Review of the Role of Divisions

GPDV RESPONSE TO REPORT OF THE DIVISIONS REVIEW

GPDV welcomes the report of the Divisions' Review of the Role of Divisions of General Practice. The major directions outlined by the Review and the characteristics of a well-functioning division sit well with the current work undertaken by Victorian divisions, although in many areas, divisions would need to be resourced at a higher level in order to make the best possible contribution to the quality of general practice, and its improved coordination with the rest of the primary care sector and the hospital sector.

GPDV has provided opportunities for Victorian Divisions to discuss the recommendations of the Review Report, both at board and at CEO level. Some of the Divisions' key messages are:

- Support for a national primary care policy, which describes how divisions fit into the national context
- The structure and governance arrangements both of Divisions, and of the Divisions' Network, should be determined by the members
- Support for accreditation, and concern about how rolling audits fit together with having been found by an external, independent assessor, to meet accreditation standards.
- Need for more resources if all the review recommendations are to be successfully implemented.

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. **Implications** – major work for the Commonwealth and extensive consultation with the States & Territories required. **Comment** – The responses to the Divisions Review highlight that in Victoria at least, divisions have developed many partnerships across the primary care sector. It will be crucial for the Commonwealth to clarify whether this and the following recommendations relate to the development of a primary care policy or a general practice policy. The scope and extent of the work of Victorian divisions suggest there is a need for a primary care policy, and GPDV has been advocating for some time for this. Supported.
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. **Implications** – **Comment** – Supported
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.

	Implications – **Comment** – Supported as essential for maintaining high levels of GP engagement. If the policy only focused on the Commonwealth & State agendas with no local discretion, GPs would be unlikely to support it.
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. **Implications** – Note that in some areas with large numbers of practices, this will be a larger impost than in other areas. **Comment** – Support the whole of practice approach, and it continues the trend through EPC and CDM implementation in Victoria.
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. **Implications** – This will mean engaging NACCHO and in Victoria, VACCHO and the VicHealth Koori Health Research & Community Development Unit from the University of Melbourne in the discussions. Note: many divisions believe that they are not currently resourced at a level necessary to engage in research. **Comment** – Support.
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. **Implications** – Collaboration usually means some resources are applied. Will these be additional resources, or additional requirements? **Comment** – Support and call for adequate resourcing for more rigorous evaluation.
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. **Implications** – Need clarity about overall workforce issues and within that, the response for the rural areas. **Comment** – A review may be useful. With regard to possible amalgamation, workforce agencies work directly with general practices, while GPDV works with divisions. This is a fundamental difference between the way the two organisations work, which may make amalgamation impractical. GPDV and RWAV are in the process of extending an MoU for three years, with commitments to working together on a range of activities relevant to both organisations.

8	That to assist in the further and future identification of general practitioner workforce issues, a formal collaboration be established between the Divisions network and the Australian Medical Workforce Advisory Committee (AMWAC). **Implications** – Division involvement in the identification of workforce issues has the potential to ensure better information is available to inform decision-making. **Comment** – Experience in Victoria suggests that workforce data collection through divisions may not be the most effective way to proceed: workforce data information is not useful unless it is complete and consistent, when, as is the case with the rural workforce dataset, it is a census rather than a sample survey. This is difficult to achieve when so many different organisations (ie all divisions, plus others) are involved in collection. Working with AMWAC is welcomed, a formal division role in data collection is cautioned against without extensive consultation with divisions.
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. **Implications** – For Victorian divisions, a continuation of existing priorities, for the most part, although more resources are necessary to fully support all these areas. **Comment** – Positive to acknowledge divisions' key roles in education, research, evaluation and development. Divisions need to see resources flow in acknowledgment of these roles, e.g. through GPET and PHCRED. Additionally, resources to SBOs to support divisions' roles in some of these areas (e.g. in GP education) would enhance the work. Lack of direct IM funding in divisions has been an impediment to population health. Divisions' role in the reduction of health inequalities is more complex than the report might suggest. Difficulties relate to: the social determinants of health, which divisions are not in a position to address (e.g. disparity of income, education, housing etc.); the difficulty of attributing improvements to particular interventions. If this section relates to access to health services, this should be stated and reflected in appropriate indicators and funding arrangements.
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. **Implications** – Important to ensure that the Main Aim statement is right, as it will influence the direction of divisions and will provide the basis for performance indicators. **Comment** – The statement of the Main Aim of Divisions that is currently in use seems still to encapsulate the work of divisions; need to ensure that if the statement is revised, it is an improvement. The suggested one in the report could be taken to suggest that divisions have primary responsibility for improving health and for improving the whole primary care system. A more modest statement that describes how divisions work (so

	that external stakeholders can understand it) as well as their aim might be along the lines of: *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.*
Chapter 7	In Pursuit of Quality and Performance: Recommendations 11–12
11	That a national performance system be established by the Commonwealth, in consultation with the Divisions network, to include: • national key performance indicators for all organisations in the Divisions network • the flexibility to add additional performance indicators for local priorities • a system of rolling audits for all organisations in the Divisions network • the 'earned autonomy' concept to reward strong performance • arrangements for managing under-performance, and • if appropriate, the quality framework of the Australian Divisions of General Practice (ADGP), including standards, and an accreditation system based on those standards. **Implications** – Has the potential to promote continued strengthening of division infrastructures. **Comment** – Earned autonomy should be based on accreditation (ie provided by an objective, external assessment) and should release divisions from the burden of overly detailed reporting. The relationship between rolling audits and accreditation would need to be clarified (the extent to which audits are necessary if an organisation meets accreditation standards). Need for consultation with divisions on performance standards and implementation.
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. **Implications** – Extensive consultation needed soon. **Comment** – This time line is likely to be unrealistic. GPDV supports ADGP's comments about the importance of establishing mutual accountability (between the Department and Divisions' Network) through the Business Management Advisory Group (BMAG).
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
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. **Implications** – **Comment** – Supported. NACCHO's submission to the Divisions' Review included a range of very useful suggestions for areas on which Aboriginal Community Controlled Health Services (ACCHSs) and divisions could usefully work together. These suggestions focused on both mainstream general practice settings and community controlled health services; and suggested ensuring that some of the support that mainstream practices have received from divisions could be extended to ACCHSs (e.g. re GP accreditation, EPC etc.)
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. **Implications** – This must be understood in the context of indigenous communities priority and preference for resourcing of Aboriginal community controlled health services. GPDV's MoU with VACCHO would require that there is engagement by ACCHSs and/or their peak bodies in this work. **Comment** – Support would be stronger if recommendation called for NACCHO and its affiliates to be funded to lead this work.
16	That Divisions support the provision of quality multi-disciplinary approaches to care for Aboriginal and Torres Strait Islander peoples by 'mainstream' general practices. **Implications** – Counter to GPDV's acknowledgment in our MoU with VACCHO that the Aboriginal community have the right to decide on how they receive health care, and to provide that within their communities. **Comment** – VACCHO would need to give a view on this and would probably wish for a differently worded recommendation. GPDV / VACCHO MOU binds us to first support care through Aboriginal community controlled settings. NACCHO's submission to the Divisions' Review included a range of very useful suggestions for areas on which ACHHSs and divisions could usefully work together. These suggestions focused on both mainstream general practice settings and community controlled health services; and suggested ensuring that some of the support that mainstream practices have received from divisions could be extended to ACCHSs (e.g. re GP accreditation, EPC etc.)
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 its alignment to state and territory health region boundaries, with the following criteria in mind: • its capacity to develop the key characteristics and core roles of a well functioning Division and a stronger focus on Indigenous health (see Chapters 4, 5, 6 and 8) • its capacity to achieve the national key performance indicators (when available) (see Chapter 7), and • its demonstrated ability to work effectively with state and territory health authorities.

	That all Divisions then negotiate with neighbouring Divisions in order to reach agreement about necessary changes. **Implications** – Very few in the short term, as KPIs not available. **Comment** – The recommendation provides little guidance, so is likely to have little impact. Criteria would need to be set at (at least) statewide level to have an effect. Individual negotiation is not likely to result in system-wide, effective change. More detailed criteria than those points in the recommendation would be necessary to make a systemic improvement.
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. **Implications** – Too little information to comment. **Comment** –
19	That those Divisions deciding to pursue size and boundary changes with funding implications for the Commonwealth be required to submit a business case to the Department of Health and Ageing for approval. This business case should cover: • justification of how the changes will achieve the best possible configuration of the Divisions involved, given the criteria in Recommendation 17 • any processes necessary for achieving the changes, such as extraordinary meetings of members, and the timeframe for these processes • a budget outlining details of: – any expected one-off costs to the Division/s arising from the changes – any expected longer-term costs to the Division/s arising from the changes, if applicable – any expected savings from the changes, both time-limited and ongoing, and • a request for one-off funding to assist in meeting the costs of implementing the changes, if justified by the identified costs and savings. **Implications** – Clarity about process may encourage amalgamations. **Comment** – The business case request is a reasonable one, and acknowledgment of 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 than general practitioners. This could be achieved by broadening the membership of Divisions, or through other structures or strategies. The Panel further recommends that a national key performance indicator be established to monitor the active engagement of Divisions with all practice staff. **Implications** – Re broadening membership: this will require a long term developmental approach, and is not a priority for divisions. Re the engagement of practice staff: for those divisions with large numbers of practices and practices with large numbers of staff, this will be a much greater task than for those with small numbers **Comment** – GPDV would support the provision of opportunities for engagement by practice staff, and many divisions are already working in this way (e.g. supporting practice nurse networks), but imposing a change to membership would not be likely to achieve best governance for divisions, and may risk the GP engagement that is

	necessary for the effective functioning of divisions.
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. **Implications** – Health department mail-outs can be onerous and costly, but worthwhile. The wishes of a small number of practices in the catchment area (to not be members of divisions) may make this recommendation difficult to implement. **Comment** – The extent of this task and the likely costs would need to be assessed, and negotiated with the public health section of state health departments.
22	That membership of Divisions be determined by an annual written application process. **Implications** – For those who do not have an annual process, this will be additional work. On the other hand, many do this already as part of a thorough assessment of their performance by their members, e.g. through an annual survey. Supported.
23	That a position be mandated for at least one community representative with full voting rights on every Division board, and further: • that each Division follow an open, fair and transparent process for the appointment of a community representative • that the Australian Divisions of General Practice (ADGP) produce guidelines and best practice models to facilitate the involvement of community representatives as members of Division boards, including training and support requirements, and • that a national key performance indicator be established to ensure the inclusion of community representatives on the boards of the Divisions network. **Implications** – **Comment** – GPDV Policy Issues Paper no. 20 (cited in the Review Report) sets out GPDV's draft recommendations which do not support this. Subsequent responses to the paper confirm that most divisions and other stakeholders believe that meaningful consumer/community input requires more than a position on the board; and do not support the imposition of a model that requires boards of management to include a consumer representative. Not supported.
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. **Implications** – Clarity about what constitutes good governance is desirable. **Comment** – Support but only after consultation.
Chapter 12	Structure and Roles of SBOs and the ADGP: Recommendations 25–28
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. **Implications** – Although described as hub and spoke, the model appears to be the usual Australian federated structure. This will be a change, but has the potential to ensure more accountability. Reduced size of ADGP board a positive move.

	Comment – GPDV would support consideration of the federated structure. The view in Victoria seems to be that a federated model would be positive for accountability reasons and would help ADGP and SBOs work together. Division representatives at the Victorian CEOs network and GPs at the Divisions' Forum (Sept 2003) stated that discussion of this model was not resolved at the Divisions' Summit in Adelaide (Aug 2003).
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** – GPDV supports the statement of roles of ADGP and SBOs, agreed by SBOs and ADGP at their meeting on 23/8/03. [(attached)
27	That the role of State-Based Organisations (SBOs) focus on leading, representing and supporting Divisions at the state and territory level, in particular: • providing program support and services to Divisions • facilitating linkages and the flow of information between Divisions and the Australian Divisions of General Practice (ADGP), and between Divisions and other relevant organisations such as the Primary Health Care Research and Information Service (PHCRIS), and • developing networks and relationships with key stakeholders at the state and territory level. **Comment** – GPDV supports the statement of roles of ADGP and SBOs, agreed by SBOs and ADGP at their meeting on 23/8/03. (attached)
28	That the Commonwealth, the Australian Divisions of General Practice (ADGP), State-Based Organisations (SBOs) and Divisions adopt the structure and roles outlined in Recommendations 25–27, with the detailed arrangements to be discussed further and agreed by all parties prior to the next round of funding agreements, due from 1 July 2004. **Implications** – **Comment** – Supported with the above reservations
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.

Implications – The report was not widely circulated when it was completed, supposedly because funding issues were to be referred to the Review of the Role of Divisions. Some divisions have expressed concern that they are unfamiliar with the recommendations of the report.
The replacement of the current RRMA formula with the ARIA (or ARIA+) formula may put the capacity of Victorian rural divisions at risk, since a change of formula put Victoria and Tasmania at a relative disadvantage. Both RRMA and ARIA formulas are only a proxy for a measurement of access to health services (ARIA recognises long distances travelled by a small number of people but not other features that affect accessibility, such as terrain, availability of transport, whether or not health services exist in a rural or regional centre etc.) GPDV would support the development of an Index of Access to Health Care for the whole of Australia (not confined to rural areas), as has been under discussion with AIHW, rural workforce agencies and others.

Comment – The full implementation of the report should be referred to BMAG. The implications of introducing the ARIA formula must be carefully examined, given some of the shortcomings of the formula (e.g. measuring geographical distance rather than accessibility). Victorian rural divisions would not support this shift unless they were arrangements to ensure that current funding levels would not be threatened. GPDV would also support development of an Index of Access to Health Care for the whole of Australia.

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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.

Implications –

Comment – Support, provided that targeted, additional funding is provided.

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

Implications –

Comment – Support.

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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.

Implications –

Comment – Support

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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.

Implications –

Comment – Strongly support

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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. **Implications** – **Comment** – Support
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. **Implications** – Although a good idea, this timeline appears to be totally unrealistic. **Comment** – Divisions would welcome clarity about the funding agreements from 1 July 2004, but at the time of writing (October), this timeline appears to be unrealistic.
36	That documents required under the common planning and reporting framework for the Divisions network: • be linked in time with completion of the Annual Survey of Divisions • continue to be submitted electronically to a national independent body for collation, analysis and feedback to the Divisions network, and • be publicly accessible via the Internet. **Implications** – **Comment** – PHCRIS does an excellent job of collecting, analysing and making available its analysis to the Network. Support.

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) targetted 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-ordinating information to and feedback from divisions where appropriate

(b) contributing to national policy and program development