authorities. That all Divisions then negotiate with neighbouring Divisions in order to reach agreement about necessary changes.	Divisions will be encouraged to review their size and boundary alignment. Those Divisions wishing to pursue change will be able to apply for additional funding. This will include funding to develop a business case and flexible treatment of flagfall payments in the initial years after amalgamation. SBOs will be asked to help support amalgamations, realignments and other means to improve the effectiveness of individual Divisions.

	Recommendation	Action
18	That the arrangements for managing under-performance in the Divisions network, to be developed as part of the national performance system, include provision for changes to the size and boundary alignments for under-performing Divisions.	Where size and boundary alignments are considered to be contributing to under-performance, a review of the Division's boundaries will be required.
19	That those Divisions deciding to pursue size and boundary changes with funding implications for the Commonwealth be required to submit a business case to the Department of Health and Ageing for approval. This business case should cover: • justification of how the changes will achieve the best possible configuration of the Divisions involved, given the criteria in Recommendation 17 • any processes necessary for achieving the changes, such as extraordinary meetings of members, and the timeframe for these processes • a budget outlining details of: – any expected one-off costs to the Division/s arising from the changes – any expected longer-term costs to the Division/s arising from the changes, if applicable – any expected savings from the changes, both time-limited and ongoing, and • a request for one-off funding to assist in meeting the costs of implementing the changes, if justified by the identified costs and savings.	Funding will be available in 2004-05 and 2005-06 to meet costs of amalgamations and boundary changes. Guidelines for this will be developed.
Chapter 11 – Membership and Governance		
20	That all Divisions be required to demonstrate how they are actively engaging with practice staff other than general practitioners. This could be achieved by broadening the membership of Divisions, or through other structures or strategies. The Panel further recommends that a national key performance indicator be established to monitor the active engagement of Divisions with all practice staff.	A performance indicator will be in the performance system.

	Recommendation	Action
21	That all Divisions be responsible for offering support and services to all general practitioners and practices in their catchment areas, and for sending them essential public health information regardless of whether or not the general practitioners are recognised as Division members.	This requirement will be in contracts and is part of what Government expects of Divisions.
22	That membership of Divisions be determined by an annual written application process.	The ADGP will be asked to develop a generic membership application for use by Divisions.
23	That a position be mandated for at least one community representative with full voting rights on every Division board, and further: • that each Division follow an open, fair and transparent process for the appointment of a community representative • that the Australian Divisions of General Practice (ADGP) produce guidelines and best practice models to facilitate the involvement of community representatives as members of Division boards, including training and support requirements, and • that a national key performance indicator be established to ensure the inclusion of community representatives on the boards of the Divisions network.	The quality system will cover governance. The ADGP will develop a policy and guidelines to improve board representation. The ADGP and SBO will be asked to strengthen leadership and governance of Divisions. The work program of Divisions should demonstrably reflect the local community's health priorities.
24	That national key performance indicators be established to ensure the maintenance of good governance and high-quality governance training for all board members of organisations in the Divisions network.	Governance will be covered by performance indicators.
Chapter 12 – Structure and Roles of SBO`s and the ADGP		
25	That the Divisions network implements a 'hub and spoke' structure to ensure a more formal membership and governance relationship between the Australian Divisions of General Practice (ADGP), the State Based Organisations (SBOs) and Divisions.	The Government expects the Divisions network to structure itself to efficiently and effectively meet the aim of the program and the expectations of Government in return for public funding.

	Recommendation	Action
26	That the role of the Australian Divisions of General Practice (ADGP) be to act as the national peak body for the Divisions network, including: • leadership, representation and advocacy for the Divisions network at the national level • policy development, strategic planning and program development at the national level, in association with relevant stakeholders and peers • negotiating with the Commonwealth Australian Government on matters affecting the Divisions network • managing standards and quality issues for the Divisions network, and • promoting communication and the sharing of information and resources within the Divisions network and with other national organisations.	These and further roles (as detailed in the Government Response) will be reflected in the funding agreement between the department and the ADGP.
27	That the role of State Based Organisations (SBOs) focus on leading, representing and supporting Divisions at the state and territory level, in particular: • providing program support and services to Divisions • facilitating linkages and the flow of information between Divisions and the Australian Divisions of General Practice (ADGP), and between Divisions and other relevant organisations such as the Primary Health Care Research and Information Service (PHCRIS), and • developing networks and relationships with key stakeholders at the state and territory level.	These roles will be covered in the funding agreement between the department and the SBOs. The Government sees SBOs as engaging state and territory health departments to achieve greater integration and coordination in the delivery of care to achieve better health outcomes; and building capacity and performance of Divisions.
28	That the Commonwealth, the Australian Divisions of General Practice (ADGP), State-Based Organisations (SBOs) and Divisions adopt the structure and roles outlined in Recommendations 25–27, with the detailed arrangements to be discussed further and agreed by all parties prior to the next round of funding agreements, due from 1 July 2004.	See above.

	Recommendation	Action
Chapter 13 – Funding		
29	That the Panel recommends that the general thrust of the recommendations of the *Report of the review of the Outcomes Based Funding formula for Divisions of General Practice* (June 2002), by the Divisions Standing Committee of the General Practice Partnership Advisory Council, be implemented.	The Government agrees that the Outcomes Based Funding formula should be structured so it reflects the characteristics of the Divisions' catchment populations.
30	That a revised Outcomes–Based Funding formula direct resources to Divisions with greater levels of health inequality, and modelling of the proposed revised Outcomes Based Funding formula be undertaken to test whether this redirection of funding is achieved.	See above.
31	That the Commonwealth examine national burden-of-disease data (when available) to determine its applicability in a future Outcomes Based Funding formula.	The department will examine this data when it is available and consider how it applies to funding.
32	That the Commonwealth, as the major funder of the Divisions network: • be clear about the objectives, priorities and outcomes for its funding to the Divisions network, and • consider fewer, broader and simpler funding streams to the Divisions network.	The Government's objectives and priorities for the Divisions network are set out in *Divisions of General Practice: Future Directions.* The department will ensure that these are covered in the contracts and performance system. The Government will provide fewer and broader funding streams, subject to funding appropriation requirements.
33	That all funders of the Divisions network be required to ensure that administration and overhead costs relevant to the purposes of their specific funding can be met from the allocation that they provide, and not from individual Divisions' Outcomes Based Funding allocations.	Government funding must not be diverted for purposes other than for what is was intended. It will be a requirement under the new contracts that Government funding is audited separately. Rolling reviews will also ensure public funding has been used for appropriate purposes.

	Recommendation	Action
34	That the Commonwealth investigates the possible introduction of a rolling triennial funding cycle for the Divisions network. If a rolling triennial funding cycle is not possible for the Divisions network, that the Commonwealth explore other options for ensuring greater certainty in relation to future funding to the Divisions network.	The Government will provide greater surety of funding through new four year contracts to be offered before July 2005. Renewal of contracts will be offered after three years, allowing 12 months advance notice of changes.
Chapter 14 – Reporting		
35	That a common planning and reporting framework covering all major Commonwealth funding streams to the Divisions network be developed for inclusion in new funding agreements from 1 July 2004.	The department will ensure that the planning and reporting requirements it expects of Divisions are as streamlined as possible but within the constraints of individual funding appropriations.
36	That documents required under the common planning and reporting framework for the Divisions network: • be linked in time with completion of the Annual Survey of Divisions • continue to be submitted electronically to a national independent body for collation, analysis and feedback to the Divisions network, and • be publicly accessible via the Internet.	The department will work to: • develop an efficient and user-friendly mechanism for the electronic collection of data on Divisions' activities, and • ensure ready access, via the Internet, to the data obtained from Divisions.