RESPONSE TO THE REVIEW OF THE ROLE OF DIVISIONS OF GENERAL PRACTICE

Executive Summary

The Review of the Role of Divisions was an opportunity to consider in-depth how the Divisions Network could actively contribute to the improvement of primary care across Australia through some bold new approaches. Whilst the Review was highly consultative and allowed broad stakeholder input to the deliberations of the Panel, the Report focuses mainly on recommendations for incremental change and operational issues.

Many Divisions are already considering broader roles and functions around focussing on the role of general practices in delivering community based care in collaboration with other primary care providers, through mechanisms such as pooled regional primary care funding. It would be a great pity if implementation of the findings of the Review were to put the brakes on this process, merely to achieve greater consistency among Divisions. It is vital that the roles and structure of the Network are discussed and agreed among Divisions, SBOs and ADGP, to ensure that "lead" Divisions can continue to move forward, whilst providing the opportunity for other Divisions to consider undertaking similar roles.

Many of the recommendations of the Review have substantial resourcing implications and timelines that will impact on the Divisions' Network's capacity to implement them. Clarity from the Commonwealth in terms of its objectives and expected outcomes will assist the Network to identify the level of funding necessary to deliver these. A timely response to the Report from the Commonwealth and an agreed process for implementation with input from the Network is vital to allow Divisions to commence planning for their future roles.

ADGP has compiled this response based on the discussions at the national Divisions' Strategic Summit in Adelaide in August 2003, which was attended by over 280 delegates from Divisions and SBOs. Additional comments on a consultation draft were received from members of the Divisions Network, including Divisions and SBOs. Whilst the views of delegates to the Summit cannot be construed as representative of every member of the Network, they did nevertheless convey general agreement on several key issues pertinent to the Review, which are reflected below.

Review Recommendations

Chapter 4 Characteristics of a well-functioning Division

- Support for general practice and GPs,
- Whole-of-practice engagement,
- Stronger role in primary health care: community orientation; health service integration
- Fulfilment of core roles: population health; accreditation support; peer review; continuing education for GPs and practice staff; research and evaluation; workforce support.

Comment

These characteristics reinforce the directions advocated by the Divisions Network in its policy paper *A Vision for Divisions of General Practice to 2007;* i.e. a focus on supporting GPs and general practices in a whole-of-practice perspective; fostering partnerships with the community; and taking a stronger role in local and regional health care planning and delivery. The *Vision for Divisions* paper was developed through a comprehensive

consultation process within the Network, and provides a clear focus to guide the Network in its future activities.

Implications

This chapter confirms the direction that many, though not all, Divisions are presently taking. The maturation of the Network over the last ten years has seen a greater focus on best practice corporate governance, accountability and transparency, continuous improvement processes, and engaging the community. Most Divisions are using direct intervention and support at the practice level to build the capacity of general practices and GPs. The Network will require increased commitment and support from the Commonwealth to build the capacity of Divisions to deliver on their core roles.

Chapter 5	Primary Health Care (Recommendations 1-4)

1	That the Commonwealth give priority to the development of a national primary health care policy and implementation framework and that the Divisions network be centrally involved in its development.

2	That the national primary health care policy and implementation framework form the basis for discussions between the Commonwealth and the states and territories in order to achieve a more seamless national approach to primary health care

Comment

These recommendations are strongly supported.

Implications

A clear framework for the delivery of primary health care covering both state- and federally funded services that is agreed between the Commonwealth and the States is necessary to assist Divisions to determine the strategic direction that will best meet the needs of general practice and their communities over the next five years. Defining the role of Divisions in the context of "primary health care" is crucial; they cannot be all things to all people. It is vital that the Divisions Network is central to this process, and to ensure a balance between national, state/territory and local priorities and the engagement and commitment of all primary health care providers.

Development of such a policy should be progressed as a matter of urgency; well in time for consideration as part of the next Australian Health Care Agreements.

3	That the national primary health care policy and implementation framework allow Divisions to tailor strategies to meet local and regional health needs and priorities.

Comment

This recommendation is strongly supported.

Implications

The need to retain the diversity and unique character of individual Divisions was a strong theme at the national Divisions Summit. One of the key strengths of Divisions is their ability to identify and enact locally relevant health solutions for their community and this should not be compromised by attempting to achieve national uniformity across the Network. Better resourcing for research and local population health data will be important to enable Divisions to fulfil this role.

4	That Divisions of General Practice be required to undertake a stronger and more consistent role in primary health care, leading to better health status for all Australians, and that they do this by focusing on general practitioners and general practices in a whole-of-practice context.

Comment

Given the comments regarding the diversity of Divisions, this recommendation is not supported in total.

Implications

A number of Divisions are already moving to take a stronger role in primary health care, however it is vital that the members of Divisions have ownership of change processes to reduce the risk of disengagement of GPs.

Delegates to the Summit agreed that retaining a strong focus on GPs was a key operating principle in the creation of greater professional and personal satisfaction for GPs and sustainable general practice as the cornerstone of primary health care. Delegates noted that Divisions are an integral part of the health system at the local level, and could become a central hub for all parts of the system to contact, connect and liaise with GPs and vice versa.

Since their inception Divisions have been engaged in building links with the broader health system. However, integration of health care services is unlikely to occur except at the margins without systemic reform. Such reform must include agreement between the different levels of Government, backed up by integrated funding and promotion of professional and organisational cultural change through opportunities such as joint education and training involving GPs, allied health professionals, nurses etc. Further, integration of patient care occurs at the provider, not the organisational level; Divisions can facilitate this process, but barriers will continue to be raised where similar support is not available for other providers (community health services, hospitals, pharmacists etc.). For Divisions to take on this role, the necessary systemic supports and mechanisms must be in place.

It is appropriate to take a medium to long term approach for such change that recognises the diversity of Divisions, and built into the development of the national primary health care policy and framework.

Chapter 6	Core Roles for Divisions (Recommendations 5-10)

5	That the scope of consultations on Primary Health Care Research Evaluation and Development (PHC RED) research priorities be expanded to ensure the meaningful involvement of both the Divisions network and Indigenous health representatives in time for its use in determining PHC RED research priorities for the next National Health and Medical Research Council (NHMRC) research grants funding round.

Comment

Supported.

Implications

The Network believes that Divisions and GPs should be an integral part of the primary health care research community. In order to do this, they must be consulted about the priorities and needs of primary health care providers at the “coal face” of delivering care and specific funding should be made available to Divisions to further develop and promote their research capacity.

There is currently considerable duplication of effort in primary health care research funding; more emphasis should be given to turning research into practice and effective use and encouragement of GP researchers (as distinct from just using general practice as a research setting).

6	That formal collaboration be required between the new Primary Health Care Research Institute and members of the Divisions network in order to improve the level of evidence-based rigour in evaluations of Divisions' activities, and to find ways of ensuring that the evaluation results are used to monitor and develop the role of Divisions.

Comment

Supported.

Implications

It is likely that formal collaboration with the Institute will be more effective if coordinated through SBOs or the ADGP. The diversity and capacity of Divisions to engage in research collaborations must be fully considered; some Divisions are already involved such projects, however others would struggle to achieve this without additional resourcing. There is a need to ensure that rural communities have equitable access to research resources, personnel and opportunities. Further, there is a need for a better independent evaluation structure accessible to Divisions to enhance the quality and integration of formal research practices into Divisional activities.

7	That the roles of Rural Workforce Agencies and the Divisions network in relation to workforce activities be reviewed, including consideration of amalgamations between the Divisions network and Rural Workforce Agencies.

Comment

Supported in part.

Implications

The structure and interaction of RWAs with the Divisions Network varies among the States and Territories according to their particular needs and histories. Strengthened collaboration between workforce agencies and the Divisions Network infrastructure may realise certain efficiencies and synergies by expanding the workforce focus to include both urban and rural areas, and other primary care providers whose services impact on general practice. However, the constituencies of RWAs and SBOs, and thus their strategic focuses, are different. A review of the respective roles of workforce agencies and the Divisions Network must take into consideration current relationships and collaborative work, as well as the needs and circumstances in each state and territory. Amalgamation of these roles has tended to occur where both populations and numbers of Divisions are small.

8	That to assist in the further and future identification of general practitioner workforce issues, a formal collaboration be established between the Divisions network and the Australian Medical Workforce Advisory Council (AMWAC).

Comment

Supported.

Implications

Support for collaboration between the Network and AMWAC was previously outlined in the ADGP/SBO Coalition submission to the AMWAC review of the general practice workforce. AMWAC has also indicated it would welcome a collaborative relationship with the Network, recognising the value of local and regional knowledge the Network can bring to workforce planning.

Broad consultation and appropriate ongoing funding (including additional funding for urban Divisions) would be required for the Network to become consistently involved in workforce data collection and analysis, with support at the state and/or national levels of the Network.

9	That all Divisions be required to undertake activities in relation to their core roles, focusing in particular on:

- population health including the reduction of health inequalities
- accreditation of general practices
- education
- research, evaluation and development
- workforce support, and
- information management and information technology. Specific national key performance indicators should monitor these activities.

Comment

As a positive acknowledgement of Divisions' current work this recommendation is generally supported.

Implications

It was agreed by delegates at the Summit that Divisions must continue their core business of advocating for, supporting and maintaining direct involvement with grassroots GPs. Divisions were also seen as having a role in local policy development and implementation - including determination of regional boundaries and local health needs - as well as providing grassroots input into policy development at both state and federal levels either directly or via the SBOs and ADGP. Other roles included both urban and rural Divisions' key involvement in workforce activities, especially feeding into workforce planning at the state and national levels.

The Divisions Network can and does support practices in the identified areas of population health, accreditation, education, research evaluation and development, and IM/IT; however, there needs to be flexibility in the core roles to recognise the diversity of both Divisions and the needs of their communities if health inequalities are to be better addressed, i.e. through better access to services.

The proposition that Divisions become responsible for reducing health inequalities across the population raises some concerns. First, Divisions have little, if any, control over the social determinants of health, which relate most strongly to income disparity and education levels, which are arguably state and federal Government responsibilities. Second, it would be extremely difficult to measure or attribute any change to inequality in health status. If this section is actually referring to inequity of *access* to health services and that Divisions should specifically target access to general practice services for disadvantaged groups in their communities, this should be clearly stated and reflected in appropriate indicators and funding arrangements.

Population health approaches in general practice are being advanced by Divisions through a focus on direct practice support to implement recall/reminder systems, better practice population data collection through age/sex/disease registers and so on. This has stalled due to the withdrawal of direct IM/IT funding in Divisions. The *Vision for Divisions* paper also recognized the role that many Divisions already play in facilitating networks of practices to enable broader and more efficient ways of delivering preventive care and managing chronic disease.

The difficulties practices and services face in meeting all accreditation requirements in areas such as remote communities, Indigenous communities and youth centres needs to be acknowledged. There should be flexibility and staged processes introduced that encourage and reward progress toward accreditation rather than blocking access to PIP

payments until all standards / requirements are met. Divisions need to be better resourced to provide targeted accreditation support in areas of low uptake that takes into account distance and access barriers.

Education continues to be an important element of Divisional activities and is integrally linked to their workforce support role. As well as their key role in providing continuing professional development for both GPs and practice staff (with many Divisions as accredited training providers), more Divisions are now becoming involved in GP registrar training since the regionalisation of the training program, and see an increasing role to provide support and professional development programs for nursing and allied health professionals – a number of rural Divisions have programs to support professionals employed under the MAHS program as a recruitment/retention strategy. This expertise needs to be better utilised to achieve sustainable workforce solutions within the Network.

The Review does not outline the balance of activities encompassed by the recommended core roles; local circumstances and local needs should dictate the relative weighting of these activities, to ensure the most consistent outcomes.

10	That the current stated aim of the Divisions of General Practice Program be reviewed to reflect the recommendations in this report. The aims of the Divisions of General Practice Program and the Divisions network should be consistent.

Comment

Supported in part.

Implications

The aims of the Divisions Network are inclusive of, but not limited to, the aims of the DGPP. The Commonwealth needs to make clear its expectations for the Divisions program in the context of the national primary health care policy. The Network should determine its own response to the Government's policy directions and determine the scope of services it can offer the Commonwealth for the funding provided.

Chapter 7	In Pursuit of Quality and Performance (Recommendations 11-12)

11 That a national performance system be developed by the Commonwealth, in consultation with the Divisions network, to include:

- national key performance indicators for all organisations in the Divisions network
- the flexibility to add additional performance indicators for local priorities
- a system of rolling audits for all organisations in the Divisions network
- the 'earned autonomy' concept to reward strong performance
- arrangements for managing under-performance; and
- if appropriate, the quality framework of the Australian Divisions of General Practice (ADGP), including standards, and an accreditation system based on those standards.

Comment

Supported.

Implications

The Divisions Network has recognised the importance of having a quality framework within which it can operate, to promote the continued strengthening of Division infrastructures. ADGP has been working with the Department for over a year on a process for development of a Quality Framework for Divisions that will be internationally recognised,

tailored to the Divisional environment, based on existing standards, and developed through a comprehensive consultation process with the Network. The standards and framework will be trialled in three stages: (1) a voluntary self-assessment process; (2) a voluntary peer assessment process; and (3) a formal accreditation process. We believe that the draft standards must be tested in the field with the willing participation of Divisions before implementation of an accreditation process. A quality framework or accreditation system for Divisions must be flexible enough to recognise the difficulties faced by practices and services in remote and Indigenous communities, and must not merely impose an additional red tape burden on top of the current reporting requirements, further reducing Divisions' capacity to actually deliver services.

It is vital that development of national key performance indicators (KPIs) occurs in partnership with the Divisions Network. The Network is best qualified to determine clear, achievable and genuine measures of performance that are broad enough to preserve capacity for local responsiveness, and mutually owned and agreed by Network members. The proposed national performance indicators must be limited to core roles and aims and the level of funding must reflect the required outcomes. They must be able to meet concerns of equity among Divisions. Flexibility to add additional performance indicators must be accompanied by flexibility to apply funding to such activities, and should be based on Divisions' own assessment of their capacity and experience to take on such activities. It is unclear why "these exceptions need to be well explained and justified to the Divisions network".

Summit delegates suggested that some Divisions may find it harder to meet nationally-determined KPIs, and there was a need for clarity on the criteria for viability. It was felt that the "one size fits all" mentality was flawed and that the Network should be enabled to identify and support Divisions with less capacity. However, having all Divisions working towards some common goals has the potential to provide more tangible and measurable outcomes.

How the system of rolling audits would be conducted, by whom, and how they would be linked to the Quality Framework process and to existing reporting requirements, needs to be clarified. Management of "under-performance" (which is as yet undefined), with the possibility of additional reporting requirements, has the potential to lock those Divisions affected into a vicious cycle of under-capacity that will work against the delivery of outcomes. Where there are Divisions that may be struggling to achieve their contracted objectives, the Network is in a position to share its expertise and mentor these Divisions.

While the Review appears to set the bar very high for Divisions, there is little reciprocal onus on the Department of Health & Ageing for accountability or performance, and little recognition of the substantial negative impact of poor performance by the Department of Health & Ageing on how the Divisions Network functions (flawed contract processes, late payments, delays in report approvals and roll-out of new initiatives resulting in underspends etc.). The opportunity to establish mutual accountability arrangements should be taken up through the Business Management Advisory Group (BMAG) already established through the Primary Care Division of the Department of Health & Ageing, and BMAG given the appropriate authority to achieve positive changes.

12	That the national performance system for the Divisions network be developed and implemented as a high priority, and in time to be included in new funding agreements from 1 July 2004.

Comment

This recommendation is not considered feasible.

Implications

Whilst it is imperative that Divisions are given certainty of funding beyond 1 July 2004, the process and timing of establishing a performance system must be decided as a matter of urgency (within the next 2-3 months) in consultation with the Network to ensure a

considered and sustainable system is put in place; BMAG provides a vehicle to commence such negotiations.

As part of this process, it will be necessary for the Commonwealth to clearly identify its "objectives, priorities and outcomes" for the Divisions Program.

Chapter 8	The role of Divisions in Improving Indigenous Health (Recommendations 13-16)

13	That the Commonwealth fund a consortium to identify models of best practice for ways in which the Divisions network and the Aboriginal community controlled health sector can engage and work together in order to improve health services and health outcomes for Aboriginal and Torres Strait Islander peoples. That the consortium include appropriate Divisions of General Practice and Aboriginal Community Controlled Health Services.

Comment

Supported.

Implications

ADGP and the National Aboriginal Community Controlled Health Organisation (NACCHO) have been working towards building stronger relationships between the Divisions Network and the ACCHS sector through a Memorandum of Understanding (MoU). Research on models for collaboration will be a focus of the MoU workplan and will involve identifying, through a scoping study, Divisions that may be interested in participating in such a consortium.

14	That the Department of Health and Ageing agree with the Divisions network and the Aboriginal community controlled health sector to a set of expectations for effective engagement between the two sectors, at each of the national, state and territory, and local levels. This set of expectations should be expressed as a common performance indicator in the Department's respective funding agreements with organisations in each sector.

Comment

Supported, with the following caveat.

Implications

The performance indicator must be flexible enough to reflect the diversity among Divisions and expectations must be matched by appropriate resourcing for each sector.

15	That a national framework be developed that defines and promotes culturally sensitive and safe 'mainstream' general practices and includes resource materials for Divisions. There must be active Indigenous engagement in the development, local delivery and evaluation of this framework.

Comment

Partly supported.

Implications

This recommendation seems to flag an intent to move the delivery of Indigenous health care into the mainstream health system; there is concern among the Network that this may not be the direction Indigenous communities want to go and has the potential to damage the good local collaborations already in place in many areas.

Development of a national framework should have clear aims, be driven by the Indigenous health sector (NACCHO and its affiliates) in partnership with the Network and other

interested parties, and reflect the substantial body of work already developed on cultural respect in health care.

It is acknowledged that Divisions have a role to play in assisting mainstream general practices to treat their Indigenous patients in a culturally sensitive and safe manner, however it should be recognised that different strategies will apply in rural and remote areas to those in urban practices. Lack of consistent and culturally appropriate methods for Indigenous identification remains a barrier to such practice. Isolated activities such as displaying Indigenous posters etc. can be regarded as tokenistic. Research may provide further insight into why Indigenous Australians access health services, including private general practice, less than the rest of the population (which may vary from region to region), however it is important that such research is community driven and designed to meet community, rather than external, needs.

16	That Divisions support the provision of quality multi-disciplinary approaches to care for Aboriginal and Torres Strait Islander peoples by ‘mainstream’ general practices.

Comment

Partly supported.

Implications

Most Divisions have recognised a key role in supporting GPs in the provision of quality multidisciplinary approaches to care, for example, through use of the EPC items, however the uptake of the items by GPs remains highly variable. It is important to recognise the significant experience and expertise that exists within Aboriginal Medical Services (AMSs) and ACCHS that could support Divisions in undertaking this work, however engaging the community controlled sector in this activity will be both time and resource intensive.

Chapter 9	Accountability – no recommendations

Chapter 10	Size and Boundary Alignment of Divisions (Recommendations 17-19)

17 That each Division urgently review its size and alignment to state and territory health region boundaries, with the following criteria in mind:

- its capacity to develop the key characteristics and core roles of a well functioning Division and a stronger focus on Indigenous health (see Chapters 4, 5, 6 and 8)
- its capacity to achieve the national key performance indicators (when available) (see Chapter 7), and
- its demonstrated ability to work effectively with state and territory health authorities. That all Divisions then negotiate with neighbouring Divisions in order to reach agreement about necessary changes.

Comment

Without the KPIs, this recommendation cannot be implemented.

Implications

While alignment of boundaries may provide greater functionality for many Divisions, the complexities of implementing such changes must be taken into account, such as the implications of State governments changing their own health service boundaries. The impact of recommendations 18-19 on each Division as an autonomous corporate entity also needs to be considered.

A number of amalgamations have recently occurred; other Divisions are currently exploring the benefits and risks. This recommendation therefore provides a constructive (funded) environment in which to pursue these discussions. There are already many examples of "virtual" amalgamations or achieving economies of scale through joint programs or contracting of services, e.g. HR, IT/IM, purchase of stores, etc., and these activities should continue to be encouraged.

Because of the impact of boundary changes across multiple Divisions, and the potential for conflict, the process could be supported via state or regional meetings in which like-Divisions could also consider alternative solutions such as virtual amalgamations. Individual negotiations are unlikely to result in system-wide, effective change.

18	That the arrangements for managing under-performance in the Divisions network, to be developed as part of the national performance system, include provision for changes to the size and boundary alignments for under-performing Divisions.

Comment

See discussion regarding Chapter 7.

Implications

Forced amalgamations or boundary changes may have broad consequences for Divisions in regard to relationships with other funding bodies, local organisations and health services, etc. Divisions must be provided with guidance and support to enable them to determine the most appropriate boundaries to deliver on their contracted objectives (with all funders).

19 That those Divisions deciding to pursue size and boundary changes with funding implications for Commonwealth be required to submit a business case to the Department of Health and Ageing for approval. This business case should cover:

- justification of how the changes will achieve the best possible configuration of the Divisions involved, given the criteria in Recommendation 17
- any processes necessary for achieving the changes, such as extraordinary meetings of members, and the timeframe for these processes
- a budget outlining details of:
  - any expected one-off costs to the Division/s arising from the changes
  - any expected longer-term costs to the Division/s arising from the changes, if applicable
  - any expected savings from the changes, both time-limited and ongoing, and
- a request for one-off funding to assist in meeting the costs of implementing the changes, if justified by the identified costs and savings.

Comment

See above.

Implications

A broader process for considering optimum sizes and alignments of Divisions, managed at the state or national level of the Network, would also assist in the development of business cases for proposed amalgamations. The acknowledgement by the Report of the costs of amalgamation is positive.

Chapter 11	Membership and Governance (Recommendations 20-24)

20	That all Divisions be required to demonstrate how they are actively engaging with practice staff other then general practitioners. This could be achieved by broadening the membership of Divisions, or through other structures or strategies. The Panel further recommends that a national key performance indicator be established to monitor the active engagement of Divisions with all practice staff.

Comment

Supported in part. See discussion regarding Chapter 7.

Implications

As the Review acknowledges, most Divisions are already undertaking substantial amounts of activity aimed at practices' clinical and business staff and at building the capacity of practices through streamlining systems and processes. A KPI on the engagement of practice staff must reflect a diversity of approaches, variable capacity (the number of practices that Divisions must engage with varies greatly), and allow for gradual change. Mandating immediate changes to membership would be counterproductive and difficult to enforce; this recommendation cannot be implemented in such a way as to cause GPs to withdraw from Divisions.

The process of opening Division membership to non-GPs will require a long-term developmental approach, and is currently not a priority for many Divisions. For some Divisions, it may be contentious for their GP members. Participants at the Summit felt it would be vital to bring members along with any change.

Further, "all other health professionals in their communities" are not the same as "practice staff". The implications of expanding Divisions' membership to this broad group "as equal members with general practitioners" are substantial, and it also seems to contradict the previous recommendation that the focus of Divisions must be on GPs and general practices.

21	That all Divisions be responsible for offering support and services to all general practitioners and practices in their catchment areas, and for sending them essential public health information regardless of whether or not the general practitioners are recognised as Division members.

Comment

Supported in part.

Implications

While most Divisions attempt to communicate with all GPs and practices in their catchment areas, regardless of membership status, this recommendation may not be practicable in all circumstances, particularly where practices may refuse information from the Division. The extent of this task and the likely costs would need to be assessed, and possibly negotiated with public health units of state health departments.

22	That membership of Divisions be determined by an annual written application process.

Comment

Supported.

Implications

This recommendation would provide a good measure of the number of GPs accessing Divisional support and/or services; it may also encourage GPs (and others if the membership is expanded) to become more actively involved in the Divisions Network and its Board(s), representation, etc. and provide information on the diversity of membership of

Divisions. It does, however, have resourcing implications for Divisions who do not currently have such a process in place. It may also have the effect of reducing the size of memberships, thus compromising the reach and effectiveness of Divisional activity. Measurement of active participation of GPs beyond just membership would also provide useful data for Division planning purposes.

23 That a position be mandated for at least one community representative with full voting rights on every Division board, and further:

- that each Division follow an open, fair and transparent process for the appointment of a community representative
- that the Australian Divisions of General Practice (ADGP) produce guidelines and best practice models to facilitate the involvement of community representatives as members of Divisions boards, including training and support requirements, and
- that a national key performance indicator be established to ensure the inclusion of community representatives on the board of the Divisions network.

Comment

Not supported.

Implications

Whilst active community participation in Divisions is strongly supported, a mandated community representative position could be regarded as tokenistic, with little guarantee that this alone will achieve a greater focus on community or evidence that it would lead to better health outcomes (as has been demonstrated in the community services sector). This recommendation would also involve amendment of constitutions, which is a lengthy and costly process (as demonstrated via the process currently being undertaken by ADGP).

Ensuring that changes to Divisions' constitutions are compatible with mature corporate governance processes is vital. As independent companies, Divisions are bound by legislation that requires the company to ensure its directors have the requisite skills necessary to carry out their duties.

The difference between "community" and "consumer" was not clearly defined in the Report. The varied environments of Divisions mean that there will be a variety of strategies to achieve effective community input to the Division. With appropriate resourcing, ADGP could work with Divisions to develop guidelines and best practice models, including training and support requirements, to facilitate the involvement of community representatives in Divisions, including but not limited to their involvement on Division boards.

24 That national key performance indicators be established to ensure the maintenance of good governance and high-quality governance training for all board members of organisations in the Divisions network.

Comment

Supported.

Implications

Several State Based Organisations (SBOs) and many Divisions have been undertaking such work for a number of years. A consultation process will be needed to identify "best practice" models already being used in business and determine the most cost-effective way to deliver such training throughout the Network (for example, ADGP negotiating national membership of bodies such as the Australian Institute of Company Directors for all members).

25 That the Divisions network implements a 'hub and spoke' structure to ensure a more formal membership and governance relationship between the Australian Divisions of General Practice (ADGP), the State-Based Organisations (SBOs) and Divisions.

Comment

Not supported without further consultation within the Network.

Implications

Although described as hub and spoke, the recommended model appears to be a federated structure. The problems identified in the Review with the current Divisions Network structure, such as "duplication of effort and services, competition for resources, arguments over responsibilities, breakdowns in communication and opportunities for game playing" could also be seen as reflective of the federated political system. The Review states that "policy development and consultation needs to be more inclusive of, and driven by, the views of grassroots members". It is unclear how removing the direct link between local Divisions and the national body in a federated model would support this.

Based on discussions at the Summit, a working party with representatives from GPs, Divisions, SBOs and ADGP is currently investigating the risks and benefits of various models that will ensure the direct line between Divisions and ADGP is retained, whilst also strengthening the links between ADGP and SBOs. These models will then be presented to the Network for comment. This work should be allowed to be completed before implementation of any new structure for the Network.

26 That the role of the Australian Divisions of General Practice (ADGP) be to act as the national peak body for the Divisions network, including:

- leadership, representation and advocacy for the Divisions network at the national level
- policy development, strategic planning and program development at the national level, in association with relevant stakeholders and peers
- negotiating with the Commonwealth Government on matters affecting the Divisions network
- managing standards and quality issues for the Divisions network, and
- promoting communication and the sharing of information and resources within the Divisions network and with other national organisations.

Comment

The Network strongly believes that its roles and functions should be mutually determined by Divisions, SBOs and ADGP. The ADGP/SBO Coalition has given substantial consideration to the respective roles of ADGP and SBOs, and has drafted a roles document that has been sent to Divisions for consultation[1].

Implications

Participants at the Summit saw a major role for ADGP in national primary health care policy and planning that adequately reflects the views of Divisions and grass roots GPs. Virtually all participants recognised the importance of a national structure to advocate for and represent the Network in federal policy development. Most participants also saw a role for ADGP in advocating and negotiating for Divisions in relation to contracts and programs.

The Review suggested that ADGP should not be involved in industrial issues or political debate about general practice, however no justification for this position was given. To be

[1] Attachment A

appropriately involved in national policy development and strategic planning that ultimately impacts on the individual practice and/or GP, ADGP believes that it must remain informed and proactive about the key issues affecting general practice and general practitioners.

27	That the role of State-Based Organisations (SBOs) focus on leading, representing and supporting Divisions at the state and territory level, in particular:

- providing program support and services to Divisions
- facilitating linkages and the flow of information between the Divisions and the Australian Divisions of General Practice (ADGP), and between Divisions and other relevant organisations such as the Primary Health Care Research and Information Service (PHCRIS), and
- developing networks and relationships with key stakeholders at the state and territory level.

Comment

See comment above.

Implications

The work undertaken by the ADGP/SBO Coalition sees a strong role for SBOs in State/Territory health policy and planning. Participants at the Summit agreed that SBOs have a major role in interacting and negotiating with state governments and other agencies and services at this level. A majority of Summit delegates felt that SBOs also have a key role in the provision of education and support for Divisions at the state level in order to enhance Divisions' capacity. This role was also thought to include responsibility for the coordination of programs, rather than direct involvement in program delivery, especially where this might lead to competition for funding against Divisions.

28	That the Commonwealth, the Australian Divisions of General Practice (ADGP), State-Based Organisations (SBOs) and Divisions adopt the structure and roles outlined in Recommendations 25-27, with the detailed arrangements to be discussed further and agreed by all parties prior the next round of funding agreements, due from 1 July 2004.

Comment

See comments above.

Implications

It is critical that the Network is supported by an appropriate representation and governance structure that provides clear role delineation, communication and transparency. Participants at the Summit agreed overwhelmingly on the need for clarity of roles amongst Network members based on mutual respect and willingness to learn from each other. It was felt strongly that redefining roles and determining the best structure to move the Network forward must be the responsibility of the Network.

Chapter 13	Funding (Recommendations 29-34)

29	That the Panel recommends that the general thrust of the recommendations of the *Report of the review of the Outcomes-Based Funding formula for Divisions of General Practice* (June 2002), by the Divisions Standing Committee of the General Practice Partnership Advisory Council, be implemented.

Comment

Not supported without further consultation.

Implications

Participants at the Summit felt the Review had a limited view of Divisions' capacity by focussing on their OBF grant. It was noted that the Commonwealth is not the only funder of the Network, and there was a strong call for Divisions to achieve greater diversity of funding. Greater clarity is also needed from the Commonwealth regarding what is being purchased if the increased accountability requirements are to be met, along with a commitment to dual accountability by both the Commonwealth and the Divisions Network.

There is a lack of clarity and information about the proposed new funding formula for Divisions and substantial concerns regarding the move to the ARIA system, particularly as to how it would affect the capacity of rural/remote Divisions. ARIA was developed as an index of accessibility; its application to allocation of funding must be carefully considered.

The Divisions Network must be provided urgently with the financial modelling of the proposed revised funding formula in order to determine its impact. Any proposal to alter the Divisions' funding model must be consultative, transparent and evidence-based, driven by the Divisions Network and supported by greater certainty of funding through a rolling funding triennium. The timeframe to review and agree on the funding formula requires urgent attention through BMAG.

30	That a revised Outcomes-Based Funding formula direct resources to Divisions with greater levels of health inequality, and modelling of the proposed revised Outcomes-Based Funding formula be undertaken to test whether this redirection of funding is achieved.

Comment

Partly supported, given caveats above.

Implications

See previous discussion on Divisions' role in reducing health inequalities.

31	That the Commonwealth examine national burden-of-disease data (when available) to determine its applicability in a future Outcomes-Based Funding formula.

Comment

Partly supported, given caveats above.

Implications

In the context of a national performance system, it must be recognised that it will cost more to achieve the same outcomes in some areas, given the unique geographic and demographic characteristics of certain parts of the country. Divisions could in fact be funded to undertake a significant role in the collection and analysis of burden of disease data.

The entire Network must be resourced at an appropriate level to allow it to meet its contracted objectives, which may require new funding to be allocated to the DGPP. Well performing Divisions should not be penalised by any reallocation of funding within the Network; appropriate funding levels should be based on the agreed performance criteria.

32	That the Commonwealth, as the major funder of the Divisions network: ▪ be clear about the objectives, priorities and outcomes for its funding to the Divisions network, and ▪ consider fewer, broader and simpler funding streams to the Divisions network.

Comment

This recommendation is strongly supported.

Implications

It is suggested in the Review that fund holding "would represent a major shift in the role and focus of Divisions". As the Review acknowledges, however, the MAHS program is a current example of small scale regional fund management, and this type of model could easily be expanded to include non-rural Divisions.

Similarly, as already partially underway in EDQUM, notional budgets for pharmacy or pathology could be managed by Divisions, or programs such as PIP cashed out and managed at the Divisional level to reduce the burden on individual GPs and practices yet ensure that population health targets are met. This debate should not only continue, it is urgently needed.

33	That all funders of the Divisions network be required to ensure that administration and overhead costs relevant to the purposes of their specific funding can be met from the allocation that they provide, and not from individual Divisions' Outcomes-Based Funding allocations.

Comment

Strongly supported.

Implications

This recommendation shows a recognition that the Network has been stretched to breaking point trying to meet all its obligations from within OBF budgets. Similarly, appropriate indexation of ongoing programs is necessary to cover increasing costs. All funders should fully cost implementation of programs, rather than relying on the 'goodwill' of the Network to accommodate administration and overheads from within existing budgets.

34	That the Commonwealth investigate the possible introduction of a rolling triennial funding cycle for the Divisions network. If a rolling triennial funding cycle is not possible for the Divisions network, that the Commonwealth explore other options for ensuring greater certainty in relation to future funding to the Divisions network.

Comment

Strongly supported.

Implications

A rolling funding cycle would provide the Network with a level of security that is currently lacking; it would allow the Network to keep valued staff and enable more meaningful forward planning beyond the three year contract period that now exists.

Chapter 14	Reporting: Recommendations 35-36

35	That a common planning and reporting framework covering all major Commonwealth funding streams to the Divisions network be developed for inclusion in new funding agreements from 1 July 2004.

Comment

This recommendation is partly supported, given the comments earlier regarding the infeasibility of the proposed timeframe.

Implications

The Network would strongly support streamlined planning and reporting. Mechanisms for integrating reporting requirements for funding under current initiatives would need to be developed at the same time. There also needs to be some clear guidelines for how the various branches in the Department of Health & Ageing roll programs out through the Divisions Network, and some onus needs to be placed on the Department for responding to reports in a timely and constructive manner.

Such a framework must be developed in consultation with the Network (BMAG may be the logical forum to undertake this).

36 That documents required under the common planning and reporting framework for the Divisions network:

- be linked in time with completion of the Annual Survey of Divisions
- continue to be submitted electronically to a national independent body for collation, analysis and feedback to the Divisions Network, and
- be publicly available via the Internet.

Comment

Supported.

Implications

PHCRIS does an excellent job of collecting, analysing and making available this information to the Network. It should be supported to continue to refine processes so that information is timely and continues to be relevant to the needs of the Network.

ATTACHMENT A

Roles of ADGP and SBOs in the Divisions Network

(agreed at national meeting of ADGP and SBOs 23 August 2003)

The Divisions Network seeks to advance the health of the Australian community through the delivery of high quality general practice services that are well linked with the broader health system. The work of divisions at a local level is supported by state-based organisations (SBO) at the state and territory level, and by Australian Divisions of General Practice (ADGP) at the national level.

Role of ADGP

The role of Australian Divisions of General Practice (ADGP) is to act as the national peak body for the Divisions Network, including

1. leadership, representation and advocacy for the Divisions Network at the national level;
2. policy development, strategic planning and program development at the national level, in association with relevant stakeholders;
3. negotiation with the Commonwealth Government and the Department of Health & Ageing on matters affecting the Divisions Network;
4. manage standards and quality issues for the Divisions Network;
5. promote the communication and the sharing of information and resources within the Divisions Network and with relevant organisations;
6. work with and support divisions and SBOs to build the capacity of the Divisions Network.

Role of SBOs

The role of State Based Organisations (SBOs) is to work in partnership with divisions to

1. provide leadership, representation and advocacy for divisions at the State/Territory level by
   (a) negotiation with State/Territory Government on matters affecting divisions;
   (b) ensuring divisions' input into policy development, program development and strategic planning at the State/Territory level;
   (c) developing networks and relationships with key stakeholders at the state and territory level;
2. support and strengthen divisions by
   (a) targeted work with divisions to build capacity;
   (b) services to divisions consistent with their aims and identified needs;
   (c) program planning, development and coordination in partnership with divisions
   (d) facilitating and promoting linkages and the flow of information and resources across the Network, and between divisions and other relevant organisations;
3. support the work of ADGP at the national level by
   (a) co-ordinate information to and feedback from divisions where appropriate
   (b) contribute to national policy and program development.

Draft