



A VISION FOR DIVISIONS OF GENERAL PRACTICE TO 2007: DIVISIONS POLICY PAPER

DRAFT 2

1. EXECUTIVE SUMMARY

- 1.1. The “Vision for Divisions” Strategic Summit in July 2002 was the first step to developing a vision and understanding of the new horizons for the Divisions Network over the next five years. Over 280 representatives from 113 Divisions and seven State Based Organisations participated in two days of vigorous discussion on where general practice and Divisions would be in 2007, and sought to find a common direction and purpose for the Divisions Network over the next five years.
- 1.2. The vision for the Divisions Network is underpinned by five key principles¹ underlining the centrality of general practice to the health system, and based on the values of generalism, whole patient care, equity and collaboration. Divisions must retain the flexibility to be sensitive and responsive to the needs of their communities, and base their work on primary health care principles.
- 1.3. The Network provides a well-developed structure for policy development, integration and service delivery at national, State/Territory and local levels. The Divisions have been a powerful tool in assisting general practice to deal with the pressures of a continually changing health care environment. The future vision includes enhanced support for practice staff, business systems, information management and technology and an extended community service role, to ensure effective support of general practice.
- 1.4. This paper has conceptualised the future work of Divisions occurring across three levels within the health system. The first tier of work occurs at the level of the individual general practitioner and general practice. The second tier encompasses networks of practices inclusive of GPs, practice nurses, allied health professionals, practice managers and other staff. At the third tier, Divisions will be interacting with a range of community based health services, as well as supporting the interface between general practice and the hospital sector.
- 1.5. The vision for Tier One is that Divisions will build capacity to ensure robust general practices with well supported general practitioners and practice staff providing quality care to their practice populations. This will be achieved through providing GPs and practices with:

⇒ Professional support;

¹ Refer to section 2.4, p. 3.

- ⇒ Business and practice management support;
- ⇒ Information management advice and support; and
- ⇒ Support for general practice teams.

1.6. Tier Two envisages local practice networks that support quality, access and efficiency, linking primary care teams through:

- ⇒ Local cooperatives;
- ⇒ Resource management networks; and
- ⇒ Networks for continuing professional development.

1.7. At Tier Three, Divisions will provide a hub for the integration of general practice and primary care services at a regional level, and support infrastructures that enable primary care workforce planning and management across the continuum of care. This will involve strong partnerships with consumers and community stakeholders, including health services involved in delivering care to Indigenous populations.

1.8. Underpinning these activities will be a strong, unified Divisions Network, with clarity of purpose and flexibility in how the vision is translated into action at the local level. It will play a significant role in influencing health policy and advocating for general practice in the local, State/Territory and national arenas, and will play an increasing role in supporting primary and secondary care management and delivery. To achieve this, the Divisions Network will be instrumental in engaging grassroots general practitioners and consumers in the development of primary care policy that is responsive to local needs and contributes to the overall goal of better health outcomes for all Australians.

1.9. To drive the vision forward, this paper suggests that in addition to extended consultation among the Network on realigning the national structure, ADGP should establish a National Divisions and Primary Care Taskforce to develop a practical, focussed, five year workplan.

2. INTRODUCTION

- 2.1. The “Vision for Divisions” Strategic Summit in July 2002 was the first step to developing a vision and understanding of the new horizons for the Divisions Network over the next five years. After ten years since the inception of Divisions, it is timely to consider the future of the Divisions Network and reach a shared vision of how it will continue to contribute to primary care delivery in Australia.
- 2.2. The strategies, processes, structure and governance arrangements necessary to achieve the agreed vision will be determined as part of an extended consultation process with Divisions, SBOs, grassroots general practitioners and other stakeholders. A further Summit is planned for 2003 to discuss the recommendations of the Review of Divisions, and to consider structural and constitutional arrangements in order to maximise the Network’s effectiveness, based on its agreed roles and functions at national, State/Territory and local levels.
- 2.3. This paper has been developed with input from the 2002 Summit participants, SBOs and Divisions, and will provide guidance to the Network, its stakeholders and funders on the future goals and directions for Divisions of General Practice.
- 2.4. Importantly, the vision for the Divisions Network is underpinned by the following key principles:
 - 2.4.1. General practice has a central role in the health system and as the first point of contact for most consumers is the appropriate setting to manage health care.
 - 2.4.2. The values of general practice – that care is high quality, general, continuous, comprehensive, coordinated, collaborative and family and community-oriented² - and the importance of primary care to health outcomes and health system efficiency, are central to all Divisional activities.
 - 2.4.3. A well-coordinated health system with an emphasis on primary care provides optimal care for the community³.
 - 2.4.4. Divisions are sensitive and responsive to the needs of their local communities.
 - 2.4.5. Divisions recognise the international primary health care principles⁴ of self reliance, consumer and community participation, inter-sectoral

² WHO (1998), *Framework for Professional and Administrative Development of General Practice/ Family Medicine in Europe*, <http://www.euro.who.int/document/e58474.pdf>, accessed 19/12/02.

³ Starfield, B (2002), presentation to Royal New Zealand College of General Practitioners national conference, September 2002.

⁴ World Health Organisation Regional Office for Europe, *Primary Care*, <http://www.euro.who.int/eprise/main/WHO/Progs/PHC/Home>, accessed 19/12/02.

collaboration, integration of health services, special attention to high risk and disadvantaged groups, and the use of appropriate technology.

3. NEW VISION NEW HORIZONS

“General practice stands at a professional crossroads. There are various forks in the road ahead, and the signposting isn’t terribly clear, but arguing to remain in the same spot and not move on, doesn’t seem a sensible option.”⁵

- 3.1. The Divisions of General Practice Network encompasses the Australian Divisions of General Practice Ltd. (ADGP), eight State Based Organisations (SBOs) and the 121 Divisions of General Practice across Australia. Over the last ten years, the Divisions Network has developed into a significant force providing representation and support for general practice. Ninety-four percent of GPs are members of a Division, making the Divisions Network the largest representative body for general practice in Australia.
- 3.2. The Network provides a well-developed structure for policy development, integration and service delivery at national, State/Territory and local levels⁶. With increasing pressure on general practice to expand its role with limited resources, it is essential that there is unity and agreement by the Network on our vision for the future, in order to be in a position to work more efficiently and effectively for the benefit of our members and the broader community. Agreement is particularly important in an environment where there is no nationally articulated overarching Primary Care Policy.
- 3.3. General practice is part of a continually changing health care environment and faces increasing pressure to adapt, maintain quality of care and contribute to improved population health. It has faced an increasing burden of regulatory and bureaucratic controls, which have devalued general practitioner time and led to low GP morale. The Divisions have been a powerful tool in assisting general practice to deal with these pressures. Over the last ten years the Divisions Network has been building its capacity and skills to proactively pave the way for the future of general practice and primary care.
- 3.4. The importance of the primary care sector in health has been the subject of much international research. There is increasing evidence to indicate that a strong integrated primary care sector has a direct impact on health outcomes, health status and improved cost effectiveness^{7,8}. General practice provides front line services in the primary care system⁹, offering comprehensive,

⁵ Doctors Reform Society (2001), *New Doctor*, Issue 74: 2000-2001; *McAvoy Models of Primary Health Care*.

⁶ Harris, M; Powell Davies, PG (2000), “Integration between GPs, Hospitals and Community Health Services” in Department of Health and Aged Care (2000), *General Practice in Australia 2000*: Canberra.

⁷ Starfield, B (1995), Health Systems effects on health status – financing vs the organization of services, *American Journal of Public Health*, 85(10), pp. 1350-1351.

⁸ Department of Health and Children (2002), *Quality and Fairness; A Health System for You*, Ireland.

⁹ University of NSW; University of Melbourne; Julie McDonald & Associates (2001), *The Role of General Practice in Strengthening Primary Health Care*, Commonwealth of Australia: Canberra.

continuing and preventive care. It is consequently targeted in health policy for delivering, coordinating and integrating primary care. Australia has a strong infrastructure within general practice on which to build an integrated primary care system, however we lack the range of multidisciplinary resources that is often available overseas, such as in the UK¹⁰.

- 3.5. To date, health care provision in the primary care sector has been fragmented, with general practice, community health services, Indigenous health services, non-government organisations and emergency departments working separately from each other with different funding, reporting and institutional arrangements¹¹. This has held the sector back from providing comprehensive primary care and from playing a stronger role in redressing the imbalance of resourcing between community and hospital based care. In order to achieve substantial change and better outcomes, the Commonwealth and State/Territory Governments must acknowledge their responsibility for this fragmentation and take steps to reduce the siloed approach to service delivery.
- 3.6. The role of general practice is expanding. It is envisaged that in the future this role will encompass a range of activities including:
 - 3.6.1. Episodic care – nursing or other clinical assistants, including culturally appropriate health workers where necessary, will provide front line triage, with the GP working more in a consulting role;
 - 3.6.2. Chronic and complex care – there will be an increasing focus on care for patients with chronic and complex needs; this will be facilitated by enrolment of patients with the practice and sophisticated information management systems that support effective, secure electronic health communication networks;
 - 3.6.3. Acute primary care – through the expanded capacity of team based care, GPs and general practice will provide care at the interface with hospitals; hospital in the home and step down services will be more widespread, with greater involvement of community-based services;
 - 3.6.4. Health management – general practice will provide the setting for teams, including specialist practice nurses and allied health professionals, to deliver comprehensive health services including health promotion/health education, patient self-management support, group clinics, e-health and telemedicine;
 - 3.6.5. Networks/chapters – GPs and clinical practice staff will be engaged in continuing professional development (CPD), case review, benchmarking, practice infrastructure development (management, HR, IT), and collection and analysis of population health data at the practice and Divisional level.

¹⁰ *Op cit*

¹¹ Powell Davies, P.G; Harris, M.F; Comino, E; Bolton, P; Fridgant, Y; Betbeder-Matibet, L; Mira, M; MacDonald, J (1997), *Integration of general practitioners with hospitals and community health services: summary report*, Centre for General Practice Integration Studies, School of Community Medicine; UNSW: Sydney.

- 3.7. The role of the Divisions Network in this environment is of utmost importance. Since the outset, Divisions have recognised that to effectively support general practice the entire setting needs to be included. Practice staff, business systems, information management and technology and an extended community service role are all part of the future vision. International reforms have provided examples of future opportunities for general practice and the Divisions in dealing with issues such as the ageing population and increasing chronic and complex needs. These include:
- 3.7.1. Expanding and building the capacity of the primary care workforce;
 - 3.7.2. Strengthening the primary care focus (e.g. prevention and early intervention, community participation, understanding and taking into account the social determinants of health);
 - 3.7.3. Supporting multidisciplinary teams;
 - 3.7.4. Establishing linkages with community based services;
 - 3.7.5. Interfacing with secondary and tertiary services; and
 - 3.7.6. Responding to changing consumer expectations and technologies.
- 3.8. Divisions will play an increasingly important role as the “third arm” of the health system, acting at the interface between the Commonwealth and State/Territory systems, and between hospital and community-based services. Divisions will need to be appropriately resourced to build their capacity to provide support or in some areas take responsibility for the management, control and delivery of primary care services and for the adoption of population health approaches in primary care.

4. A FRAMEWORK FOR CHANGE

- 4.1. This paper has conceptualised the future work of Divisions occurring across three levels within the health system. The first tier of work occurs at the level of the individual general practitioner and general practice, and includes the provision of support to:
- 4.1.1. GPs in their work, careers and profession; and
 - 4.1.2. General practices, through structured support for business and management systems, communications infrastructure, practice teams, quality improvement and population health approaches.
- 4.2. Divisions will also engage in activities that span groups of practices, coordinating multidisciplinary and intra-disciplinary networks of GPs, practice nurses, allied health professionals, practice managers and other staff. These networks represent the focus of the second tier of Divisional activity.
- 4.3. At the third tier, Divisions will be interacting with a range of community-based health services including aged care services, as well as supporting the interface between general practice and the hospital sector. They will facilitate community liaison and input into all areas of activity. A strong, integrated

primary care system, with links to secondary and tertiary services, will be underpinned by effective electronic information systems that provide timely, accurate information to inform both service delivery and planning at the regional level.

5. THREE TIERS OF DIVISION CORE BUSINESS IN 2007

5.1. Tier One - Practice and GP Support

The Vision: Divisions will foster robust general practices with well supported general practitioners and practice staff providing quality care to their practice populations.

- 5.1.1. In 2007 there will be a diversity of general practice business and ownership models, including solo GP practices supported by a range of professionals, practices with multiple GPs, practices linked through virtual amalgamation, direct employment of primary care teams by Divisions through population-based contractual arrangements, and practices owned by State/Territory and local governments, Aboriginal Community Controlled Health Organisations and private corporations.
- 5.1.2. In supporting general practitioners to work within a team environment, with extensive interactions with the broader health system and under a flexible financing system, a key role of Divisions will be fostering GP wellbeing, quality of life and career mobility.
- 5.1.3. Divisions will have a key role in supporting practices with the personnel, information and financing management systems necessary for providing high quality care. In some areas, this may be in a sub-contracting or hands-on operational role. Divisions will assist practices to develop strong business management systems and a sustainable and a comprehensive financing platform for the primary care team, encompassing governance, quality improvement, risk, financial planning, insurance, HR, contract negotiation and resource management.

Professional support to GPs

- 5.1.4. Division support for GPs will cover areas such as:
 - ⇒ training in clinical and business skills;
 - ⇒ providing the structure to allow a range of professional roles including: maintaining generalist clinical work; acting as team leaders and health managers within the practice; expanding their skills in specific areas of primary care; providing sessional work in other clinical settings; taking on a health promotion role; working within the Division's structure in various roles such as CEO, medical director, program manager; and undertaking research and/or pursuing an academic career¹²; and

¹² Ward, Lopez and Kamien (2000), General Practice Research in Australia, *MJA*, 2000; 173: 608-611.

- ⇒ assisting GPs to follow a long term career path with the capacity to practice in different geographical settings and work to a career and retirement plan.

General practice business support

5.1.5. In 2007 general practices will have a solid financial/business base from which to provide high quality health care to their practice populations. Divisions will assist general practices to optimise their business capacity by:

- ⇒ assisting in the development of business cases;
- ⇒ developing general practice business models and supporting GPs to gain the skills they need to implement them; and
- ⇒ offering direct business support including practice management, employment of staff, and IM/IT advice, based on GP demand for such services.

5.1.6. In 2007 general practice will have comprehensive risk management approaches in place including coordinated continuous quality improvement and risk management programs. This will be essential in a more litigious society and with the additional responsibilities of managing a primary care team. Divisions will assist practices to meet these demands through:

- ⇒ providing relevant professional development;
- ⇒ conducting and supporting quality driven small group learning, by facilitating groups and providing the data and evidence base for discussion¹³;
- ⇒ providing links with academic institutions; and
- ⇒ identifying and promoting continuous quality improvement approaches to general practice that encompass both clinical and organisational dimensions.

Information management support and systems advice

5.1.7. In 2007 general practice will use automated systems to manage a variety of tasks such as data collection and analysis for clinical feedback, recall and reminder registers, decision support, patient education, research and evidence based medicine, record keeping, prescribing and referrals, and communication. Emerging technologies and innovative uses for technology (such as telemedicine¹⁴) will also become more prevalent over the next five years.

¹³ King J (2001), *General Practice Building on Quality Synthesis of Divisional Models*; Monash Institute of Health Services Research: Melbourne.

¹⁴ Celler, Lovell and Chan (1999), The potential impact of home telecare on clinical practice, *MJA*, 1999; 171: 518-521.

- 5.1.8. Divisions will have a key role to keep up to date with technological advances and to provide practical advice to general practice in areas of technology infrastructure, communications, security, general systems, integration, resourcing, standards, and education. They will:
- ⇒ provide advice and support in identifying and matching practice information and technology needs;
 - ⇒ provide education to general practitioners and the practice team on the better use of data and information;
 - ⇒ promote the better management of practice-based electronic information systems such as decision support tools, practice population registers, practice management systems etc.;
 - ⇒ assist practices with the analysis of clinical and population data; and
 - ⇒ provide avenues for practices to expand their evidence base.

Team Support

- 5.1.9. The primary care team will be a central platform for general practice in 2007. In this environment the GP will be able to delegate care to a practice nurse, allied health professional or other health worker in order to focus on clinical care and health management. The team will have a number of important characteristics including:
- 5.1.9.1. skills matched to the practice population;
 - 5.1.9.2. financial capacity and flexibility to provide a range of services in a single setting;
 - 5.1.9.3. patient centred – ensuring continuous “whole person” care and involving patients in self-management¹⁵;
 - 5.1.9.4. organised links to other primary care providers;
 - 5.1.9.5. collection and utilisation of patient data for health planning of the practice;
 - 5.1.9.6. strong links with teaching and research programs; and
 - 5.1.9.7. functioning under a best practice and clinical governance framework, providing high quality evidence-based care^{16,17}.
- 5.1.10. Different practices will have different primary care team mixes depending on local needs. Divisions will offer practices tailored personnel services such as:
- ⇒ training and recruitment of staff and/or provision of personnel services across a range of disciplines, such as nursing, allied health, practice management, accountancy, and administration;
 - ⇒ human resource management expertise; and

¹⁵ Stewart et al (1995), *Patient Centred Medicine*, Sage Publications, CA.

¹⁶ Sackett, Rosenberg et al (1996), *Evidence Based Medicine*; *BMJ*, 1996; 312: 71-72.

¹⁷ Monash Division of General Practice (2002), *Evidence Based Medicine*: Victoria.

⇒ training in the skills and capability to capitalise on information and business systems necessary for modern business management.

5.1.11. In 2007 general practices will have the capacity to take a comprehensive population health approach to managing their practice populations. This will include identifying and targeting groups within their practices that have chronic conditions or are at risk, providing education in self-management to patients with chronic disease and complex care needs, making a broad range of skills available to their patients through a multidisciplinary team, and having strong links with other service providers and community-based services. Divisions will support practices and GPs to build this capacity by:

- ⇒ assisting multidisciplinary team members, including GPs, to access relevant training¹⁸;
- ⇒ providing advice on identifying and targeting practice populations;
- ⇒ identifying and promoting successful models of practice population health approaches;
- ⇒ providing relevant clearinghouses for appropriate data, resources and information; and
- ⇒ linking with academic institutions.

5.1.12. In 2007 general practice will be the cornerstone of a strong primary care sector which has links to both acute care and the community sector. General practice will be operating in a complex multilayered health system. Divisions will have a key role in providing a buffer for general practice from the bureaucracy, red tape and information hungry system.

5.2. Tier Two – Practice Support Networks

The Vision: Divisions will link general practices and primary care teams through local networks that support quality, access and efficiency.

5.2.1. Divisions have been instrumental in combating the traditional isolation of general practice in Australia. They have provided local resources and infrastructure to link GPs with each other and with the wider health system in their day to day work¹⁹. The Divisions Network, as with similar structures overseas, arose from a desire of general practitioners to reduce the segregation and pressure of individual private practice in a system dominated by public health organisations and culture. The benefits of developing stronger and more sustained relationships with their peers and with other health care providers involved in the care of

¹⁸ University of NSW; University of Melbourne; Julie McDonald and Associates (2001), *ibid*.

¹⁹ Commonwealth of Australia (1998), *General Practice: Changing the Future Through Partnerships: Report of the General Practice Strategy Review*, Department of Health and Family Services, 1998: Canberra.

their patients, impacts on both the quality of patient care and the work experience of GPs²⁰.

5.2.2. In 2007 the Divisions will provide a local organisational focus for general practice within the community by:

⇒ providing support to and facilitate networking across general practices;

⇒ offering a range of practical, practice-focussed services, capitalising on the economies of scale not available to individual practices; and

⇒ supporting the development of skills and resources among practice staff to create supportive working environments that build their capacity to manage workload and change effectively²¹.

5.2.3. The structure and focus of services will reflect local circumstances and support local needs. This will be particularly critical in areas of low infrastructure, low workforce ratios and high risk populations.

General practice cooperatives

5.2.4. Divisions will be key drivers of after hours arrangements that reduce the burden on individual practitioners through supporting shared after hours rosters and cooperative GP-run after hours clinics, in many cases attached to hospital Emergency Departments and serviced by GPs on a sessional basis, and supported by telephone triage systems²². Continuity of care is underpinned by effective information systems that allow the timely and secure flow of patient information between all providers involved in patient care.

5.2.5. The benefits to both GPs and patients of such arrangements are self-evident²³: access to after hours primary care is increased; the primary care patient load on Emergency Departments is reduced; patients receive more appropriate care in the most appropriate setting; and the safety and wellbeing of after hours care providers is enhanced. In addition, the after hours workload is spread among a larger number of primary care providers.

5.2.6. Similar cooperatives will be established across a number of other areas, particularly staffing and practice management. In some areas this will include practice equipment and supplies, with some Divisions acting as bulk purchasers of services or equipment. Brokerage may cover items such as private health insurance for practice staff, medical indemnity, occupational health services, and practice consumables. Divisions will:

⇒ support inter-practice resourcing and information sharing; and

²⁰ Wilkin D, Dowswell T, Leese B (2001), Modernising primary and community health services, *BMJ*, 2001; 322: 1522-1524.

²¹ Huby G, Gerry M, McKinstry B, Porter M, Shaw J, Wrate R (2002), Morale among general practitioners: qualitative study exploring relations between partnership arrangements, personal style and workload, *BMJ* 2001; 325: 140-145.

²² For example, see the Maitland After Hours GP Service run by the Hunter Urban Division of General Practice, www.hudgp.org.au.

²³ Christie, B (1998), GP Cooperatives in Scotland benefit patients and doctors, *BMJ*, 1998; 317: 1035.

⇒ facilitate working groups between practices on areas of shared interest.

For example, a group of practice staff may seek to work on shared policies and procedures that support re-accreditation, or simply exchange information concerning a new resource that has been found to be effective in delivering patient care.

Resource networks

5.2.7. Where practice capacity does not support individual employment of all practice staff, the Division will:

⇒ facilitate sharing of such resources through recruiting, contracting or employing staff on behalf of practices (e.g. allied health professionals); and

⇒ support virtual resource sharing among practices through mobilising local IT networks.

Collectively Divisions now have substantial HR knowledge, extending to cover legal, EBAs and awards. These will be applied to the benefit of practices, possibly on a fee for service basis. The provision of specialist practice nurses or allied health professionals, employed across a number of practices, will support quality patient care and enhance practice efficiency.

Continuing professional development

5.2.8. Divisions already have well-established continuing education programs for GPs, and in recent times have developed specific networks to address the needs of other staff, including practice managers, practice nurses and administrative staff. Such programs will be specific to local areas and populations.

5.2.9. In 2007 Divisions will be the hub for well-organised multidisciplinary and intra-disciplinary networks of GPs, practice nurses, practice managers and other staff that provide opportunities for both social and professional interactions. Peer review networks will undertake clinical and practice reviews using practice data collated and analysed by the Division for feedback and support. The Division's role may range from being a source of advice and support for such networks, to providing hands-on coordination.

5.2.10. The networks will provide career and professional development opportunities for GPs, other clinical team members and non-clinical practice staff, providing further support for workforce recruitment and retention strategies. At certain times and for particular areas of interest GPs, nurses, practice managers or other staff may choose to become clinical or practice leaders and mentors to other members within the network. These roles will be supported by the Division, which will provide access to education and training opportunities for team members²⁴.

²⁴ Wilkin et al (2001), *ibid*.

- 5.2.11. GPs, practice managers and other health professionals will be able to access vertically integrated education and training specific to primary care management and multidisciplinary team working, spanning undergraduate, postgraduate and lifelong learning needs. Divisions will have partnerships with universities, T.A.F.E. Colleges, Indigenous health organisations and governments in the development of accredited courses and training programs relevant to staff working in general practice and primary care.
- 5.2.12. These arrangements will support in-service training for GPs, nurses and allied health professionals in working in a multidisciplinary primary care environment and linking with other providers, allowing them to access the knowledge and skills that may not have been emphasised in their clinical training²⁵. They will also be linked to undergraduate training for medicine and other health disciplines in order to support greater uptake of primary care careers by doctors, nurses and other health professionals.
- 5.2.13. Through their links with universities and higher education institutes, Divisions will be actively supporting primary care and general practice research. They will be partners in developing and undertaking particular research topics, and also the setting for research projects examining models of health service delivery. Divisions will also provide support for clinical primary care research by GPs.
- 5.2.14. Through the supplementary clinical and practice roles established by the networks, Divisions will support the development of enhanced career structures for GPs, practice managers and other members of the primary care team. Divisions will also provide opportunities for managerial and leadership roles in primary care that extend beyond the general practice setting.

5.3. Tier Three – Community Linkages and Local Health Networks

The Vision: Divisions will provide a hub for integration of general practice and primary care services at a regional level, and support infrastructures that enable primary care workforce planning and management across the continuum of care.

- 5.3.1. General practice operates in a community environment. In order to link the practice and the community more comprehensively, by 2007 Divisions will be a key player in the planning of health services and the appropriate allocation of resources to meet the needs of both their communities and regions.
- 5.3.2. This work will be supported by the engagement of stakeholders and information sharing at a State/Territory and national level (refer to National Networks section).

²⁵ Smith R (2001), Why are doctors unhappy?, *BMJ*, 2001; 322:1073-1074.

Integration of general practice and primary care services at a regional level

- 5.3.3. Integrated care requires supportive infrastructure and mechanisms to be in place²⁶. This involves the establishment of joint processes for assessing the needs of the particular population base and planning and implementing interventions as required. In playing a key role in the planning of primary care services for a given region, Divisions will have in place strategies to target the large population group that does not regularly access general practice services, before unhealthy lifestyles are established. This may include facilitating alternative funding mechanisms that ensure access to quality affordable general practice services for disadvantaged groups.
- 5.3.4. Divisions are the mechanism to bring together a local, State/Territory and national focus, through networking with community organisations and other health providers. This includes not only public and private health care agencies, but also other organisations that play a role in maintaining the health of the community, such as local governments and government departments, schools, police departments, service clubs and other key community groups.
- 5.3.5. Divisions have an important role in collaborating with health services that provide care to Aboriginal and Torres Strait Islander populations, including Aboriginal Community Controlled Health Services (ACCHS) and State/Territory-managed services, recognising that this is a highly resource intensive and long-term activity for which they would need to be appropriately resourced. Divisions will also have a role in negotiating with secondary, tertiary and aged care services across the continuum to allow services to be coordinated around the needs of a particular population or community²⁷.
- 5.3.6. Divisions will have partnerships with primary care stakeholders and community groups to undertake joint planning to assess the needs, wants and expectations of the population and determine how services can be better integrated.

Engagement of State/Territory health services

- 5.3.7. Community health services are an important part of primary care delivery and constitute a significant component of State/Territory-funded primary care services. Improved links between community health services and GPs through Divisional structures are an essential element in the successful integration of primary care services²⁸.
- 5.3.8. The development of effective and enduring service coordination links with the full range of public hospital and private providers, community health organisations and community support services will enhance

²⁶ Department of Health and Aged Care (2000), *General Practice in Australia: 2000*, Department of Health and Aged Care: Canberra.

²⁷ Janovsky, K (1998), *The Challenge of Implementation: District Health Systems for Primary Health Care*, World Health Organisation: Geneva.

²⁸ La Trobe University (1999), *Community Health and General Practitioners: Partnerships in Care*, Primary Health Care Research and Development Centre; La Trobe University: Melbourne.

continuity of care and provide support for those consumers who have complex care needs. Engaging with State/Territory health services will provide opportunities for joint data collection, involvement in local health planning and sharing of resources. Divisions will have:

- ⇒ strategic alliances with State/Territory health authorities to facilitate collaborative approaches to the delivery of primary care; and
- ⇒ joint planning/support sessions with State/Territory health services on the interface between the primary care and hospital sectors.

Fostering regional systems of care

5.3.9. The Divisions Network provides a solid structure for regionally efficient organisation of services that supports GPs in their care for their practice population and in particular for people with chronic and complex conditions. This includes after hours care, aged care services, maternal and child health care, and chronic disease management.

5.3.10. Divisions will work with GPs and other health service providers to meet local gaps in services through flexible program delivery and contracting of services from GP cooperatives, GPs and practices as required, through:

- ⇒ developing models specific to their population base that foster regional systems of care; and
- ⇒ using appropriate indicators and evaluation methods to monitor the capacity and effectiveness of the regional systems²⁹.

Infrastructure to support taking the lead in primary care

5.3.11. The health system is already moving away from isolated, incidental care to supporting greater continuity and from a focus on service providers to an informed patient focus³⁰. The Divisions Network will be actively supporting care across the continuum of service planning and delivery, including prevention, screening, health education, diagnosis, acute management, chronic management, and rehabilitation. This support will entail the following:

Systemic changes to support a continuum of care for patients

5.3.12. In order to understand the full dimensions of future general practice and to better support the continuum of care for patients, Divisions will:

- ⇒ have systems in place that map patient flows and patient care in the community-based sector, which complement the data collected by hospitals (including preadmission and shared care programs, workers' compensation and hospital in the home); and

²⁹ Integration Support and Evaluation Unit (2000), *Diabetes Care in General Practice, Developments in Australia and Perspectives from the Literature*, Commonwealth Department of Health and Aged Care: Canberra.

³⁰ Yellowless and Brooks (1999), Health Online: the future isn't what it used to be, *MJA*, 1999; 171: 522-525.

⇒ actively support primary care system integrity, including quality management standards across key sector intersections, integrated information management systems and systems that take into account the key impacts and drivers of effective health care collaborations.

Engagement of the community in primary care planning and provision

5.3.13. Divisions have already adopted a number of strategies to involve and develop partnerships with consumers such as consumer reference groups and organisational agreements. Sharing of experiences and successes can occur through clearinghouse function in collaboration with relevant agencies³¹. To support community engagement Divisions will:

- ⇒ have in place a consumer participation policy³², providing an organisational context to support greater consumer participation and guide the development of multiple strategies to increase their capacity for consumer involvement;
- ⇒ have consumer/community representation on planning groups, and in planning and policy development processes; and
- ⇒ provide information to consumers about health status, planning processes and service options.

Structures that enhance consumers' responsibility for their health

5.3.14. Health information will continue to become more accessible via the Internet by 2007. Computer technologies will become more affordable and their use more widespread and this will promote change within the therapeutic relationship. Care will be complex and holistic and there will be an increase in disease prevention and particularly patient self-management. The appropriate use of information could empower patients by providing disease and lifestyle advice and perhaps 'self-maintenance plans' or preventative self-interventions.

5.3.15. Patients with chronic disease will be the primary managers of their own care, working in partnership with health practitioners to maximise disease control and reduce the physical, psychological, social and economic consequences of chronic illness³³. The doctors' role will be more advisory, analytical and interventionist. GPs will need to assess information from many different sources and become expert in clinical reasoning, with a focus on evidence-based maintenance of health. This process has already commenced³⁴.

5.3.16. In order to enhance consumer responsibility, Divisions will assist practices to share their experiences and develop models of care that

³¹ such as the National Resource Centre for Consumer Participation in Health and the Primary Health Care Research and Information Service.

³² Flinders University (2000), *Improving Health Services through Consumer Participation*, for the Commonwealth Department of Health and Ageing; Commonwealth of Australia.

³³ Clark, N.M; Gong, M (2000), Management of Chronic Disease by Practitioners and Patients: Are we teaching the wrong things?, *BMJ*, 2000; 320:572-575.

³⁴ Pemberton and Goldblatt (1998), The Internet and the Changing Roles of Doctors, Patients and Families, *MJA*, 1998; 169: 594-595.

empower consumers to make decisions through information acquisition and lifestyle modification.

A strengthened evidence base – clinical and management data for health and systems planning

5.3.17. The use of data and research in primary care is crucial for future planning and effective primary care delivery. Data collection and analysis that contributes to knowledge is essential to the provision of modern, quality primary care³⁵. Data also plays a significant role in continuous quality improvement within general practice. Much progress has been made in the standardisation and consistency of data collections, and in the quality and interpretation of government data sets. Advances in computerisation and electronic access to data have revolutionised dissemination of information³⁶. Divisions will:

- ⇒ work with IT and software developers to ensure that systems are efficient and user friendly;
- ⇒ support provider and patient education on use of data in their own practices for quality improvement as a first concern;
- ⇒ assist practices to provide information to consumers that encourages their involvement in self-management;
- ⇒ work with health planners and information technology experts in gaining an understanding of the true costs involved in data collection, be it time, finances or patient and GP goodwill. Costs needs to be outweighed by the potential benefits that may be gained by collecting the data³⁷;
- ⇒ ensure that control of individual data remains with the patient and the practice, but undertake the collection and analysis of regionalised de-identified data to facilitate planning and allocation of resources for “best fit” solutions based on community need;
- ⇒ have mechanisms and agreements in place that recognise Divisions as key sources of localised and reliable data to support regional health planning; and
- ⇒ be key players in primary care research, either conducting primary research in health care systems and modelling, or working in partnership to lead the development of evidence around primary care service delivery in an integrated service structure³⁸.

Primary care service structures

5.3.18. The establishment of primary care service structures will provide a mechanism for linking primary care stakeholders and support the

³⁵ Commonwealth Department of Health and Aged Care (1997), *Data Issues in General Practice Workshop*; Canberra.

³⁶ Commonwealth Department of Health and Aged Care (2000), *General Practice in Australia 2000 – General Practice Data Issues 461-469*; Canberra.

³⁷ Carlisle, Sefton (1998), HealthCare and the Information Age: Implications for Medical Education, *MJA*, 1998; 168: 340-343.

³⁸ Johnson, P (2002), *Divisions: A New Future – What do you see?* Logan and District Division of General Practice; Queensland.

delivery of best practice primary care services. Information management will be a critical component underpinning such structures, supporting the management of budgets, planning and developing services and improving quality. The Divisions will:

- ⇒ have established collaborative primary care service structures that link primary care stakeholders at local, State/Territory and national levels; and
- ⇒ be a key player in the development of information management systems to support primary care structures.

Primary care workforce planning and management

5.3.19. Profound workforce pressures will continue to shape the future of general practice. The current shortage of GPs across the country will continue to affect the capacity of general practice to manage an extended role. The ability of general practice to provide high quality care is also affected by workforce shortages faced by other health professionals. By 2007 Divisions will be involved in the development of models for primary care workforce planning and management. Initiatives will include:

- ⇒ Participation in the collection of accurate GP workforce data that is used to inform workforce policy, and involvement in the training, recruitment and retention of greater numbers of GPs;
- ⇒ Partnerships with universities, regional health services and other local medical services in researching, planning and developing local and national primary care workforce solutions. Solutions may include remodelling of provider numbers, proposing provider number quotas, providing entry and exit strategies and career paths for GPs and primary care professionals, and marketing to and nurturing GP registrars and health graduates across the primary care spectrum.
- ⇒ Support for practice-based primary care teams with GPs as the 'health manager' through recruitment, retention and continuing professional development strategies for all team members. Such strategies will be developed in partnership with regional health services and professional and educational organisations.

6. THE NATIONAL NETWORK

"Unity in purpose, diversity in implementation"

6.1. The Divisions Network is a unique structure within the Australian health care system. It provides opportunities for grassroots general practice input into service delivery, planning and policy at all levels: local, State/Territory and national. It has a key role in ensuring that the development of national policy is strongly grounded in the best available evidence and in installing local flexibility and adaptation into broad programs to reflect local needs.

- 6.2. At the State/Territory level, it is responsible for ensuring that general practice and primary care providers and systems are included in State/Territory program and policy development that impacts on hospital and community services, and supports the work of local Divisions. At the national level, the Network provides a focus and voice for GPs and general practice, and ensures that on-the-ground issues are fed into and utilised in the development of national primary care policy.
- 6.3. Part of the future role of the Network will be finding efficiencies in the current health and financing systems and selling these to governments for a better funded primary care system (e.g. through mapping models of patient flow and patient care). This will be instrumental in realising this vision.
- 6.4. The Network will also have a key role in liaising, consulting with and influencing other structures and organisations involved in primary care, including the General Practice Partnership Advisory Council (GPPAC), National Aboriginal Community Controlled Health Organisation and its State/Territory and local affiliates, peak organisations for allied health professionals, nurses, etc., the National Rural Health Alliance (NRHA), other general practice representative organisations such as the Royal Australian College of General Practitioners, Australian Medical Association, and so forth.
- 6.5. In 2007 the Network will have built on its current strengths, work as an effective, integrated structure, and have clarity of purpose at all levels. It will be involved in:

Influencing national primary care policy development

The Network will:

- 6.5.1. provide mechanisms that ensure the grassroots GP voice flows into the national policy arena;
- 6.5.2. provide leadership and advocacy for general practice in the national primary care agenda in cooperation with other GP representative organisations;
- 6.5.3. be a key source of information and expertise in the development of national primary care policy and directions;
- 6.5.4. investigate and demonstrate innovative approaches to primary care delivery to support the emerging future (an ageing population etc); and
- 6.5.5. support the development of generic systems and solutions – so that existing solutions are identified and disseminated.

Implementing alternative funding arrangements to support a primary care focus and the redirection of resources to areas of identified need including:

- 6.5.6. contractual arrangements that provide capacity, sustainability and flexibility for individual approaches to meet local needs whilst ensuring a high level of consistency in outcomes across Australia;
- 6.5.7. clearly defined governance arrangements inclusive of the range of primary care providers and stakeholders;

- 6.5.8. diverse funding sources derived from both Commonwealth and State/Territory Governments as well as private sector organisations purchasing a broader range of services from the Division;
- 6.5.9. membership contributions including individual GP membership and practice membership;
- 6.5.10. purchasing/delivery of practice support services on a partial or full cost recovery basis;
- 6.5.11. regionalised funding for the local management and delivery of services such as after hours medical care, community care, allied health and practice nursing;
- 6.5.12. additional measure and share funding opportunities which quarantine efficiencies for re-investment in primary care activities at the local level;
- 6.5.13. collaborative initiatives – combining of resources to buy capacity; and
- 6.5.14. sponsorship or funding from business sources.

Developing systems to involve/empower grassroots GPs and the community in policy change

The Divisions Network will:

- 6.5.15. provide a non-factional atmosphere in which all players can speak freely and voice alternative points of view, but are able to reach compromise on key issues;
 - 6.5.16. run education programs on policy development and processes and systems of government to increase knowledge and understanding of these;
 - 6.5.17. ensure grassroots GP input is used to inform policy development;
 - 6.5.18. analyse and communicate the implications of State/Territory and national policy development in order to influence government planning and directions;
 - 6.5.19. support the development of an evidence base around Divisional support activities and interventions; and
 - 6.5.20. take a lead role in increasing the status of general practice and primary care in the community.
- 6.6. In order to achieve the vision, a strong, vital Network with clarity of purpose at each level will be essential. In 2007 the Divisions Network will have an integrated structure that facilitates staff portability and continuity of employment. It will be focussed on quality business practises while at the same time allow diversity, flexibility and local responsiveness to continue. There will be:
- 6.6.1. a focus on membership and capacity building at all levels;
 - 6.6.2. clearly articulated roles and responsibilities between ADGP, SBOs and Divisions and how they work with their membership, communities, local/regional, State/Territory and national/Commonwealth organisations to enhance health service delivery. These roles will be recognised through

the Australian Health Ministers Advisory Council and the Australian Health Care Agreements;

- 6.6.3. clear lines of communication and accountability between members of the Network, allowing it to operate as a unified whole;
- 6.6.4. quality corporate governance and organisational structures and standards; and
- 6.6.5. a continuous quality improvement culture.

7. ACTIONS

- 7.1. The vision will need commitment, hard work and trust among all members of the Divisions Network. Immediate actions that need to be taken are:
 - ⇒ Commitment to change by both Divisions and State/Territory and Commonwealth Governments, perhaps demonstrated through changes to the new Divisional contracts in the next funding cycle and the Australian Health Care Agreements;
 - ⇒ A maturing of the contractual and reporting arrangements between the funding agencies and the Divisions Network in which accountability is focussed around key outcomes and performance indicators that allow for local flexibility and innovation;
 - ⇒ A more coordinated, targeted and sophisticated approach to marketing and promoting Divisions' capacity and strength as responsive and effective local structures in the delivery of health services; and
 - ⇒ Unification of the Divisions Network – agreement on and ratification of a structure that supports timely and effective communication between ADGP, SBOs and Divisions and the sharing of experiences, and provides a base for working together towards the future.
- 7.2. The strategies, processes, structure and governance arrangements necessary to achieve the agreed vision will be determined as part of an extended consultation process with Divisions, SBOs, grassroots general practitioners and other stakeholders.
- 7.3. A further Summit is planned for 2003 to discuss the recommendations of the Review of Divisions, and to consider structural and constitutional arrangements in order to maximise the Network's effectiveness, based on its agreed roles and functions at national, State/Territory and local levels.
- 7.4. A National Divisions and Primary Care Taskforce with members drawn from throughout the Network and coordinated by ADGP could focus on development of a five year workplan that will enable the Network to move forward towards its vision.