AUSTRALIAN DIVISION OF GENERAL PRACTICE LTD

ADGP

Submission to the Commonwealth Review of the Role of Divisions of General Practice

20 December 2002

CONTENTS

AUSTRALIAN DIVISIONS OF GENERAL PRACTICE (ADGP) LTD

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Purpose

1. To provide a submission to the Commonwealth Department of Health and Ageing *Review of the Role of Divisions of General Practice* that reflects the views and experience of the national peak body representing Divisions of General Practice.

Recommendations

Recommendation One

That the Divisions of General Practice Network is appropriately resourced through policy and funding to realise its *Vision for Divisions of General Practice to 2007: Divisions Policy Paper* (consultation draft at Attachment B) and to:

- identify and establish the minimum capacity required by Divisions, reflecting the diversity of their geographic and demographic characteristics, to effectively deliver support to GPs and communities (refer also to Recommendation Four);
- aggregate and analyse de-identified local general practice population data;
- develop additional clinical and health services research capacity through strategic links with relevant academic institutions; and
- develop formal links with local, regional, State/Territory and Commonwealth health authorities, other primary health care professional representative groups, NGOs and other primary care providers such as Aboriginal Community Controlled Health Organisations and local communities to plan, allocate resources and support the delivery of services in the areas of:
  - Chronic disease and complex care management
  - community and residential aged care
  - hospital demand management; and
  - workforce recruitment and retention.

RecommendationTwo

That through a continued focus on responding to the needs of its members (Divisions and general practice) the Divisions Network builds and enhances its capacity to:

- provide balanced and informed grass roots general practice input to policy and program development at all levels of government that affects general practice and primary care; and
- develop and promote solutions focussed policy and programs that are locally responsive to community need.

Recommendation Three

That the determination of systems of organisation and structure for the Divisions of General Practice Network needs to be undertaken through a process of consultation with its members. There is currently insufficient data to warrant the external imposition of such a process and insufficient understanding of the consequences of decisions made nationally on local populations.

Recommendation Four

ADGP proposes the following strategy to identify the implications of the Network's *Vision for Divisions Policy Paper* on the size and number of Divisions, governance arrangements of Network members and the roles ADGP and the State Based Organisations:

- Finalise *A Vision for Divisions of General Practice to 2007: Divisions Policy Paper* by March 2003 through consultation with Divisions Network members and stakeholders;
- Prepare discussion papers addressing the organisational and structural implications of the *Vision for Divisions Policy Paper* for consideration at a National Divisions Network Summit;
- Convene a National Divisions Network Summit in June 2003 with representation from all Network members to:
    - consider and make recommendations to the Network about the organisational and structural implications of the *Vision for Divisions Policy Paper*;
    - examine the recommendations of the *Review of the Role of Divisions of General Practice* and their implications for the *Vision for Divisions Policy Paper*;
- Prepare a submission to the Commonwealth of the Divisions Network position on the organisational and structural implications of the *Vision for Divisions Policy Paper* and a response to the recommendations of the Review.

Recommendation Five

That Divisions Network members are funded over a five year funding cycle as opposed to the current three year contracts.

Recommendation Six

That contracts between the Commonwealth and Divisions Network members reflect the maturity of the relationship between the two and provide for streamlined reporting and accountability against broad key performance indicators without micro-management.

Recommendation Seven

That modelling of the impact of a change from RRMA to ARIA Plus as a classification of remoteness/access in Division funding be made available to the Divisions Network to allow for an informed debate on the proposed changes.

Recommendation Eight

That national key performance indicators for the Division Network be developed in consultation with the Network and reflect the role of Network members as described in *Vision for Divisions Policy Paper* are based on the work of the ADGP Quality Framework for Divisions Taskforce.

Background

2. Established in 1998, Australian Divisions of General Practice Ltd. (ADGP) is the peak national body representing 121 Divisions of General Practice across Australia. Through a formal Memorandum of Understanding (MoU), ADGP also advocates on behalf of the eight State Based Organisations across Australia in recognition of the vital role SBOs play as members of the Divisions Network (Divisions, SBOs, ADGP).

3. Approximately 94 per cent of Australian GPs are members of a local Division of General Practice.

4. ADGP's Vision and Mission are:

   Vision – A high quality primary health care sector integrated through general practice that improves the health of all Australians.

   Mission – To provide leadership and support for the Divisions of General Practice Network to achieve quality and vitality in primary health care.

5. In its leadership role ADGP has prepared (in partnership with Divisions and SBOs) and distributed for consultation *A Vision for Divisions of General Practice 2007: Divisions Policy Paper* (Attachment B). The paper is the culmination of some twelve months of research, discussion and consultation and is designed to deliver a common vision for the Divisions Network to take it forward over the next five years. ADGP and all Network members will be able to use the *Divisions Policy Paper* as an important resource for their planning and negotiations with governments and other funders with regard to resource allocation and service delivery.

General Comments

6. In the absence of a unifying and nationally articulated Primary Care Policy, primary care program and policy development and implementation continues to lack the desired level of cohesion and integration. The strength, efficiency and effectiveness of the primary care sector in Australia including the Divisions Network is undermined by this lack of an overarching policy in which to locate the services and programs designed to improve health outcomes.

7. Nationally consistent career path and leadership development for GPs and Division staff is another important element currently missing from the primary health care environment. ADGP has developed a national leadership development program (Attachment C) that if appropriately resourced would address this issue.

8. The continuing improvement in communication and collaboration between levels of the Divisions Network will further reduce duplication of programs and structures as well as support on-going governance and structural reform (refer to Recommendation Four).

9. More accurate and sophisticated measurement of the impact of local, regional and national burden of disease in both a social and economic context is needed to enable demonstration of the effectiveness and efficiency of services delivered by general practice with the support of the Divisions Network. Division Network access to good data and links with relevant stakeholder groups will be particularly important when targeting and evaluating the effectiveness of services in communities with high morbidity.

Specific Comments against the Review Terms of Reference

10. ToR 1: the future role of Divisions of General Practice

Ensuring that Divisions contribute as effectively as possible to the achievement of the best possible health outcomes for Australians

10.1 Divisions of General Practice have made significant contributions to improved health outcomes for their communities. One of the notable of these from a national perspective has been the improvement in age appropriate childhood immunisation rates through the nationally co-ordinated General Practice Immunisation Program.

10.2 Divisions have become key stakeholders in the ongoing development of an integrated primary care sector.

10.3 Sustaining and building on the capacity of Divisions to continue to effectively contribute to the improvement of health outcomes relies on appropriate resourcing around a range of factors including:

- capacity to undertake local needs analysis;
- improved identification and measurement of health outcomes;
- identifying the minimum capacity required to deliver support to GPs and communities;
- continuing leadership, professional and career path development across the Network;
- access to and technical capacity to analyse regionally aggregated practice population health data;
- improved clinical and health service research and evaluation capacity;
- streamlining Commonwealth accountability and reporting requirements; and
- partnerships with local, regional, State/Territory, and Commonwealth health authorities, other primary health care professional representative groups, NGOs and other primary care providers such as Aboriginal Community Controlled Health Organisations and local communities.

Ensuring that Divisions are able to assist general practice in responding to current and emerging developments in Australia's primary health system and the role of general practice in that system

10.4 The Divisions Network's ability to assist general practice in responding to current and emerging developments in Australia's primary health care system and the role of general practice in that system is critically dependant on two elements:

- access to practicing GPs at the local level as members of Divisions; and
- advocacy for GPs at the local, State/Territory and national levels

10.5 These two elements enable the Divisions Network to engage GPs in debate as part of the policy/program development process and makes the Network a valuable partner in both responding to and driving developments in the Australian primary care system.

10.6 Ensuring that the Divisions Network can continue to assist general practice in this way requires:

- adequate resourcing; and

- links with/exposure to academia and international bodies and models of primary health care.

10.7 The elements of access to GPs and advocacy on behalf of GPs also places the Divisions Network as a prime structure to trial innovative models of health service delivery that cut across traditional State/Commonwealth boundaries eg the Maitland After-hours GP Service (MAGS).

11. ToR 2: the implications of the future role of Divisions for the organisation and structure of Divisions of General Practice

11.1 Examination of the future role of Divisions of General practice, particularly in the context of the *Vision for Divisions Policy Paper* will be undertaken by the Divisions Network in partnership with key stakeholders.

11.2 The Review of the Role of Divisions of General Practice does not have sufficient time or data regarding the local and regional diversity of the Divisions Network to properly consider and make recommendations on such issues as:

Size and number of Divisions, including consideration of boundaries relevant to other health structures and programs;

Governance arrangements of Divisions; and

The roles of the Australian Divisions of General Practice, and the State Based Organisations.

11.3 In consultation with the Network ADGP is developing a strategy to examine the future role of the Divisions Network. The ADGP strategy may include examination of:

Size and number of Divisions, including consideration of boundaries relevant to other health structures and programs:

- establishment of minimum and maximum sizes (population and area covered, no. of GPs etc) for Divisions to be viable/sustainable and effective;
- optimum size will reflect the community, demographics, culture and relevant boundaries;
- ensuring Divisions are small enough to be locally responsive yet large enough to be viable;
- current cooperation between Divisions, sharing of resources and intellectual and research collaborations;
- potential for virtual amalgamations;
- of conflicting boundaries (eg, Local governments, SLAs, regional (area) health services, postcodes); and
- Division boundaries coinciding with relevant/related health administration boundaries (however this may be impractical given frequent changes to State/Territory boundaries as a result of changes to governments).

Governance arrangements of Divisions:

- diversification Divisions' Boards to include relevant expertise such as business expertise, nurses, allied health workers, practice staff and consumers while retaining majority GP membership;
- the evidence on the most appropriate and effective board structures;
- consumer involvement, focusing on the research/evidence on how to secure best results from consumer involvement in the Division. The distinction between

consumer and community expertise and the need for Division planning and service program to be informed by both;
- succession planning and links with ADGP's proposed leadership program.

The roles of the Australian Divisions of General Practice, and the State Based Organisations

- the structure of the Divisions Network;
- dual membership by Divisions of ADGP and SBOs;
- the importance of State/Territory level liaison and leverage (State/Territory health authorities, primary care and allied health involvement, Australian Health Care Agreements, bilateral memorandums of understanding, relationship to secondary and tertiary systems);
- the importance of retaining as direct a link as possible between GPs, Divisions and ADGP for effective advocacy at the national level.

Future funding arrangements under the Divisions of General Practice Program (including the possible development of national key performance indicators, the balance between national performance indicators for all Divisions and scope for individual Divisions to respond to local needs and issues, and the calculation of funding allocations for individual Divisions).

11.4 A major challenge for Divisions Network members in the recruitment and retention of quality staff and the administration of the core business aspects of Divisions (lease arrangements for accommodation etc) is the current three year term of OBF contracts. Attracting quality staff to positions which at best can only be guaranteed for three years and often for only one year is particularly difficult in regional, rural and remote areas where significant relocation may be necessary.

11.5 A five year OBF contract would provide Divisions with improved corporate security and improved capacity for staff recruitment and retention.

11.6 Similarly the level of complexity in holding multiple separate contracts with the Commonwealth and State/Territory Governments absorbs unacceptable amounts of Divisional financial and staff resources in their maintenance, reporting and accountability requirements. The IM/CDM contract with its single reporting is a model to pursue.

11.7 The Divisions Network has matured to the stage where it should be possible to enter into more flexible contract arrangments with funders that do not involve micro-management by government departments and that respect the professional capacity and integrity of Network members to deliver agreed outcomes responsibly and efficiently.

11.8 These arrangements should also provides capacity for innovation in models of funding for the Divisions Network.

11.9 Current consideration by the Commonwealth of a move from RRMA to ARIA Plus classifications of remoteness/access as a means of calculating Divisional funding have yet to be satisfactorily and publicly modelled in order to inform the debate around this issue. A broad and informed discussion about such modelling will contribute to ensuring that all Network members can appreciate the impact of the proposed changes.

11.10 Development of any national key performance indicators for the Divisions Network should be undertaken through consultation with the Network and should recognise work already being undertaken through the ADGP Quality Framework for Divisions Taskforce.

Commonwealth Review of the Role of Divisions of General Practice

Additional Questions from the Review Panel

1. *What are the three major contributions that Divisions of General Practice (Divisions) are making to the achievement of improved health outcomes?*

1.1 Capacity building in general practice

Divisions have played a vital role in the:

- uptake of IM in general practice;
- delivery of continuing medical education and professional development;
- delivery of practice business systems improvement; and
- establishment of multi-disciplinary practice teams.

This activity enables general practices to improve their management of their patients, particularly those with chronic disease and complex care needs and to engage in Commonwealth and State/Territory population health initiatives.

The National General Practice Immunisation Program and the Federal Budget 2001 Chronic Disease Budget initiatives rely on this contribution by Divisions of General Practice.

1.2 Provision of informed, pragmatic advice to local, State/Territory and Commonwealth Governments on the development and implementation of population health programs

Through their access to and familiarity with general practice at the local level, Divisions are able to provide reliable advice on the appropriateness, viability, and implementation of population health programs and services that are design to improve health outcomes.

1.3 Linkages between general practice and other health professionals and health and care service providers

- the number and range of formal, semi-formal and informal relationships between Divisions, their GP members and other services/providers is extraordinary. Examples include:
- formal memorandums of understanding (MoUs) between Divisions and regional health authorities,
- facilitation by Divisions of regional medication Advisory Committees for local Aged Care Homes
- MoUs between SBOs and State governments
- shared care programs between Divisions and local hospitals

The *Vision for Divisions Policy Paper* recognises the capacity of Divisions to bring together primary care services at the regional level and proposes the expansion and reinforcement of this capacity as an important tool in improving the efficiency and effectiveness of primary care delivery.

2. *How can the effectiveness of Divisions be enhanced?*

2.1 Through appropriate resourcing to integrate support for population health initiatives

Divisions support to general practice around Commonwealth initiatives such as More Allied Health Services, Enhanced Primary Care, Information Management and Chronic Disease Management is traditionally funded through separate contracts with discrete outcomes and deliverables.

The effectiveness of Divisions in supporting general practice with such initiatives could be enhanced through an integrated approach to funding/reporting, employment and service delivery.

Effectiveness of Divisions could also be enhanced through:

- the development and provision of career paths through the Divisions Network to retain and share corporate knowledge;
- improved sharing of information and collaboration across the Divisions Network and across programs;
- improving research and evaluation expertise and practice among both GPs and Division staff.

3. *Are Divisions contributing to an improvement in health care delivery within their local region? If yes, how? If no, why?*

3.1 Yes. At the practice level through:

- building practice capacity;
- supporting practice utilisation of DMMR, EPC and Chronic Disease Management etc Item numbers

At the regional level through:

- shared care arrangments;
- provision of after hours care services;
- delivery of continuing medical education and professional development;
- developing/supporting workforce recruitment/retention initiatives;
- establishing links with other primary/acute health and care service providers;
- delivery of Quality Use of Medicines education etc.

4. *What are the three major weaknesses of Divisions?*

4.1 Resources that could be allocated to service delivery are being consumed by unnecessarily complex and detailed reporting and accountability requirements imposed by Commonwealth and State/Territory Government contracts.

4.2 Staff turnover due to uncertain/short term funding arrangements. The associated loss of corporate knowledge is a major difficulty faced by Divisions. If staff leave midway through contracts, the cost and resources involved in recruiting and familiarising new staff with an existing program are substantial and invariably lead to delays in service provision.

4.3 A lack of consistency in the delivery of services and programs across the Network as a result of capacity, size of Divisions, demographics, boundary issues etc.

Where nationally co-ordinated programs provide the effective and efficient delivery of program outcomes across the country through such things as national consistent templates and procedures, the local circumstances of Divisions including capacity geography and demographics play an important role in the way individual programs are delivered on the ground.

Identification and establishment of the minimum capacity for Divisions, regardless of their geographic or demographic circumstances, is necessary for delivering programs consistently across the country.

5. *Should consumer involvement in Divisions be encouraged? If yes, how? If no, why not?*

5.1 Yes. With an evidence based approach, ie establish what sort of consumer involvement is the most effective. This can be achieved through partnerships with agencies such as the Consumer's Health Forum and the National Resource Centre for Consumer Participation in Health and consultation with Network members.

There is already a range of models of consumer involvement in Divisions ranging from formal director status on Boards to program-specific consumer reference groups.

Some ADGP specific examples include:

- consumer representative (observer status) on the ADGP Board of Directors;
- inclusion of a consumer participation award in the inaugural Divisions Awards with the winner announced at the National Divisions Network Forum in November 2002.

5.2 Consumer and community engagement will be one of the Divisions Network's key levers in negotiating with local, State/Territory and commonwealth health authorities under the role of Divisions outlined in the *Vision for Divisions Policy Paper*.

6. *Can Divisions play a broader role in promoting/encouraging/supporting the provision of Primary Care within their region? If yes, how? If no, why not?*

6.1 Yes. Divisions can and do play a broader role in enhancing the provision of primary care within their region.

6.2 In the context of the *Vision for Divisions Policy Paper*, Divisions will within five years be the key resource and partner in mapping local primary care needs and trends (including workforce) and developing the initiatives and allocating resources to address them. The Divisions role will extend more formally to address the primary/acute interface. Divisions will be key stakeholders in promoting and maintaining continuity of care for local communities across the care continuum.

7. *What contribution do State Based Organisations and the Australian Divisions of General Practice (ADGP) make in both leading and supporting the work of Divisions?*

<u>SBOs</u>

7.1 SBOs play a critical role at the State/Territory level in levering primary care partnerships with and funding from State/Territory governments and authorities and ensure linkages with State/Territory NGO and community stakeholders. They provide leadership and support in the drive by Divisions to more effectively and formally engage with State/Territory Governments and authorities to maximise outcomes and services across their respective States/Territories.

7.2 SBOs also make an important contribution in State/Territory co-ordination of national programs, providing hands on support to Divisions (particularly those with capacity limitations), delivering state-wide training/induction opportunities and in facilitating the collection and presentation of State/Territory Divisional opinion/assessment on policy and program development and implementation.

7.3 The information dissemination role played by SBOs at the State/Territory level provides an important avenue for Divisions to share knowledge and capacity and to prevent duplication of effort in the administration of programs and services.

ADGP

7.4 ADGP's contribution in leading and supporting the work of Divisions and SBOs covers a range of activities and issues including:

- Representation and advocacy on behalf of Divisions in the development of national primary care policy and programs;
- Facilitating Division lead development of national policy and vision relating to the growth and future of primary care;
- National co-ordination of population health programs and advocacy on behalf of the Network on issues involved with program implementation and evaluation;
- Communication of information and resources throughout the Network;
- Building partnerships with key stakeholders to support the integration of Divisions and general practice with the broader health system; and
- Building capacity with the Network.

7.5 Examples of ADGP's contribution in support of the work of Divisions include:

- Signatory to the General Practice Memorandum of Understanding;
- Joint design of the funding formula and outline of the more Allied Health Services Program with the Commonwealth;
- Development of a submission to the Federal Budget that lead to Federal Budget 2001 Practice Nurse Initiative;
- Convening National Divisions Summits to discuss general practice financing and the future of Divisions.

7.6 ADGP also makes an important contribution in the dissemination of information that is relevant to the work of Divisions through the annual Divisions Network Forum, its e-News bulletin and more recently through its web site. The Forum is recognised across the country as the premier general practice and primary care conference in Australia.

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 principles[1] 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.

Consultation DRAFT

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-oriented[2] - 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 community[3].

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 principles[4] of self reliance, consumer and community participation, inter-sectoral

Consultation - DRAFT

[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 levels[6]. 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 system[9], offering comprehensive,

Consultation - DRAFT

[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 UK[10].

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 arrangements[11]. 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.

Consultation - DRAFT

[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

Consultation DRAFT

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 career[12]; and

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

Consultation - DRAFT

⇒ 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 discussion[13];

⇒ 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 telemedicine[14]) will also become more prevalent over the next five years.

Consultation - DRAFT

[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-management[15];

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.

Consultation - DRAFT

⇒ 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 training[18];

⇒ 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 work[19]. 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

Consultation - DRAFT

[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 GPs[20].

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 effectively[21].

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 systems[22]. 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-evident[23]: 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

CONSULTATION - DRAFT

[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 members[24].

Consultation - DRAFT

[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 training[25]. 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).

Consultation - DRAFT

[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 place[26]. 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 community[27].

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 services[28].

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.

Consultation DRAFT

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 systems[29].

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 focus[30]. 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

Consultation DRAFT

[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 agencies[31]. To support community engagement Divisions will:

⇒ have in place a consumer participation policy[32], 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 illness[33]. 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 commenced[34].

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

Consultation DRAFT

[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 care[35]. 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 information[36]. 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 data[37];
- ⇒ 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 structure[38].

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

Consultation - DRAFT

[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.

CONSULTATION - DRAFT

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;

Consultation - DRAFT

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

Consultation - DRAFT

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.

Consultation DRAFT

AUSTRALIAN DIVISIONS OF GENERAL PRACTICE LTD

Proposal to the (then) Department of Health and Aged Care for a Portfolio of Leadership and Management Programs for the Divisions of General Practice Network

Background

At the time of their establishment, Divisions of General Practice were seen as mechanisms for improving the integration of general practice with the other parts of the health care system; enhancing the quality of general practice; and addressing workforce issues of oversupply and maldistribution. In 2001, the core business of Divisions of General Practice also encompasses an important component of change management in the delivery of primary health care.

As a result of the changing health care environment, Divisions of General Practice are undertaking a number of comprehensive programs that extend from the needs of their GP members. They are also taking on more wide-ranging issues relating to the profession as a whole.

To adequately address the pressures for change sweeping general practice, it is critical for Division of General Practice leaders and staff to have multiple opportunities to develop their performance, leadership and management capabilities.

In June 2000, ADGP formed a Steering Committee comprising representatives from ADGP, SBOs, Divisions of General Practice, DHAC, RACGP and AMA. The aim of the committee was to explore leadership and management requirements of Divisional members and staff and to recommend how these requirement would be met through a series of complementary components. It is their belief that investment in leadership and management should be a long, not short, term investment. This requires a strategic approach which in particular encourages young GPs, and female GPs, who might currently be blocked from entering leadership positions.

ADGP was awarded a grant to develop the portfolio including a scholarship program and tender documents for GP and Division of General Practice Staff development programs. The grant required ADGP to research leadership programs for several scholarships and consult with Divisions of General Practice, SBOs and GPs on program outcomes and objectives. Based on this research, ADGP respectfully submits a proposal for the development of five leadership and management programs, outlined below, for the Divisions of General Practice network.

GP Scholarship for Leadership Advancement:

Outcome	- To expose a new generation of GP leaders to intensive training and enhance their capacity to lead reforms in primary health care. - To award scholarships to eight GPs who have demonstrated the capacity to effectively lead change in the Divisions of General Practice program. [Two scholarships (one urban and one rural GP) would be awarded to attend a cutting edge, high calibre international health leadership program. Six scholarships (three urban and three rural GPs) would be awarded to attend an advanced high level Australian leadership program.]
Scholarship Name	- It is proposed the scholarship be named the *GP Scholarships for Leadership Advancement: International (Harvard) and Australian (MGSM) sponsored by ADGP and funded by DHAC*
Programs	<u>INTERNATIONAL PROGRAM SCHOLARSHIP</u> - Scholarships would be awarded to two GPs (one urban and one rural) to attend the John F. Kennedy School of Government (Harvard University)- *Skills for the New World of Health Care program* - The program is designed for physicians, trustees and non-physician leaders in the health care industry. It explores recent trends and developments in managed care, health care, economics and health policy. - During an intensive nine-day program, participants learn about health economics, managing risk, the legal framework of health care and the changing nature of liability. They are introduced to the workings of the media and the political system. They are taught skills in negotiation, conflict resolution and leadership. They also consider the impact of information technology, genomics and quality improvement on the future of health care. - The program comes highly rated, with participants on average assigning it a rating of 4.8-4.9 on a 5-point scale. Several Australians have attended the program and highly recommend it.
	<u>AUSTRALIAN PROGRAM SCHOLARSHIP</u> - Six scholarships (three urban and three rural) would be awarded to attend the Macquarie Graduate School of Management (MGSM) program- *Strategic Leadership and Change with Murray Steele* - The program is designed to give participants the opportunity to enhance their strategic leadership ability and apply the concepts and theories of the program to their own organisation. During an intensive four-day residential program, GPs would be challenged to stretch their thinking and develop strategies for change. GPs would benefit from the exposure to new approaches to existing problems. - The program is highly rated with an average rating on the course value as 8.8 on a 10-point scale.

Selection Criteria	The scholarship selection criteria listed below would be competitive, composed of written and oral elements, including references. <u>SELECTION CRITERIA</u> **Compulsory:** GP (including OMP) **Desirable:** Demonstrated capacity to work across all sectors involved in health. **Compulsory:** - Be able to demonstrate future commitment to General Practice in Australia - Two supporting statements (one must be from a board member of their Division) - Must be available for an interview via videoconference - Must be able to report on their experience and give a formal presentation at the National Divisions Forum **Application Questions:** - GP History - History of Division activity (including leadership positions) - History of involvement with other professional organisations - History of community involvement - History of leadership positions held outside of Divisions - A statement about what they would bring back to Australian General Practice - A statement on why it is important to develop GP leaders - A statement on what are the future issues that general practice will have to confront in Australia and internationally - A statement about leaders that they have admired - A statement about whether or not leadership can be learned <u>Selection Panel</u> The panel would be composed of five members: - A representative from the Board of Training - A senior representative from DHAC - 2 ADGP reps (one urban and one rural GP) - An academic leader in primary health care
Administration	- First scholarship would be awarded in 2001 to attend the programs offered in the August and November 2001. - Initial funding is sought for scholarships over two years. - ADGP would provide secretariat support to the scholarship selection panel and scholarship holders.

GP Leadership Development Program:

The Program	- It is envisaged this program would be targeted to GPs assuming a leadership position in a Division (a new board member, chair of a project, program or committee). It would be a two to three day residential program with 25 to 30 participants and would be offered four times a year in different regional areas around Australia for a total of 100 GPs annually. It is possible there will be a distance learning component. - Funding is sought for two years including its development and delivery beginning in 2001. - It would be competitively tendered to an independent consultant/institution. - SBOs, Divisions, and GPs have provided input into the tender specifications via a comprehensive consultative process undertaken by ADGP including GP focus groups.
Program Objectives	- Strengthen the leadership skills and competencies that are required of GP Divisional leaders to create knowledge based organisations which are leading change in primary health care; - Participants will increase their understanding of the nature of strategic policy development as it relates to primary health care; - Participants will consider their personal role in terms of leadership style and behaviors such that they will be capable of leading effectively; and - Participants will improve their understanding of the critical success factors for performance in primary health care and broaden their perspective of how to operate more strategically as a GP leader.
Program Outcomes	Some of the program outcomes include: - Increased understanding of their own leadership style and abilities and difference between leadership and management; - Increased understanding of systems and structures to build effective teams with GPs and staff members; - Increased understanding of change management models applicable to Divisions of General Practice; - Increased understanding of the role of Divisions in the broader health system environment and their position to lead change management; - Increased understanding of financial responsibility and performance accountability as a board member; and - Improved capacity for effective delivery on outcome based funding (including consideration of measurement and evaluation techniques).
Administration	- ADGP would provide the secretariat to the program, including oversight and approval of all components of the program, with the successful tenderer responsible for the program's content, organisation and delivery. - DHAC would provide the initial funding however there is also the potential for partnering with industry sponsors. Divisions would also be expected to provide some nominal support.

Division Staff Professional Development Program:

The Program	- It is envisaged this program would be targeted to senior staff members of a Division. It would be a three to five day residential program with 25 to 30 participants and would be offered four times a year in different regional areas around Australia for approximately a total of 100 attendees annually. A select number of selected DHAC staff will be able to attend the program to foster their development. - Funding is sought for two years including its development and delivery beginning in 2001. - It would be competitively tendered to an independent consultant/institution. - SBOs, Divisions, and GPs have provided input into the tender specifications via a comprehensive consultative process undertaken by ADGP including Division staff focus groups.
Program Objectives	- Enhance the leadership and management skills of Divisions of General Practice senior staff (and selected DHAC staff) to develop the skills required to create organisations leading change in primary health care; - Participants will consider the role of individuals and their values and beliefs in the change process; - Participants will enhance their individual professional capacity in change management, organisation governance and increase their understanding of the nature of strategic policy development as it relates to primary health care; - Participants will focus on personal development and effectiveness, leadership capabilities, and contemporary management approaches including a focus on leading effective knowledge based organisations; and - Participants will improve their understanding of the critical success factors for performance in primary health care and broaden their perspective of how to operate more strategically and flexibly.
Program Outcome	- Increased understanding of how to engage GPs effectively and strategically; - Increased capacity to effectively work with their boards of directors and the effective use of corporate governance procedures; - Increased understanding of their own leadership style and abilities, innovations in leadership and difference between leadership and management; - Increased understanding of change management models and tools applicable to Divisions; - Understand the value and capacity of knowledge based organisations; - Understand how to create strategic alliances, marshal constituencies and develop coalitions for action; and - Improved capacity for effective delivery on outcome based funding (including consideration of measurement and evaluation techniques).
Administration	- ADGP would provide the secretariat to the program with the successful tenderer responsible for the program's material, content and delivery. - DHAC would provide the initial funding however it would be expected that Divisions also provide some support.

Corporate Governance Program:

The Program	- It is envisaged the program would broaden the capacity of Divisions of General Practice Board of Directors (or Management Committees) to understand the realities and practicalities of corporate governance.
Outcome/Objective	- GPs would gain an increased understanding of corporate governance, code of conduct, role of director and separation between management and governance responsibilities. - GPs would increase their capacity to serve effectively as a director and provide value to the organisation.
Specifics	- It is envisaged the Program would be competitively tendered to a SBO that would utilise the best of the corporate governance programs already developed and adapt and/or enhance them to create a national program. - It is envisaged the program would include a mixture of self-study modules as well as group exercises run by an independent facilitator.
Administration	- The program would be coordinated through the SBO awarded the tender with ADGP oversight. - It is envisaged approximately 60 divisions would participate in the program annually. - DHAC would provide the on-going funding for this program.

Registrar Leadership Skills Post:

The Program	A GP registrar would have a six-month leadership training skills post with rotations at ADGP, DHAC and the Office of the Minister of Health. The post would also include some clinical work in the ACT region.
Outcome	Develop the leadership skills and potential of GP registrars as future leaders within Divisions of General Practice.
Scope	- The registrar's responsibilities would be designed to expose him/her to all aspects of health policy development and funding. - The General Practitioners Registrars Association would select the candidate though a process agreed with ADGP and DHAC.
Administration	- DHAC would fund two positions annually. - ADGP would work with the General Practitioners Registrars Association in the development of the skills post however the General Practitioners Registrars Association would administer the program.