Submission

Review of the Role of Divisions of General Practice

December 2002

The future

Divisions work at the local level to improve the GP contribution to health care and population health by:

- *Enhancing the quality of general practice in the local area*
- *Improving coordination between GPs and other health providers.*

The Divisions Network is essential to any attempts to improve the Australian health system because divisions are the only vehicle through which GPs, who are the key component of primary health care services, can be effectively engaged. Divisions will increasingly be recognised as the best platform at the regional level for innovation and development of the health system and as the conduit for the delivery of primary care programs and services for both State and Commonwealth.

Divisions will provide the link between Commonwealth and State health systems and between public and private providers. They will link with state-funded services and the private sector to promote the integration of all primary care services and their better co-ordination with acute services. Divisions will enable continuing quality improvement in general practice and other primary care services, support the management of systems change and, through the Divisions Network with SBOs and ADGP, create productive linkages with primary care services and the acute sector at regional, state and national levels.

Boundaries

If changes to divisions' boundaries are proposed they must be based on clear criteria and a rationale. The importance of working with other health services and the need to collect comparable health data suggest that the building blocks for divisional boundaries should be similar to those for other health services. As other services, and Victorian Health Department's (DHS) Regions, base their boundaries on aggregations of local government areas (LGAs), the use of these as the basis for divisions' boundaries would assist divisions' involvement in local health planning and coordination/integration work.[1] Whatever areas are proposed as the basis for division boundaries, the aggregations into divisions should be influenced by other relevant factors such as hospital catchments and natural population flows.

GPDV suggests that the Panel recommend that criteria for the definition of divisions' boundaries be adopted and that the actual determination of the boundaries be carried out by the field in consultation. The involvement of divisions in the decisions will ensure that GPs accept the changes more readily than if new boundaries were to be determined by the panel, DoHA or another central source.

[1] GPDV has analysed Victorian divisions' involvement in Primary Care Partnerships (PCPs), which bring together all the state-funded primary care services along with general practice, and found that where the boundaries of divisions and PCPs are less well aligned there is less involvement of the division in the activities of the PCP.

Divisions' reaction to proposed changes to division boundaries tends to be influenced by funding considerations because the funding formula is based on the population within divisions' areas. It would be helpful if the issues of funding could be separated from the definition of boundaries, or at least if funding were much less dependent upon divisions' "territory". This would enable boundaries for divisions to be set according to criteria that aim to enable them to function optimally. These criteria would be related to the ideal size of a division (both geographically and in terms of the number of practices it covers), and to other health services and providers (primary and acute) with which divisions work.

The current funding formula is based on population (with additional loadings) but this is not the most relevant factor when determining the capacity of a division to contribute to improving general practice and coordination with the rest of the health sector. Other relevant factors are distances within the division, the number of other health services with which the division has to collaborate and the number of general practices in the division. The number of practices is a particularly important measure because of the targeted practice support[2] services that are essential to the enhancement of the quality of general practice and to enable GPs to take up Commonwealth programs.

Key features of an improved system for determining the size and boundaries of divisions are:

- Clear criteria for division boundaries, based on existing categories such as LGAs, aggregated to recognise the catchments of hospitals and other health services with which divisions work.
- Division boundaries that do not cross over health department region boundaries, to enhance the capacity of divisions to work with the health and community services within their regions.
- Separation of boundaries and funding, so as not to contaminate the issue of practicable boundaries with how to retain current funding levels.
- Basing determination of minimum core funding for divisions on the work already done on the cost and capacity of divisions, with additional analysis by a health economist
- Ensuring that adjustments to boundaries do not result in divisions that are so large they risk losing that local focus which promotes relevance to general practice and GP involvement. (S*ee GP engagement below)*[3]
- that any new boundaries make as few changes as possible to present divisional boundaries in order to retain the engagement of GPs with their divisions that has been built up over the years.

GP engagement

The Panel has the opportunity to reinforce the high levels of GP engagement in divisions (currently over 90%) that are necessary for effective implementation of quality improvement programs in practices.

The strength of divisions is that they have gained support among the majority of GPs by linking groups of GPs together and focussing on building practice capacity and responding to local needs

[2] GPDV promotes a 'systems thinking' approach for practice support that divisions undertake when they implement a range of initiatives. This involves divisions assisting with analysis of current practice systems, so that each practice can identify what they need to add to, or alter in, their system, so that improvements, or new initiatives (e.g. CDM) can be implemented.

[3] The levels of GP involvement, which are currently over 90%, are necessary for effective implementation of quality improvement programs in practices, including those specifically funded in the 2001 Commonwealth budget.

within division boundaries. This has created a sense of ownership of divisions by GPs that is critical to their ongoing success and is based upon the divisions' current credibility with their members. To maintain this credibility, it is important for the Panel's recommendations to ensure that divisions are able to continue to respond to the needs of the local population, together with other primary care services in the area, as well as to implement national programs. This requires adequate core funding to provide flexibility to address local health issues in addition to the targetted funding for national programs.

Divisions work to enhance the quality of general practice by promoting:

- *Evidence based practice for high quality clinical care – the 'science' of practice*
- *Effective patient engagement – the 'art' of practice*
- *Good quality practice systems – the 'technology' of practice*

Workforce

To deliver the high quality general practice services expected by Australians there must be enough GPs, with appropriate skills supported by effective practice systems and infrastructure. When GPs are so busy that they can focus only on patient consultation after patient consultation, it is extremely difficult to make sustainable improvements to practice, to take up population health programs, to set up any of the systems necessary to make those improvements (e.g. EPC items) or to find time for effective involvement in divisions of general practice. Adequate GP numbers are therefore essential.

Since substantial change to GP numbers requires Commonwealth government policy intervention, the future role of divisions and SBOs in this area will be to contribute to a well-trained, sustainable workforce, rather than to increase GP numbers. For that reason, divisions' future focus needs to be on supporting the existing GP workforce (and to some extent relieving workload pressures on it). Programs like those included in GPDV's Key Result Area of GP Workforce will help divisions achieve this:

- Nurses in general practice (using other health professionals to relieve pressure on GPs)
- GPs for Aboriginal health (working with Victorian Aboriginal Community Controlled Health Services to fill GP vacancies within those health services. *See Attachment B*)
- Divisions in GP education and training (in recognition of divisions' role as a major provider of continuing professional development)
- General Practice Business Advantage (promoting a national program that aims to improve practice capacity, viability and quality in ways that maximise links with divisions and division programs)
- After Hours Primary Care Services (solutions to enable GPs to participate in after-hours services without reducing their daytime services).

The workforce shortages in urban areas show the need for the development of strategies to deal with the pressure on GPs everywhere, not just in rural divisions. The impact of workforce issues on all aspects of general practice and the variety of solutions available to divisions, as shown above, suggest that to separate workforce issues from other activities of divisions will reduce the chances of success. There are a number of ways to address workforce issues and the solutions in each state are different. GPDV recommends that if the Panel proposes changes to the provision of workforce support for general practice, it enables each state to make arrangements, within the Panel's guidelines, to suit the circumstances in that state.

Divisions and Primary Care

The need for all parts of the primary care sector to work together is widely accepted; divisions have played a prominent part in promoting the integration of services. The Victorian GPII is a good example of joint work, involving divisions, state health and local government. *(Attach't A).*

The creation of 'Divisions of Primary Care' has been proposed as a natural development of Divisions of General Practice, much as Primary Care Trusts have succeeded Primary Care Groups in Britain. Nevertheless the concept of 'Divisions of Primary Care' is not clearly defined and needs significant development. Divisions of Primary Care could be a mechanism for the extension to other health professionals of the services provided to GPs by divisions of general practice and a conduit for the roll-out of Commonwealth programs by all parts of the primary care sector. On the other hand, they have been proposed as a vehicle for the more effective direct delivery of health services to consumers. If service delivery is the goal, then there would need to be a detailed implementation strategy devised in collaboration with the state health departments, since so much of the primary care sector is funded by the states.

Imposing a new structure on divisions to make them 'Divisions of Primary Care' rather than 'Divisions of General Practice' is not likely to be the most effective way of achieving integration between general practice and the rest of the primary care sector and cannot resolve the State/Commonwealth problems that are systemic. It risks losing the interest of non-GP primary care providers, who may not welcome a structure that appears to place general practice in a privileged position; it may also risk the involvement of GPs, if they perceive that they no longer have 'ownership' of the division.

In Victoria, divisions of primary care appear likely to duplicate the role and function of the Primary Care Partnerships, the Department of Human Services' strategy that brings together all state-based primary care agencies, including general practice through divisions, to achieve better coordination of services, assessment and referral for patients entering the primary care system.

The situation of the Central Australian Division, where only a very few GPs are in private practice, is very different from most of Australia, so that a structure that has worked well there may not be easily reproduced in other areas.

Structure of SBOs and ADGP

Although the present formal structure of the Divisions Network is far from ideal, the real issue for the Panel is the clarification and further development of their respective roles and functions. Rather than specify the organisational relationships of ADGP, SBOs and divisions, the Panel might make recommendations about their roles: for example at what level ADGP works, whether they provide direct support to divisions and GPs, how they provide useful co-ordination and resources to SBOs; how SBOs provide leadership, capacity building for divisions and links to state health departments, etc. Form follows function and unless the roles are clear it is not really possible to say what the structure should be. As divisions, SBOs and ADGP are all separately incorporated entities it is more appropriate for their formal structures to be determined by them than by funding bodies.

GPDV's views about the respective roles are set out in our answer to Question 7 in the Standard Questions Attachment.

GPDV
20 December 2002

Attachment A

Collaboration at the state level: an example

Building on the General Practice Immunisation Incentives in Victoria

Given that local government provides approximately half of all childhood immunisation services in Victoria, bringing together divisions and local government was an essential part of making the General Practice Immunisation Incentives (GPII) effective in this state. Collaboration between the two allowed for identification of one of the barriers to the program (data inaccuracies) which in turn not only improved immunisation rates, but allowed local government and divisions together to better target the hard-to-reach groups. This was achieved when GPDV negotiated with the State for a contribution to the GPII program. The result is the DHS Regional Data Cleaning Program in which DHS funds regional project officers, to implement a systematic approach to monitoring and improving immunisation reporting with divisions and local government.

The data cleaning showed that the actual number of immunisations being performed was higher than the recorded figure. As a result the data in the ACIR database is now more accurate. The program of collaboration between divisions and local government is resulting in quality improvements in other areas of immunisation service provision.

Collaboration for better health – local government's view

'I think it [GPII in Victoria] has enabled local government and divisions to work together to meet one objective – increased coverage rates'

Do divisional immunisation coordinators assist your local government?
Yes: 68% (n=57 local government respondents)

How effective are divisional immunisation coordinators in improving collaboration ?
Very effective or effective: 69% (n=55)

From Centre for Community Child Health, Royal Children's Hospital Melbourne, 2002, Effect of GPII funding to Divisions of General Practice on Immunisation Provision in Victoria pp. 40-43.

Attachment B

Victorian Divisions' contribution to improving Aboriginal health

In the context of Aboriginal health GPDV recognises the principle of Aboriginal self-determination and community control and works on areas identified as priorities for general practice services to Aboriginal communities by the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and its members. GPDV promotes the use by divisions of protocols endorsed by VACCHO for consultation and collaboration with Aboriginal Community Controlled Health Services (ACCHSs), when working with their local communities. At the statewide level, GPDV works with VACCHO towards the goal of each Aboriginal community having its own community-based, locally-owned, culturally-appropriate and adequately-resourced primary health care facility in which general practitioners have a role.[4]

RWAV and VACCHO have identified the GP vacancies in Victorian ACCHSs, and GPDV is involved in the work with those organisations and divisions to help fill them.

GPDV has collated information on the amount of funding received by Victorian divisions through the ATSI loading ($2.55 per person), in response to VACCHO's request. Divisions receive between $517 and $6,500 per division, depending on the reported population (although ABS statistics for the Aboriginal population are unreliable – *see excerpt from submission below*) or $60,000 for the whole of Victoria. A better use of this limited funding in Victoria would be to pool it to fund one statewide staff position at VACCHO, to work on the interface between divisions and ACCHSs. Divisions could be asked by the Commonwealth to include their work with the local ACCHS as a key performance indicator. Preliminary discussions suggest that VACCHO would support this funding change to strengthen the contribution of general practice to improving Aboriginal health.

Excerpt from GPDV's submission to the Review of the Funding Formula for Divisions of General Practice (January 2002):

It is widely accepted that census figures for the Aboriginal population are completely inadequate. The funding Review does not refer to this problem at all. A recent VACCHO report states:

> "The 1996 Australian Bureau of Statistics Census reported that there are 22,587 Aboriginal people living in Victoria (ACCHS believe that these figures are understated by up to 60%) and it should be acknowledged that the [current] survey points out that Aboriginal people use both mainstream and ACCHS." (VACCHO, 2001, *Current Workforce & Future Needs Analysis: Results of community consultations* p.9)

While the ABS figures are acknowledged to underestimate the Aboriginal population, there may be other ways of allocating funding to divisions, which would need to be examined in consultation with Aboriginal health organisations. For example, it might be possible to consider AMSs' needs for the general practice workforce. In Victoria, VACCHO found (in 2001) that there are 29 (9 EFT) GPs in the 21 Aboriginal Community Controlled Health Services (ACCHSs). 50% of ACCHSs did not have a doctor working at their organisations and 90% required additional doctors. While GPDV is not advocating a particular formula for allocating funds to divisions, we believe this issue could be more thoroughly examined by the Review committee and NACCHO could be invited to have some input. NACCHO have previously stated publicly that they have concerns about funding allocated to divisions for Aboriginal health, and divisions' accountability for it. In Victoria, VACCHO is also concerned about how the money is actually used by divisions.

[4] A copy of GPDV's MoU with VACCHO was provided to the Panel on 9/12/02 and can be viewed at www.gpdv.com.au/Final%20MOU.pdf.

Feedback from some divisions suggests that divisions of general practice are also sensitive to these issues. One division suggested that those divisions receiving substantial funding on the basis of ATSI population within their boundaries should be obliged to report specifically on the activities undertaken with that funding. Another division points out that it might be more likely for divisions to undertake activities in Aboriginal health if this loading were not subsumed into the core grant.

The current funding Review could provide an opportunity to examine the best method for allocating funds to divisions to encourage their work in Aboriginal health. This must be done in consultation with Aboriginal health organisations.