Answers to the Review Panel's Specific Questions

Review of the Role of Divisions of General Practice

December 2002

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

   - Enabling the Commonwealth and other organisations to reach GPs at the practice level – a precondition for any program that involves an improvement to health outcomes via general practice?
   - Linking GPs effectively to other health service agencies to enable the GP perspective to be included in planning
   - Supporting practices in making the systems changes needed for the delivery and evaluation of population health programs

(Concrete examples: GPII, Q Fever *(see below)*, HMR, Asthma 3+. Another potential example: Better Medication Management System (BMMS), as any system-wide change to patient records involving general practice cannot work unless divs are involved)

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

   - Consolidation of current programs and activities before embarking on further innovation.
   - Accreditation
   - Evaluation
   - Structure and governance

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

   - linking GPs to other health services, improving mutual referral, joint program planning and implementation
   - making other agencies aware of the potential contribution of general practice to joint programs and services
   - delivering programs to local population – bringing together State and national e.g. Q Fever (a national program rolled out through state health department seeking GP involvement); data cleaning project as part of immunisation (bringing together state and local government and divisions to improve coverage).

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

   - short-term program funding leading to short-term employment and loss of valuable staff (the thing that OBF was supposed to overcome)
   - boundaries
   - relative newness of GPs to the skills needed for governance, management and politican negotaion with govt bodies such as local govt, state hlth dept regions etc. (Solution: more training – which is resource intensive – and experience, over time.)

Weakness of the <u>Divisions' Program</u>:

   - Commonwealth funded organisations working in a state system where Commonwealth funded services are peripheral and without a Commonwealth primary care policy

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

See attachment on division engagement with consumers/community

In brief: Yes. But need to be clear about its purpose. Distinguish:

- consumer input at the practice level - or the division's program delivery level (to increase access) from
- input to planning and policy at the division or state-wide level.
- SBOs assist/advise divisions in considering how best to involve consumers and community in division
- SBOs run workshops on orientation to divisions for their consumer reps
- NRCCPH develops tools/resources/processes for divisions to use to support consumers and consumer groups and enable them to contribute to divisions' planning and programs.

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

Yes. Divisions can provide the regional link between Commonwealth and State health systems. There are examples of this that have occurred and provide good models for future work, to strengthen the role. One is the Q Fever vaccination program, where GPDV persuaded the Victorian State Health Department to use divisions to reach the target population groups rather than attempting to deal directly with individual GPs, as they originally intended. 280 GPs were trained by 10 divisions and more than 20,000 Q Fever vaccinations were given over an eight week period, the majority in mass clinics in general practices.

Another example involving collaboration between GPDV, divisions, DHS and local government in data cleaning occurred as part of the GPII rollout in Victoria. (See attachment A to GPDV submission).

If this question refers to creation of divisions of primary care, GPDV has some reservations, outlined in our submission. In brief, further development of the concept would need to clarify whether the proposal is for:

- Service delivery or
- Coordination/organisation for more professional groups in the same way as GPs.

If service delivery, how would the state contribute, since rest of PC sector is state funded or private?
If coordination/organisation, this would seem to duplicate the PCP arrangement in Victoria.

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

Both **ADGP & SBOs:**

- interpret for divisions and GPs the policies of govts and the programs of depts and negotiate with govts and depts to help make their policies and programs more practicable and capable of benefitting from the GP contribution to health care.
- Provide a national group to ensure consistency of implementation of Commonwealth programs
- Channel divisions' views to govts to make it more likely that programs will be able to be implemented.

SBOs

As the statewide peak bodies for divisions of general practice, the SBOs' primary roles relate to the provision of leadership in:

1. **Capacity building for divisions.**

   An aspect of leadership, a core role for SBOs is to assist divisions with building their capacity to implement Commonwealth programs to enhance general practice and the health of the community, respond to the health needs of their local population, link to State programs and function as efficient, accountable organisations with strong local GP engagement. GPDV has found that an extensive program of carefully targeted statewide events for divisions staff and boards (facilitated by accredited staff) are well attended and highly valued by divisions and are an important way of building the capacity of divisions.[1] Statewide events provide an opportunity for divisions to hear from and discuss issues with State and Commonwealth departments and other stakeholders (e.g. universities, other peak bodies). GPDV held 47 statewide events this year and in the six months to December 2002, 13 of 15 rural divisions and 9 of 15 urban divisions attended 20% or more of all events.

   Other methods for building capacity include facilitation for strategic and business planning and provision of advice on needs assessment, and planning and implementation of specific programs.

2. **Bringing together the aspects of the state and commonwealth systems that affect divisions, and the initiatives from both levels of government that seek GP engagement, to support divisions in promoting them; and to make input to policy that will enable the initiatives to be successfully implemented.**

   (For example, making suggestions about the Better Medication Management System, which, like any other part of HealthConnect that targets GPs, will be successfully implemented only with divisional involvement. SBOs are able to make suggestions grounded in knowledge of how systems work at the practice level, across different areas and in different practice contexts, to enable GP – and divisional – engagement.)

3. **Negotiation with state health departments to ensure that general practice is included when systemic improvements that affect primary care are considered, both in the primary sector and the acute sector.**

   There is a tendency for levels of government to focus only on what they fund, but divisions, like general practices, and indeed the public, live in a world that includes health services that are funded by commonwealth and state, as well as local government. Like our counterparts in other states, GPDV has had some success with ensuring that general practice is considered at both the hospital-community interface and as part of the whole primary care system.[2] Without an organisation functioning at the state level, this important general practice input to state planning and policy development is impossible.

   To ensure that each level of the Divisions Program can perform its roles effectively it is important to clarify their limits. GPDV believes that some roles are inappropriate for SBOs:

   - Funding divisions and contract management of divisions' programs (funders' role)
   - Managing projects at division level or competing with divisions for funds (GPDV has a formal policy to that effect)
   - Providing services directly to general practices (divisions work with practices; SBOs work with divisions; ADGP works with SBOs).

[1] GPDV's CEO survey (November 2002) indicates that 81% of Victorian divisions believe GPDV provides the right level of coordination through workshops, updates and consultancy to the division to enable divisions to implement Commonwealth programs like EPC, ITIM and CDM effectively.

[2] Key achievements include:

- the the Victorian General Practitioner Registry, which lists all GP details for transmission of hospital admission and discharge information, which 89 Victorian hospitals use, including the major metro tertiary teaching hospitals
- inclusion of performance indicators about general practice (developed in consultation with divisions) in Victoria's Effective Discharge Strategy
- high levels of GP participation in the Hospital Admission Risk Program (HARP), including the establishment of a DHS working party on the GP-hospital interface, which the then-Chair of GPDV was invited to chair
- a DHS-funded primary care position at GPDV to promote GP engagement in state-funded primary care.

ADGP

ADGP provides the national voice for divisions and national coordination for the program areas, allowing the Divisions' Program to maintain its national character. This is an essential function and should not be compromised or diluted by attempting to provide direct support to individual divisions. This is the role of the SBOs who know state context within which divisions work and are in regular and frequent direct contact with divisions.

The more appropriate role for ADGP as a national peak body is to provide national resources, information, co-ordination and support to SBOs, to enhance their ability to develop the capacity of the divisions in their state and to receive their input on national issues for advocacy to government and to health organisations at the national level.. This would better complement ADGP's role in liaison and advocacy at the national level, and communication to divisions and facilitation of communication between them nationally.

Structure

The most common structure of organisations in a federated system – ie local organisations with membership of a statewide body, which in turn has membership of a national body – would result in divisions being members of the SBO and electing its board and the SBOs being members of, and electing the board of, ADGP. This model, which is the usual Australian structure warrants consideration by the Review Panel, as it makes the roles of each organisation, and the lines of representation and accountability clearer.

However, the specification of the structure is not the priority. Form follows function and the first priority is to make recommendations that clarify the respective roles so that a structure can be designed by the field to suit the roles and functions.

GPDV
20/12/02

Attachment to GPDV Answers to Specific Questions

Consumer/community engagement with divisions

GPDV supports the use of a range of different models for divisions' engagement with consumer/community members, including:

- Working with groups representing consumers in the local community for more effective implementation of the division's programs (e.g. ensuring that the local Aboriginal community is able to easily access the division's Heart Health Clinics)
- Consumer input to and participation in divisions' programs of continuing professional development for GPs
- Divisions' representation on boards and reference groups of other organisations3
- Consumer advisory groups to provide advice to the division's board of directors
- Community membership on a division's board of directors.

It is important that the model for involvement should not be limited to a prescribed (single) position on a board of directors for a consumer representative, which risks tokenism. GPDV does not support the view that community or consumer representation on divisions' boards of directors should be promoted as the most desirable or effective strategy for engagement.

An appropriate role for SBOs is to provide guidance for member divisions seeking advice about consumer and community engagement, and to offer orientation to divisions for consumer/community representatives. In 2002, GPDV designed and delivered an orientation program for divisions' consumer and community representatives, which has been extremely well-received, and which will be offered again in 2003.[4] The workshop gives detailed information about general practice and divisions, and encourages participants to identify areas of common interest between GPs, divisions and consumers, and to understand the divisions' context they will be working with as they promote consumer issues.

Among the nationally available resources produced about consumer/community involvement in health, there are very few that are applicable to divisions, for two major reasons:

- Many have been developed for hospitals, not general practice
- Even those that are relevant to primary care are about health services, and although a general practice is a health service, a division is not a health service.

There are two tiers to consider in consumer involvement in divisions.

1. Division-level. This may include structures that divisions establish to ensure consumer involvement: input of other organisations into needs assessment, review of strategy and business plans, reference groups, consumer advisory groups, consumer representative position on board etc.
2. The end point of divisions' work: health service delivery. This is primarily in a general practice setting, or in another setting through a division-sponsored, GP outreach program (e.g. in schools, the workplace etc.)

[3] GPDV's audit of Victorian divisions' involvement with their local communities (2001), to which 23 divisions responded, found that 52% of divisions are represented on boards of management for other organisations. The full report is at www.gpdv.com.au/consumers/.

[4] Attended by 25 representatives and 4 division staff members on 4/12/02. Workshop evaluations indicated a very high level of satisfaction with the workshop. When asked to nominate on a scale of 1-10 to what extent participants would recommend the workshop to other consumer and community representatives, 70% rated 10/10, 90% nominated 9 or over and no-one rated lower than 6.

This level of complexity has not been well understood to date in the direction by DoHA on how divisions should involve consumers/community in their work. Divisions tend to report on their consumer involvement referring only to the first tier (their organisational structures), mainly in response to the questions put to them. For example, the standard format for business plan reporting by divisions to the Commonwealth does not facilitate comprehensive exploration of division engagement with their community.

We know that the National Resource Centre for Consumer Participation in Health is interested in information on the range of divisions' activities related to consumer/community involvement that is not well captured in current reporting. GPDV welcomes this work, and plans to produce a discussion paper in the new year to further explore the ideas outlined here, and gather comments from divisions and other stakeholders, to inform future directions for involvement.