Effect of GPII funding to Divisions of General Practice on Immunisation Provision in Victoria

An independent report prepared for General Practice Divisions Victoria

Prepared by:
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The evaluation team would like to acknowledge the important contribution of Immunisation Coordinators from Divisions of General Practice and Local Government throughout Victoria.

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The evaluation team

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Abbreviations used in this report

ACIR	Australian Childhood Immunisation Register
ADGP	Australian Divisions of General Practice
CME	Continuing Medical Education
DHAC	Department of Health and Aged Care (Commonwealth Government)
DHS	Department of Human Services (Victorian State Government)
Division	Division of General Practice
GP	General Practitioner
GPDV	General Practice Divisions Victoria
GPII	General Practice Immunisation Incentive
LGA	Local Government Area
MAV	Municipal Association of Victoria
MOH	Medical Officer of Health (Local Government)
NHMRC	National Health and Medical Research Council
RDQO	Regional Data Quality Officer
SBOIC	State Based Organisation Immunisation Coordinator
SIP	Service Incentive Payment

Table of Contents

1. EXECUTIVE SUMMARY

1.1. Introduction

In September 2001, General Practice Divisions Victoria (GPDV) engaged the Centre for Community Child Health to independently examine the impact of the General Practice Immunisation Incentive (GPII) scheme in Victoria. This project focused on one component of the GPII scheme - infrastructure funding to Divisions which was used by most Divisions to employ an Immunisation Coordinator. Of specific interest was the impact of the Divisional Immunisation Coordinator's role on communication and collaboration between General Practitioner (GP) and non-GP immunisation providers. This is particularly important in Victoria, where half of all childhood immunisations are provided by Local Government.

1.2. Methods

The views of Victorian immunisation program coordinators were sought using a range of methods. Group telephone interviews and a focus group were held with Divisional staff. Following this, a questionnaire was developed and sent to all 31 Divisional Immunisation Coordinators. A separate questionnaire was sent to all 78 Local Government Immunisation Coordinators. During the final stages of the project seven key stakeholders, representing a range of organisations, were interviewed.

Information about resources and educational activities developed by Divisions since the introduction of the GPII scheme was collected through questionnaires, entered onto an Access database and transferred to GPDV.

1.3. Main findings

Funding to Divisions

Not all Divisional immunisation activities were completely funded by the GPII scheme. In most Divisions, over 75% were funded from this source. There was considerable variation amongst Divisions regarding the proportion of the Immunisation Coordinators' salary covered by the GPII scheme. The hours that Divisional Immunisation Coordinators worked on immunisation ranged from 5 - 25 hours per week.

Role of Divisional Immunisation Coordinators

Divisional Immunisation Coordinators played an important role in disseminating information to GPs. In the early stages of the GPII scheme, much of the Divisional Immunisation Coordinators' time was spent developing resources. This has changed over time and appears to have been replaced by data cleaning. Currently, the main activities of Divisional Immunisation Coordinators are dissemination of information (96%), data cleaning (88%), practice visits (79%) and collaboration with non-GP organisations (79%). As immunisation is a constantly changing field, there is an on-going need to provide information to GPs. Divisional Immunisation Coordinators are well placed to undertake this task. At present, they assist the Department of Human Services (DHS) in conveying information to GPs. If GPII funding ceased, DHS would have to review how it disseminated information to GPs.

Divisional Immunisation Coordinators also disseminated information and resources to other organisations. The majority of Local Government Immunisation Coordinators

reported Divisional Immunisation Coordinators assisted their Local Government. The most common forms of assistance were data cleaning (76%), sharing of information (76%), provision of information to GPs (53%), joint projects (42%) and cold chain audits (24%).

Collaboration between providers

A total of 96% of immunisation coordinators in Divisions and 84% in Local Government reported that they were involved in collaborative activities. There was general agreement amongst both Local Government and Divisional staff that collaboration between the two organisations was beneficial. Some of the reported effects of collaboration were an increased understanding of the issues faced by other providers and being able to work together on the common goal of achieving improved immunisation rates. Very little collaboration took place prior to the introduction of the GPII scheme. In most cases, Divisional Immunisation Coordinators appeared to have initiated this collaboration and were seen by the majority of respondents as effective in improving collaboration.

The Victorian State Government funded initiative of data cleaning was also important in promoting collaboration. It should be acknowledged that GPII infrastructure funding was instrumental in the development and implementation of this initiative. It is a limitation of this project that the direct effects of the two initiatives cannot be separated.

Relatively few Divisions undertook collaborative activities with Maternal and Child Health Nurses (MCHNs). Thirteen per cent of Local Government immunisation services were delivered by MCHNs and all MCHNs are required to discuss immunisation with parents. Therefore it is crucial that Divisions include MCHNs in collaborative activities.

Only a few Divisions shared training with non-GP providers. When Divisions conduct immunisation training of relevance to non-GP professionals, it would be beneficial to invite them to attend.

Impact of the GPII scheme on Local Government

One of the reported effects of the GPII scheme was decreased attendance at Local Government immunisation sessions, forcing some Local Governments to reduce their services. If GPII funding ceases it is possible that fewer GPs will continue to immunise. If Local Government services are reduced and are unable to quickly respond to this shift, then immunisation coverage in Victoria may decrease.

A number of barriers to collaboration were identified, including those resulting from lack of financial incentives for immunisation for Local Government and the differing levels of resources available to both organisations to work on joint projects.

State Based Organisation Immunisation Coordinator Position

The great majority of Divisional Immunisation Coordinators believed that the State Based Organisation Immunisation Coordinator (SBOIC) supported their work by facilitating communication between Divisions, promoting best practice and guiding the Divisional Immunisation Coordinators in their work. The SBOIC also played a role in facilitating collaboration between Divisions and Local Government.

Other emerging issues

Most Divisions reported receiving information about the same immunisation issue from multiple sources. This may be an inefficient use of resources. Divisional Immunisation Coordinators reported that they translated information from State and Commonwealth Governments into a form that was more user-friendly for GPs. This task is time consuming and it may result in inconsistency of information. Resources could be conserved if the information was written in an appropriate form for its target audience at source.

1.4. Recommendations

1. With the possibility that GPII Divisional infrastructure funding may cease, DHS should consider making contingency plans to ensure continued effective communication with GPs. This could take the form of State Government funded Divisional Immunisation Coordinators, or possibly regional Immunisation Coordinators located in Divisions.

2. The position of Immunisation Coordinator should be retained in Divisions. This position has changed considerably since the introduction of the GPII scheme and is likely to continue to change in response to new initiatives. On-going review of the time required to undertake this role is recommended.

3. Divisions should include MCHNs in collaborative activities.

4. Divisions should invite local non-GP professionals involved in immunisation to any relevant training they provide for GPs and practice staff.

5. If DHS wishes to maintain the current Victorian immunisation system, which offers the choice of public or private providers, it should ensure the viability of Local Government immunisation programs.

6. The position of State Based Organisation Immunisation Coordinator should be retained.

7. A GP communication strategy, which reduces duplication and ensures consistency of information, should be jointly developed by GPDV and DHS.

2. INTRODUCTION AND BACKGROUND

2.1. Introduction

This report documents the findings of a project commissioned by General Practice Divisions Victoria (GPDV) to independently examine the impact of the General Practice Immunisation Incentive (GPII) scheme in Victoria. The project focused on the impact of infrastructure funding to Divisions on both General Practitioners (GPs) and other immunisation providers. This section of the report provides background information about the GPII scheme and the Victorian immunisation service system.

2.2. The GPII scheme

The GPII scheme is an integral part of the Immunise Australia Seven Point Plan. This plan was announced by the Commonwealth Government in February 1997 and aimed to increase the childhood immunisation level. Funding for the scheme became available as a result of funds being re-directed from traditional fee-for-service payments to incentive payments linked to improved outcomes.

2.2.1. The Seven Point Plan

The impact of the GPII scheme cannot be considered in isolation from the other components of the Seven Point Plan. The components of the Seven Point Plan are provided below as background information for this project.

1. Initiatives for parents
Incentives to encourage parents to have their children immunised in the form of bonuses added to the Maternity Allowance and Childcare Cash Rebate were introduced in January 1998.

2. Bigger role for GPs
The GPII scheme was introduced in July 1998 to encourage a greater role for GPs in immunisation. It provided financial incentives to GPs who monitored, promoted and provided age appropriate immunisation services to children under the age of seven years in their practices. Divisions of General Practice were encouraged to increase their involvement to ensure that GPs followed current immunisation protocols and submitted data to the Australian Childhood Immunisation Register (ACIR).

3. Monitoring and evaluation of immunisation targets
Data on immunisation rates from the ACIR are published quarterly. This is designed to encourage competition and inspire those with low rates to improve their coverage.

4. Immunisation days
A series of immunisation days were held in areas with low immunisation coverage in 1997.

5. Measles eradication
A school based measles control campaign, which offered measles vaccination to all primary school aged children, was undertaken in 1998.

6. Education and research
A community education campaign was conducted in 1997. There was also a strategy for service providers to inform them of the National Health and Medical Research Council's (NHMRC) policies and guidelines related to immunisation. The

National Centre for Immunisation Research and Surveillance was established in 1997. Its role is to conduct epidemiological and sociological research, and provide policy information.

7. School entry requirements
The Commonwealth is working with State and Territory Governments on uniform school entry requirements to ensure that parents submit details of their children's immunisation history when they enrol children for school. Legislation has been achieved in New South Wales, Victoria, Tasmania and the Australian Capital Territory.

2.2.2. Components of the GPII scheme

The GPII scheme has the following components:

- **A service incentive payment** (SIP) made to GPs and other medical practitioners who notify the ACIR of a vaccination that completes an age appropriate immunisation schedule.

- **An outcome payment** – a tiered series of payments to practices that achieve certain proportions of full immunisation. In 2001 practices that achieved immunisation rates of 80% to less than 90%, and 90% and over were rewarded. From January 2002 the payment structure will be changed to 85% to less than 90%, and 90% and over. From January 2003 payments will only be made to practices that achieve 90% and over.

- **Immunisation infrastructure funding** (previously Divisional funding) which provides funds to Divisions of General Practice. Most Divisions used this part of the funding to employ staff responsible for immunisation (Divisional Immunisation Coordinators), who were expected to work with GPs to increase their immunisation coverage levels, as well as linking with other providers and organisations doing immunisation locally (KPMG Consulting, 2000).

  The funding provided to Divisions was $3 million in each financial year. Funding for each Division is calculated using an algorithm with a fixed amount of $15,000 per annum and a variable amount based on the number of children under seven years of age within the Division and the rurality of the Division.

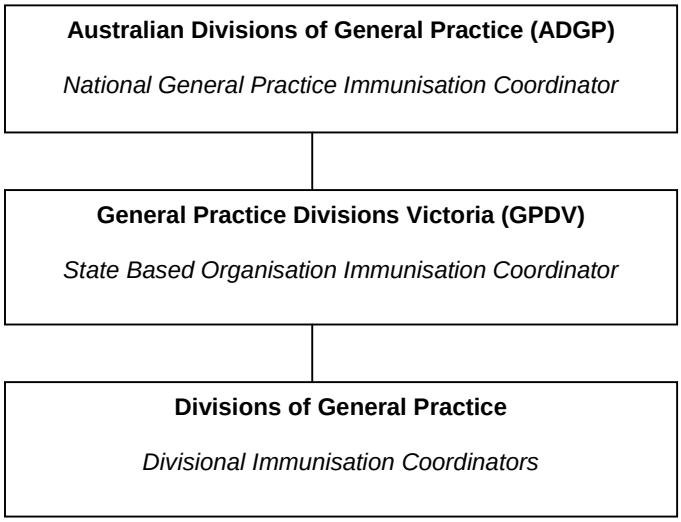
  Funding has also been provided for state and national coordinators to help Divisions set up appropriate structures to support immunisation on a national and state basis. This part of the program is designed to establish better links with State and Commonwealth Governments and committees, other providers, develop educational and training material, and target groups with low immunisation rates. The infrastructure provided by the GPII scheme in Victoria is illustrated in Figure 2.1.

In providing the rationale for the GPII scheme, the Health Insurance Commission (HIC) highlights the importance of general practice in improving immunisation rates. It recognises that GPs have significant levels of contact with children in the target group (under the age of seven years) and that each consultation is an opportunity for monitoring a child's immunisation status and for providing immunisation services if required. The role of other immunisation providers in improving immunisation rates is also acknowledged:

The GPII scheme is not simply payment for direct immunisation services. The incentives are aimed at helping to improve the national immunisation level. This can be achieved by GPs who actively encourage immunisation by other immunisation providers, as well as by those GPs who immunise. This initiative is intended to augment the services provided by Local Governments and Public Health Units in order to help improve Australia's immunisation level (HIC, 2001).

Funding for the GPII scheme has recently been extended following a national evaluation of the scheme and consultation with stakeholders undertaken by the Commonwealth Department of Health and Aged Care (DHAC). The SIP and outcome payments have been extended until June 2003. No changes will be made to Divisional infrastructure funding until at least June 2002.

Figure 2.1: The infrastructure provided by the GPII scheme in Victoria



2.3. Background to the project

The national evaluation of the GPII scheme resulted in a comprehensive report with recommendations for future program development (KPMG consulting, 2000). This evaluation covered all the components of the GPII scheme on a national basis. The key findings from the national evaluation of relevance to this project are:

- The Seven Point Plan has operated in a systematic way to cause increases in immunisation coverage. It is impossible to separately quantify the impacts of the individual elements.
- There is some indication that the strongest impacts have been through parent inducements – the school entry requirements and welfare payment strategies – with GPII playing a lesser, but significant role.
- The Service Incentive Payment was important in encouraging GPs to participate in the scheme and has had a substantial impact on the reporting of data to the ACIR.
- The Outcomes Payment has become more important to GPs over time and has encouraged them to approach immunisation in a more strategic manner than previously.
- The National, State and Divisional coordination roles have been essential to the success of the scheme. The Divisional Immunisation Coordinators have

contributed to the uptake of the scheme by GPs, increased awareness of population health issues and improved the quality of immunisation practice generally within general practices. There is some evidence also of their importance to the coordination of state and local level activities and programs among other non-GP providers.

In discussing the future directions for the GPII scheme, the evaluators made the following comment:

> *The greatest gains in reaching the remaining unimmunised children are to be made through better coordination and collaboration across settings and between providers* (KPMG consulting, 2000).

2.3.1. The Victorian context

Victoria differs from most other Australian states, in that the majority of immunisations were traditionally provided by Local Government. Since the introduction of the GPII scheme, there appears to have been a shift of immunisation provision from Local Government to GPs. In 1994, it was estimated that only 15% of immunisations were provided by GPs (Bazeley and Kemp, 1994). Currently, 49% of immunisations are provided by Local Government and 49% provided by GPs (ACIR data, September 2001). The following points should be considered when examining these figures. There is some evidence that the shift from Local Government to GP provided immunisations began prior to the implementation of the GPII scheme. In addition, it is likely that some of the increase in the proportion of GP immunisations is due to improved reporting to the ACIR (KPMG Consulting, 2000).

A number of other factors have impacted on the Victorian immunisation system in recent years. In the mid 1990s compulsory competitive tendering in Local Government resulted in the redevelopment of a number of municipal immunisation programs. It also resulted in reduced communication and collaboration between services. Since 1997, training has been available for nurses to become accredited public vaccinators. Increasing numbers have taken up positions working in Local Government and some are also employed in hospitals and general practice.

In June 2001, the Department of Human Services (DHS) provided funding for data cleaning in each region. The aim was to further improve the accuracy of ACIR data through working with Local Government and Divisions. The funding was for a period of two years.

2.3.2. Summary of the implementation of the GPII scheme in Victoria

GPDV employed their first State Based Immunisation Organisation Immunisation Coordinator (SBOIC) in November 1998. The SBOIC coordinated activities between Divisional Immunisation Coordinators. A key activity was to identify Divisions that were working exceptionally well on immunisation issues, and if possible, add value to this work, then pass on the information to other Divisions.

Each Division was able to decide how their allocated GPII funding was to be spent. Most used the funding to appoint Divisional Immunisation Coordinators and based their activities on the model developed by the North East Valley Division in Melbourne. In brief, these activities included:

- Practice visits to educate GPs and practice staff
- Cold chain audits
- Assisting practices with data management.

One of the complications in implementing the GPII scheme in Victoria was that Local Government had traditionally been the major immunisation provider and had legislative responsibility to provide immunisation services under the Victorian Health Act. As noted in a GPDV newsletter, this meant that Victorian Divisions had a much greater task than just GP support: the establishment of general practice as a cooperative and effective partner with Local Government in increasing immunisation levels was also a crucial role (Tremellen, 2000).

GPDV initiated meetings with the Municipal Association of Victoria (MAV), the peak body for Local Government. With a view to increasing collaboration between Divisions and Local Government, GPDV and the MAV organised a workshop for Divisional staff to discuss the matter in June 2000. A second workshop for both Local Government and Divisional staff was held in June 2001 and was well attended.

2.3.3. This project

Following the national evaluation of the GPII scheme, GPDV were interested in obtaining more information about the impact of the scheme in Victoria, given its unique mix of public and private immunisation providers. Of particular interest was the infrastructure provided by GPII funding and its impact on communication channels between immunisation providers (both public and private), as well any collaboration between providers that had taken place as a result of the GPII scheme.

GPDV were also interested in documenting the range of resources and educational activities developed by Divisions since the introduction of the GPII scheme. The resulting database of resources and activities could then be made available through the GPDV web site to facilitate information sharing amongst Divisions.

In September 2001, GPDV contracted the Centre for Community Child Health to undertake this project.

The aims of the project as described in the brief were:

- To describe/document processes and impact of Division and State Based Organisation (GPDV) GPII Program implementation in Victoria
- To contribute to discussion in Victoria on future strategic directions in immunisation service delivery and provider support
- To determine what else needs to be done and where the best bets are for sustainability

The project had two main components. Firstly, the views of Victorian immunisation providers and program coordinators about the impact of the infrastructure provided by GPII funding were sought. The methods used were focus groups, questionnaires and interviews. In the second part, information about immunisation resources and educational activities developed by Divisions since the introduction of the GPII scheme was obtained through questionnaires. This report documents the findings of the first part of the project, and summarises the second component. More detailed information about Divisional resources and educational activities can be found on the database developed for this project, which is now held by GPDV.

It is anticipated that the information obtained from this project will be used by GPDV to make recommendations for future strategic directions in immunisation service delivery and provider support, particularly with regard to sustainability.

3. METHODS

3.1. Focus group and group interviews

In order to collect background information for the project and to assist with the development of questionnaires, a focus group and group interviews were held with Divisional staff involved in immunisation.

Divisional staff were invited to attend focus groups at GPDV in September 2001. Several were interested in participating but could not attend so it was decided to conduct two group interviews by phone with these people. In addition, a focus group with those who could attend GPDV was conducted.

The same list of questions was used for both the phone interviews and focus group. Participants in the phone interviews were asked each question individually and then given an opportunity to comment on the responses given by others, whereas focus group participants were able to spontaneously respond to issues raised by the facilitator and other participants. The main issues explored were:

- The role of the Divisional Immunisation Coordinator
- The role of the SBOIC
- Collaborative activities with non-GP immunisation providers
- Communication about immunisation initiatives/issues
- Impact of the GPII scheme on GPs, Divisions and Local Government
- Future of the GPII scheme.

See Appendix 1 for the focus group/group interview schedule.

Analysis of the data emerging from the focus group and group interviews involved summarising the key themes raised by participants (see Section 3).

3.2. Divisional Immunisation Coordinators' questionnaire

In Victoria in June 2001, 80% of Divisions employed a Project Officer to specifically oversee immunisation activities. In the six Divisions which had no Project Officer, immunisation programs were administered by a designated individual, including Program Officers, Practice Support Managers and the Executive Officer (ADGP, 2001). For the purposes of this project, the main person employed by the Division to work on immunisation issues was considered to be the Divisional Immunisation Coordinator.

A list of Divisional Immunisation Coordinators in Victoria was obtained from GPDV. In November 2001, a questionnaire was sent to all 31 Divisional Immunisation Coordinators. The questionnaire had two parts (see Appendix 2 for details). The first part requested information about the Divisional Immunisation Coordinator's position, how they received and disseminated immunisation information, details of any collaborative activities with non-GP immunisation providers and the impact of the GPII scheme.

The second part of the questionnaire requested information about immunisation resources and educational activities developed by the Division since the introduction of the GPII scheme. This information was entered on to an Access database and transferred to GPDV.

3.3. Local Government Immunisation Coordinators' questionnaire

A list of Victorian Local Government Immunisation Coordinators was obtained from DHS. In November 2001, a questionnaire was sent to Immunisation Coordinators in all 78 Local Governments. The questionnaire requested information about any collaborative activities undertaken with Divisions, the nature of this collaboration and the impact of the GPII scheme.

For both questionnaires, quantitative data were analysed using SPSS (version 10). Qualitative data were analysed by developing coding categories, deriving themes and summarising the information (see Sections 4 and 5).

3.4. Key stakeholder interviews

In order to gain more in-depth information about the impact of the GPII scheme on service provision in Victoria, a number of face-to-face and telephone interviews with key stakeholders were conducted. The names and positions of those interviewed are listed below:

- Pam Berton, Immunisation Coordinator, Mildura Rural City Council
- Belinda Caldwell, SBOIC, GPDV
- Peter Eizenberg, Director, North East Valley Division of General Practice
- Clare Hargreaves, Senior Policy Adviser - Social Policy, Municipal Association of Victoria
- Stephen Pellisier, Immunisation Coordinator, DHS
- Helen Pitcher, former Immunisation Coordinator, City of Banyule
- Sonya Tremellen, former SBOIC, GPDV

The interviews were semi-structured and the questions asked varied depending on the background of the person being interviewed. The main themes arising from the interviews were summarised and are presented in Section 6 of this report.

3.5. Project reference group

A reference group comprising the following individuals provided guidance at key stages of the project:

- Dr Lyndal Bond, Head of Research, Centre for Adolescent Health
- Belinda Caldwell, SBOIC, GPDV
- Dr Peter Eizenberg, Director, North East Valley Division of General Practice
- Dr Jo Molloy, Program Manager, Geelong Division of General Practice; MOH, City of Greater Geelong.

4. FOCUS GROUP AND GROUP PHONE INTERVIEW DATA

4.1. Profile of participants

Two group interviews and a focus group were conducted with Divisional staff. The four participants in the first group phone interview were: three Divisional Immunisation Coordinators from rural Victoria and a GP who worked in rural Victoria on Divisional immunisation projects and as a Medical Officer of Health (MOH) for a metropolitan Local Government. The five participants in the second group phone interview were all Divisional Immunisation Coordinators from rural Victoria. Participants in the focus group were all from metropolitan Divisions. There were five Divisional Immunisation Coordinators and two GPs who worked with Divisions and as MOHs for Local Government. Data from the group phone interviews and focus group were aggregated and are presented below.

4.2. Main roles of Divisional staff

4.2.1. Role of Divisional Immunisation Coordinators

Participating Divisional Immunisation Coordinators saw their main role as providing support for GPs and practice managers, particularly with regard to the provision of information. This often took the form of practice visits, as it was considered to be the best way of ensuring that GPs received the information. In larger Divisions, it was not possible to visit all GPs, instead practices with large numbers of children and those with low immunisation rates were targeted. Immunisation Coordinators also used newsletters, faxes, and Continuing Medical Education (CME) seminars to convey information to GPs.

The information provided to GPs addressed issues such as new vaccines, changes to the immunisation schedule, infectious diseases information, administrative issues and assistance with accreditation. The most popular information sources were DHS, ACIR and Australian Divisions of General Practice (ADGP).

It was considered that some of the information, such as that coming from DHS, was not well presented for GPs as it was too detailed. One of the reported roles of the Divisional Immunisation Coordinators was to summarise information and present it in a user-friendly form for GPs.

Other activities undertaken by Divisional Immunisation Coordinators included:

- Conducting campaigns
- Providing information technology (IT) support
- Monitoring cold chain
- Redistributing vaccines
- Educating child-care staff
- Data cleaning
- Developing parent resources
- Producing recalls and reminders
- Providing a helpdesk
- Maintaining a link between Divisions and Local Government.

4.2.2. Role of GPs in Divisions

One participating GP described his role in the Division as providing support and advice to the Immunisation Coordinator. Most of the participating GPs provided

information about clinical and administrative issues to other GPs in their Divisions and sometimes to practice managers. The methods used to disseminate this information included telephone hotlines and CME sessions. Some administered immunisations and one reported that she ran an immunisation service for homeless men. GPs also conducted campaigns, responded to infectious disease outbreaks and supervised Regional Data Quality Officers (RDQOs).

4.2.3. Change in Divisional Immunisation Coordinator's role over time

Most Divisional Immunisation Coordinators agreed that their work had changed from an initial emphasis on cold chain to the current focus on data cleaning. Some were employed as RDQOs as well as being Divisional Immunisation Coordinators. One participant maintained that the focus of the Divisional Immunisation Coordinator's work should be on supporting GPs.

> *We need to move the focus away from data cleaning now and it is important for the Divisional Immunisation Coordinator to remain focused on GPs' needs, ensuring that there is adequate information and take responsibility for ensuring they are doing the practice of immunising well.*

4.3. Collaborative activities

Most participants were involved in collaborative activities with other immunisation providers, particularly Local Government or hospitals.

As well as working for Divisions, some of the Divisional Immunisation Coordinators worked as nurse immunisers for Local Government and all three GPs worked as MOHs for Local Government. One GP reported that she had an understanding of how both organisations worked and could act as a bridge between them.

Some participants talked about immunisation reference groups or working parties that they had been on with Local Government representatives. Others commented that a reference group would not work in their area.

Participants were involved in a range of collaborative activities including provider networks, newsletters, development of school entry immunisation kits and childcare sessions. One participant described a TV campaign that had come about through joint funding. Others mentioned joint funding of the Big 4 Bear initiative (an initiative to promote immunisation of four year olds). A few participants had run in-services for hospital staff.

> *This initiative* (hospital in-services) *works really well because it makes them advocates for immunisation and they see Divisions as a way of getting information.*

Some participants had provided a service to other organisations by monitoring the cold chain in hospital and Local Government fridges. Others had provided an information service to non-GP providers and invited them to immunisation workshops held by the Division.

A focus of collaborative activities in many Divisions was data cleaning. For some this was the first time they had worked with non-GP providers, but for others it was an extension of the work they had already done together. One participant commented that the RDQO position in their area had helped to consolidate relationships between providers.

In some Divisions, the same information that was sent to GPs was also disseminated to other providers, including Local Government and MCHNs.

4.3.1. Barriers to collaboration

One participant reported that there had initially been some difficulty in convincing management at the Division that they should collaborate with Local Government. A barrier to collaboration raised by one participant from rural Victoria was limited time and geographic spread. Another issue potentially affecting collaboration was the lack of correspondence of Divisional boundaries with Local Government boundaries, particularly for those Divisions covering multiple Local Government Areas.

Differences in the availability of resources between Local Government and Divisions was also a barrier to collaboration, as illustrated in the following comments:

> *I suggested to our Council about going into TAFE for the adult MMR campaign but they were too busy and didn't have any money.*

> *Council won't spend any extra money on anything. Collaboration has tended to be all one way from our side. They are quite happy to attend anything that doesn't cost them any money.*

4.3.2. Impact of collaboration

A number of positive effects of collaboration were cited by participants, including:

- Increased knowledge of how to access and distribute resources
- Providers given a broader view of immunisation
- Increased awareness by Local Government of cold chain requirements
- Greater awareness of immunisation
- Increased data accuracy
- Improved reminder systems
- Strengthened relationships between providers
- Increased information exchange

> *Practice staff can ring Local Government for advise on 'catch ups'. GPs ring me and if I can't help them I direct them to other agencies.*

- Encouraged a united approach to promoting childhood immunisation

> *There are issues that you can address in a collaborative way that as a Division you couldn't address on your own.*

4.4. State Based Organisation Immunisation Coordinator position

All participants agreed that the SBOIC position was very helpful to them, particularly with regard to facilitating communication between Divisions. This ensured that Divisional Immunisation Coordinators did not waste time duplicating resources. The SBOIC organised meetings of Divisional Immunisation Coordinators and generally kept the network going. The SBOIC also provided advice and information to Divisional Immunisation Coordinators.

> *Great reference point. One contact if you've got something you are trying to chase up.*

Invaluable for people like myself with issues of distance. The organisation of meetings in Melbourne is a great opportunity to catch up.

A few participants commented on the usefulness of the workshops that were held at the beginning of the program. Some said that they valued being able to share information across Divisions via email. One participant commented on the valuable advocacy role played by GPDV.

Another participant suggested that the position could be improved by linking with external networks, such as the Royal Children's Hospital, to ensure information about new initiatives reached Divisions. Increased input into the content of workshops and seminars was also requested.

4.5. Communication flow

When participants were asked where they received immunisation information from the most common response was DHS. This information was sent via email, newsletters and letters. Another information source was ADGP. The information received from these sources was relayed to GPs and, in some cases to Local Governments, usually through newsletters. Fax was often used to disseminate information to GPs.

You don't feel like you are going to miss out on information. If there is something going on you are going to hear about it.

4.6. Impact of the GPII scheme

4.6.1. Impact of the GPII scheme on Divisions and GPs

Several participants believed that the GPII scheme had raised the profile of Divisions, so that GPs would more readily contact Divisional Immunisation Coordinators for information, rather than DHS.

Division's profile has skyrocketed. It has been a great stepping stone for other programs. No negative effects on GPs, money is money!

Some participants felt that the GPII scheme had acted as a catalyst for engaging GPs. It had increased their awareness of immunisation and provided funding for further education.

It has given GPs ownership of immunisation, where in Victoria it was primarily a Council task. It has increased GPs' awareness that immunisation is their job. Up-skilled GPs.

In some Divisions, the first contact GPs had with Immunisation Coordinators was through cold chain monitoring. This had improved cold chain procedures in practices and shown GPs how Divisions could support their work.

Doing cold chain was the first step in the door and they are happy letting us in now because they know we are there to help them……..

One participant thought that the GPII scheme had provided an opportunity for Divisions and Local Government to collaborate. Another felt it had been good for

competition and had not prevented Local Governments from continuing to offer immunisation services.

In summing up the impact of the GPII scheme the following comment was made:

> *It has worked really well and will hopefully continue. The Divisions and funding go hand in hand, it was the combination that led to the success.*

4.6.2. Impact of the GPII scheme on Local Government

A number of participants commented on the lack of financial incentives for Local Government. Some pointed out that the GPII scheme had resulted in fewer children attending Local Government immunisation sessions.

One participant commented that there was a perception that money was taken away from Local Government and given to GPs and this was because the GPII scheme was not adequately promoted to Local Government.

4.7. Future of the GPII scheme

Most participants agreed that continued GPII funding for Divisions was required as there was an on-going need for provision of information to GPs, particularly with regard to schedule changes.

One participant pointed out that if the Divisional Immunisation Coordinator position was maintained that person could then draw on their experience with the GPII scheme to help introduce other population health incentive schemes.

Most felt that outcome payments to GPs should be continued. However there was some disagreement about the service incentive payments (SIP), with some suggesting a decrease. One participant thought that consideration should be given to redistribution of the SIP to Local Government. Others felt that the SIP was an important incentive for GPs and should be continued in its current form.

A few participants requested the simplification of reporting systems.

> *We have one particular area of GPs from a range of cultural backgrounds and the complexity of GPII is too much for them.*

5. DATA FROM THE DIVISIONAL IMMUNISATION COORDINATOR QUESTIONNAIRE

5.1. Profile of responding Divisions

Twenty-four Divisional Immunisation Coordinators responded to the questionnaire, giving a response rate of 77%. Not all respondents answered all the questions, therefore the total sample size was less than 24 for some questions, due to missing data.

Fourteen (58%) of the responding Divisions were located in metropolitan Victoria. The remaining 10 (42%) were located in rural Victoria. There are 17 Divisions in metropolitan Victoria and 14 in rural Victoria (National Information Service, 2001), thus our population represents 82% of metropolitan Divisions and 71% of rural Divisions.

Most responding Divisions (20) had catchments in one DHS region, three Divisions had catchments in two regions and one rural Division had a catchment in three regions.

The number of Local Government Areas (LGAs) located within each Division ranged from two to eight (see Table 5.1). Metropolitan Divisions tended to have fewer LGAs. Thirteen of the 14 (93%) metropolitan Divisions had less than five LGAs, whereas four of the nine (44%) rural Divisions had less than five LGAs.

Table 5.1: Number of Local Government Areas located within each Division

No. of LGAs	Rural Divisions		Metro Divisions		Total	
	n	%	n	%	n	%
2	2	*22*	4	*29*	6	*26*
3	1	*11*	6	*43*	7	*30*
4	1	*11*	3	*21*	4	*17*
5	3	*33*	0	*0*	3	*13*
6	0	*0*	1	*7*	1	*4*
7	1	*11*	0	*0*	1	*4*
8	1	*11*	0	*0*	1	*4*
Total	9	*100*	14	*100*	23	*100*

When asked how many general practices were in their Division, 16 had 100 practices or less and eight had more than 100 practices. Metropolitan Divisions were more likely to have a greater number of practices than rural Divisions (see Table 5.2).

Table 5.2: Number of general practices within each Division

No. of general practices	Rural Divisions		Metro Divisions		Total	
	n	%	n	%	n	%
Less than 50	8	*80*	1	*7*	9	*38*
51-100	1	*10*	6	*43*	7	*29*
101-150	1	*10*	3	*21*	4	*17*
151 or more	0	*0*	4	*29*	4	*17*
Total	10	*100*	14	*100*	24	*100*

Almost half of the responding Divisions (11) had more than 90% of their total immunisation activities and resources funded by the GPII scheme. Only two Divisions had less than 50% of their immunisation activities and resources funded by the scheme (see Table 5.3).

Table 5.3: Percentage of immunisation activities and resources funded by GPII

Percentage of activities and resources funded by GPII	Divisions	
	n	%
Less than 50%	2	*9*
51-75%	1	*4*
76-90%	4	*17*
More than 90%	11	*48*
Not sure	5	*22*
Total	23	*100*

5.2. Profile of responding Divisional Immunisation Coordinators

There was considerable variation amongst Divisional Immunisation Coordinators in terms of the percentage of their salary that was funded by the GPII scheme. For eight Divisional Immunisation Coordinators less than 50% of their salary was funded by the GPII scheme, whereas for a further eight more than 90% of their salary was funded by this source (see Table 5.4).

Table 5.4: Percentage of Divisional Immunisation Coordinator's salaries funded by GPII

Percentage of salary funded by GPII	Divisional Immunisation Coordinators	
	n	%
Less than 50%	8	*35*
51-75%	2	*9*
76-90%	1	*4*
More than 90%	8	*35*
Not sure	4	*17*
Total	23	*100*

Four Divisional Immunisation Coordinators worked one day or less per week for the Division, six worked approximately two days, five worked approximately three days, a further five worked approximately four days and the remaining four worked full-time (see Table 5.5). The mean number of hours Divisional Immunisation Coordinators were employed by the Division was 21 hours per week.

Less than half of the respondents spent their time exclusively on immunisation. Eight worked one day or less per week on immunisation, thirteen worked approximately two days, and two worked approximately three days (see Table 5.5). The mean number of hours Divisional Immunisation Coordinators spent on immunisation was 12 hours per week.

Table 5.5: Time Divisional Immunisation Coordinators usually spent on immunisation

Division	Hours worked at Division	Hours spent on immunisation	Percentage of time
1	28	5	18
2	6	6	100
3	6	6	100
4	28	7	25
5	7	7	100
6	32	8	25
7	30	8	27
8	8	8	100
9	30	10	33
10	20	10	50
11	10	10	100
12	10	10	100
13	22	11	50
14	22	12	55
15	20	13	65
16	38	14	37
17	38	15	39
18	38	15	39
19	15	15	100
20	16	16	100
21	16	16	100
22	22	22	100
23	37	25	68
24	16	-	-
Mean	**21**	**12**	**64**

Most Divisional Immunisation Coordinators had been employed by their current Division for some time. Only six had been employed by their current Division for 12 months or less. Five had been employed for 1-2 years, four for 2-3 years and the remaining nine for three years or more.

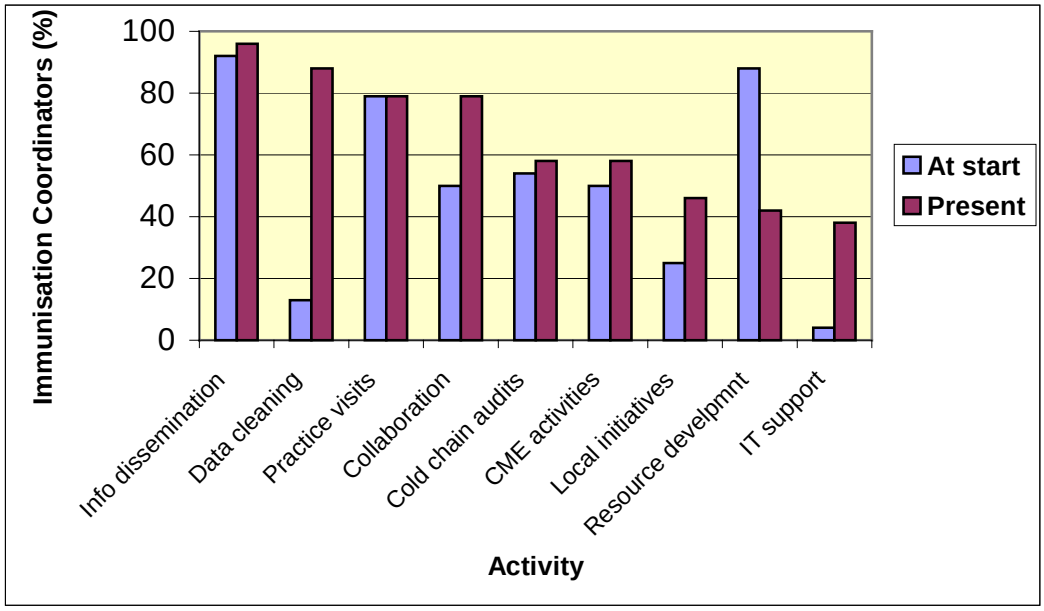
To determine if the activities undertaken by Divisional Immunisation Coordinators had changed over time, respondents were asked to identify their main activities when they first started in this role and their current main activities. Dissemination of information and practice visits were undertaken by most respondents and this had not changed over time. Cold chain audits and CME activities were conducted by about half and this also had not changed with time. The most significant change was the increase in numbers working on data cleaning from 13% to 88%.

Other activities that had been taken up by increasing numbers of respondents over time were:

- Collaboration with non-GP providers (50% to 79%)
- Local campaigns and initiatives (25% to 46%)
- IT support (4% to 38%).

It is likely that the increase in these activities is associated with the increase in data cleaning activities. Fewer respondents cited the development of resources as a current main activity compared to when they first started with the Division (88% to 42%). See Figure 5.1.

Figure 5.1: Main activities of Divisional Immunisation Coordinators when they started with the Division compared to the present (n=24)



5.3. Sources of information

Respondents were asked to identify information sources for a range of immunisation issues (more than one source could be identified). Information about the immunisation schedule was most often obtained from DHS (83%) and GPDV (71%). DHS and GPDV were also popular sources for information about vaccines (79% and 63% respectively), the catch-up schedule (58% and 54% respectively), and cold chain requirements (54% for both organisations). Information about the Australian Childhood Immunisation Register was most often obtained from GPDV (71%). DHAC was the most popular source of information about Commonwealth Government immunisation initiatives (71%), and to a lesser extent ADGP (63%). The main sources of information about State Government immunisation initiatives were DHS (92%) and GPDV (88%). See Table 5.6.

Table 5.6: Information sources for Divisions (n=24) (more than one response was allowed)

	Information sources for Divisions (%)								
Topic	**DHAC**	**ADGP**	**GPDV**	**DHS**	**Division**	**Local govt.**	**Pharm Co.**	**ACIR**	**Health Centre**
Schedule	58	42	71	83	8	0	4	0	0
Vaccines	42	29	63	79	8	4	13	0	0
Catch-up	42	13	54	58	4	8	0	0	4
Cold chain	42	17	54	54	17	0	4	0	0
ACIR	29	38	71	33	17	0	0	33	0
Commonwealth initiatives	71	63	58	33	4	0	0	0	0
State initiatives	13	8	88	92	4	4	0	0	0

Respondents were requested to rate the information that they received from GPDV. About half the respondents were satisfied and the remaining half were very satisfied with the information in terms of relevance, clarity and timeliness (see Table 5.7).

Table 5.7: Rating of information received from GPDV

Issue	Very dissatisfied		Dissatisfied		Neither		Satisfied		Very satisfied	
	n	%	n	%	n	%	n	%	n	%
Relevance	0	*0*	0	*0*	0	*0*	12	*50*	12	*50*
Clarity	0	*0*	0	*0*	0	*0*	14	*58*	10	*42*
Timeliness	0	*0*	0	*0*	0	*0*	14	*58*	10	*42*

In comparison, slightly fewer respondents were very satisfied with information that they received from DHS, particularly in terms of clarity (22%) and timeliness (13%). See Table 5.8.

Table 5.8: Rating of information received from DHS

Issue	Very dissatisfied		Dissatisfied		Neither		Satisfied		Very satisfied	
	n	%	n	%	n	%	n	%	n	%
Relevance	0	*0*	0	*0*	0	*0*	16	*70*	7	*30*
Clarity	0	*0*	0	*0*	0	*0*	18	*78*	5	*22*
Timeliness	0	*0*	0	*0*	2	*9*	18	*78*	3	*13*

5.4. Dissemination of information

Divisional Immunisation Coordinators disseminated immunisation information to a range of professionals and organisations. Most disseminated information to practice managers (96%), GPs (92%) and practice nurses (92%). A number disseminated information to Local Government (67%), Maternal and Child Health Nurses (MCHNs) (33%) and other Divisions (17%). See Table 5.9.

Table 5.9: Who Divisional Immunisation Coordinators disseminated information to (n=24) (multiple responses were allowed)

Professional/organisation	Division	
	Frequency	Percentage
Practice managers	23	96
GPs	22	92
Practice nurses	22	92
Local Government	16	67
Maternal and Child Health Nurses	8	33
Other Divisions	4	17
Allied health professionals	1	4
Kindergarten parent groups	1	4
Local community	1	4
Regional immunisation group	1	4
Pharmaceutical representatives	1	4
Obstetricians/paediatricians	1	4
School nurses	1	4
Media	1	4

5.5. State Based Organisation Immunisation Coordinator Position

Twenty-two respondents agreed that the position of SBOIC supported the work of Divisional Immunisation Coordinators. One was not sure as yet and the other did not respond to the question. When asked for additional comments, several reported that the position provided excellent support and another maintained that the position held the network together. Two respondents felt the position was less visible than it had been in the past.

When asked how the position of SBOIC could better support the work of Divisional Immunisation Coordinators, several respondents commented that they were happy with the position as it was. Suggestions for improvements included:

- Having more face-to-face visits
- Providing more information about resources developed by other Divisions and greater access to these resources
- Spending increased time with newly appointed Divisional Immunisation Coordinators
- Encouraging local Divisional networks
- Advising Divisions about collaborative opportunities
- Facilitating closer cooperation with State and Federal governments

5.6. Collaboration with other organisations

Twenty-three respondents (96%) reported that they were involved in collaborative activities with non-GP immunisation providers. In only two cases did these collaborative activities exist prior to the introduction of the GPII scheme. Twenty-three respondents reported that they had collaborated with Local Government.

5.6.1. Nature of the collaboration

Respondents were asked about the nature of their collaboration with other organisations.

Sharing information and resources
Almost all of the Divisions shared information and resources with other organisations. For the most part this took place with Local Governments, but also with MCHNs, regional immunisation committees, hospitals, schools, kindergartens, Regional Data Quality working groups, travel agents and pharmacy representatives.

Regular meetings
Fifteen Divisions reported having regular meetings with Local Governments, three met regularly with regional immunisation committees, which included Local Governments and Divisions. Only two reported meeting regularly with MCHNs.

Joint initatives/projects
Sixteen Divisions reported conducting joint initiatives/projects with Local Government. Other organisations included schools, kindergartens, hospitals, MCHNs, child care centres, welfare agencies, Aboriginal cooperatives, regional immunisation committees and pharmacies.

Shared training
Fewer Divisions shared training with other organisations. Six shared training with Local Governments, two with hospitals and one with MCHNs.

Data cleaning
Twenty-one Divisions participated in data cleaning activities with at least some of the Local Governments in their catchment areas.

Proportion of Local Governments collaborated with
Half the responding Divisions collaborated with three or more Local Governments, with four Divisions reporting that they collaborated with 7-11 Local Governments. About half of the Divisions appeared to be collaborating with all the Local Governments in their catchment areas.

5.6.2. Focus of the collaboration

When asked specifically about their collaboration with Local Government, many respondents reported that the focus of the collaboration was data cleaning (96%), local immunisation issues (78%), ACIR issues (61%) and joint projects (61%). Fewer used this collaboration to provide updates on their recent activities (48%), or to discuss State (30%) or Commonwealth (26%) Government initiatives. See Table 5.10.

Table 5.10: Focus of collaboration with Local Government (n=23)
(more than one response was allowed)

Issue	Divisions	
	Frequency	Percentage
Data cleaning	22	96
Local immunisation issues	18	78
ACIR issues	14	61
Joint projects/initiatives	14	61
Updates on recent activities	11	48
State Government initiatives	7	30
Commonwealth Government initiatives	6	26
School entry certificates	1	4
Protocols	1	4

5.6.3. Impact of the collaboration

Most respondents reported that collaboration with non-GP immunisation providers had resulted in increased communication and the sharing of resources, information and expertise. Several mentioned that collaboration had helped to break down barriers that existed between providers and increased understanding of the issues faced by other providers. A number believed that collaboration would lead to improved services and immunisation rates. Some stated that collaboration had resulted in joint projects, including the targeting of disadvantaged groups in their communities. Below are some of the comments received about the impact of collaboration:

> *Working with local councils has been invaluable and a critical factor in ensuring complete data cleaning within the Division.*
>
> *Working together to provide a true picture of the truly overdue children in the region and planning strategies to immunise these children.*
>
> *Improved relations between organisations, taken away the barriers and allowed for productive discussion. Often ACIR issues; initiating data cleaning together was like a natural progression. Also,……all promote GP and council, not one or the other.*

5.6.4. Barriers to collaboration

Eleven respondents (48%) reported that they had encountered barriers to collaboration with non-GP immunisation providers. The main barrier was initial resistance from Local Government. Some commented on lack of resources in the public sector and inequity in funding between public and private providers. A few mentioned that the Regional Data Quality Officer had improved collaboration. One Division had a policy which did not permit their participation in data cleaning and this had been a barrier.

Other reported barriers to collaboration with various providers were:

- MCHNs who only promoted council sessions
- Travel agents who were unwilling to promote immunisation due to legal liability issues.
- Poor attendance at meetings by some representatives

…… early on (1998) there was reluctance to share information or statistics. Council found it frustrating and maybe was resentful toward GPII payments where they saw their role as a major provider in Victoria and not recognised in same way.

At commencement GPs on Divisional Steering Committee were MOHs for respective LGAs. This established a co-operative spirit from the start.

Immunisation representatives at local councils have been very co-operative and we have forged strong, constructive collaborative relationships with them.

5.7. Impact of the GPII scheme

Twenty-two respondents (92%) reported that appointment of Divisional Immunisation Coordinators had been effective or very effective in improving collaboration between immunisation providers (see Table 5.11). Several respondents commented that the position had facilitated networking opportunities and collaboration would not have taken place otherwise. One respondent, who had worked as a Divisional Immunisation Coordinator for less than six months, commented that she did not know that this was part of her job.

Many Immunisation Coordinators in Divisions also work for Local Government – great for networking.

Table 5.11: Effectiveness of Divisional Immunisation Coordinators in improving collaboration

Effectiveness	Divisions	
	Frequency	Percentage
Very effective	13	54
Effective	9	38
Neither	2	8
Ineffective	0	0
Very ineffective	0	0
Total	24	100

Nineteen respondents (79%) believed that the GPII scheme as a whole had been effective or very effective in improving collaboration between immunisation providers. Four (17%) thought that it had been ineffective (see Table 5.12). Some of the perceptions of respondents are listed below:

- There was no collaboration prior to the introduction of the GPII scheme
- GPII has facilitated communication and information sharing
- Some Divisions would not have Immunisation Coordinators or activities without GPII funding

- GPII has caused some barriers due to funding inequities
- GPII is aimed at GPs not other providers.

Table 5.12: Effectiveness of GPII in improving collaboration

Effectiveness	Divisions	
	Frequency	Percentage
Very effective	13	54
Effective	6	25
Neither	1	4
Ineffective	4	17
Very ineffective	0	0
Total	24	100

5.7.1. Impact of the GPII scheme on Local Government

One of the main effects of the GPII scheme on Local Government cited by respondents was resentment that GPs received more funding for the same work. Several noted decreased attendance at public immunisation sessions. Positive impacts included increased information sharing and collaboration, and adoption of universal standards and reporting procedures.

> *Some* (Local Government) *immunisation sessions have been cancelled as clients are going to doctors. There has been some discussion re the viability of their immunisation programs. They have had to rethink their delivery of the service.*
>
> *Has created bitterness because LGAs are not receiving the same incentives and they know that in Victoria LGAs are immunising 50% of children.*
>
> *I believe that financial incentives available to GPs through GPII have encouraged GPs to be more proactive in the area of immunisation. This has been at some cost to public immunisation programs run by Local Government.*

5.7.2. Impact of the GPII scheme on Victorian immunisation providers

When asked about the effect of the GPII scheme on Victorian immunisation providers in general, a number of respondents commented on incentives for GPs to undertake immunisation, increased knowledge and awareness of immunisation, improved reporting of immunisation encounters and increased immunisation rates. A few suggested the promotion of linkages and common goals between providers, and improved service provision. Individual respondents reported the following:

- Increased benefits to GPs
- Increased responsibilities for GPs
- Increased benefits to the community
- Increased choice for parents
- Community shift from public to private providers
- Divisions now being seen as sources of information
- No benefit for public providers
- Greater awareness of nurse immunisers.

One respondent summed up the effect of the GPII scheme on immunisation providers in the following way:

> *GPs: Essential for heightened awareness of immunisation and of recording process, for updating on vaccines and techniques and for cold chain awareness. Other providers: Divisions now seen as source of information for vaccination issues like catch-ups, essential help in cold chain.*

5.8. The future

Respondents were asked for their views of the future of the GPII scheme and the impact of recent initiatives, such as the employment of RDQOs.

5.8.1. Future role of the Divisional Immunisation Coordinator

Many respondents felt that one of the main roles of the Divisional Immunisation Coordinator in the future was to coordinate and disseminate up-to-date information and resources to GPs. A number felt that the education of GPs through practice visits, collaboration with other providers, data cleaning and cold chain audits would continue to be significant activities for Divisional Immunisation Coordinators. Two respondents mentioned encouraging self-sustaining practices.

5.8.2. Impact of the Regional Data Quality Officer position

Fourteen respondents (58%) believed that the RDQO position would impact on their positions as Divisional Immunisation Coordinators. Eight (33%) thought it would have no effect and two (8%) were unsure. Four respondents reported that their Divisions were directly involved in the program. Some felt it fostered a positive relationship between providers and would increase immunisation rates. Three thought it would reduce their workloads. One respondent felt that the RDQO position primarily supported Local Governments and that assistance for data cleaning in general practices was needed.

> *Will give me an extra job, fitting in the reports and visits, but will save me the job of direct assistance to providers. Will extend my role for the period of the program and ultimately reduce the data cleaning component of immunisation programs. But will not affect my <u>major</u> role which is resource information and training around recall initiatives.*

> *Prior to the appointment, not a great deal of data cleansing occurred because of lack of time. This person is from LGA and has been beneficial in fostering relationship between GP and other providers. Common goal.*

> *It will provide great assistance to my Division, as it gives me more time to work on other issues besides data cleaning.*

5.8.3. Future of the GPII scheme

Several respondents stated that the GPII scheme was a great program and should be maintained. Some felt that if the scheme was discontinued, the result would be decreased immunisation rates. A few stated that GPII payments should be continued, while others thought the payments should be decreased or eliminated, particularly incentive payments to GPs. One respondent felt there should be more support for public immunisation programs, especially through the Maternal and Child

Health Service, although not at the expense of the GPII scheme. Listed below are some of the comments received about the GPII scheme.

> *Eliminate the SIP, reduce the outcomes* (payment) *but do not entirely eliminate, maintain payment to Divisions (as long as they offer a directly related service).*
>
> *I think if they discontinue it, it will result in a drop in immunisation rates. The amount of information and the complexity of the forms results in GPs ignoring them. Needs Division to explain it succinctly in person, via weekly fax or practice visit. Cold chain standards will slip. Need to keep up education for new staff.*
>
> *…….Divisional funding I see as important as there are links between GPs, practice staff and outside organisations with Divisions, and able to assist at working level with ACIR data, information dissemination, CME and visits (which are often needed to clarify practices and procedures).*
>
> *If GPII is out, there is no doubt that GP participation will drop (and probably immunisation rates). Increased GP immunisation has lead to reduced Local Government infrastructure for public immunisation. If GPs reduce their efforts there will be a major lag before Local Government could respond……..The SBOIC is the 'accelerator' of the Divisional programs. Excessive paperwork, constant changes, lack of security in funding (and therefore loss of high quality staff) and the complexity of GPII/ACIR due to overdue rules and payment eligibility are the 'brakes'. GPII funds are the 'fuel'. Divisional Immunisation Coordinators come in a variety of makes and models, but they all need fuel to run!*

5.9. Immunisation resources and activities developed by Divisions

All Immunisation Coordinators in Victorian Divisions were sent a questionnaire as part of this project. The questionnaire requested information about immunisation resources and educational activities that had been developed by the Division since the introduction of the GPII scheme. This information was entered onto an Access database and transferred to GPDV. It is anticipated that this information will be accessible to all Divisions via the GPDV website. Below is a brief summary of the information that can be found on the database.

5.9.1. Immunisation resources developed by Divisions

A total of 87 resources have been developed by Divisions since the introduction of the GPII scheme (see Table 5.13). The most commonly reported resources were manuals, resource kits, posters and stickers, with a number of Divisions producing more that one of these resources. The majority of manuals produced by Divisions contained a complete guide to immunisation practice and covered a multitude of topics. Others focused on a single topic area. A commonly produced poster used by Divisions was the Big 4 Bear poster and a number of the resource kits included electronic temperature loggers for vaccine fridges. The majority of resources produced by Divisions (32) were targeted to GPs, Practice Nurses and Practice Managers. Some were targeted to GPs and Practice Nurses (14) while others specifically targeted GPs (8) (see Table 5.14).

Table 5.13 Resources developed by Divisions (n=24)

Immunisation resource type	No. Divisions developing this resource type	Total no. resources developed
Manuals	21	31
Resource kit	12	16
Posters	8	11
Stickers	7	10
Educational package	4	6
Magnet	4	4
Computer resource	4	4
Audit tools	3	3
Document holder	2	2

Table 5.14 Target groups for immunisation resources (n=24)

Target group for immunisation resources	Number of resources
GPs; Practice Nurses; Practice Managers	32
GPs; Practice Nurses	14
GPs	8
Practice Nurses; Practice Managers	6
GPs; Practice Nurses; Practice Managers; Parent/Guardian	3
Childcare; Kindergarten	3
Kindergarten	3
Parent/Guardian	3
Childcare; Kindergarten; Parent/Guardian	2
GPs; Practice Nurses; Practice Managers; LGA	2

5.9.2. Immunisation activities developed by Divisions

A total of 66 activities have been developed by Divisions since the introduction of the GPII scheme (see Table 5.15). The main activities run by Divisions were practice visits, CME sessions and workshop / seminars. The majority of practice visits were focused on general immunisation updates, the immunisation schedule or cold chain. Similarly the topics for CME sessions included general immunisation issues, the immunisation schedule, travel vaccination and GPII/ACIR issues. The workshop / seminars tended to have a more practical focus and addressed the ACIR, Internet and data cleaning. As with the immunisation resources developed by Divisions, the main target group for the activities consisted of GPs, Practice Nurses and Practice Managers (27). Only a few extended invitations to non-GP immunisation providers (see Table 5.16).

Table 5.15 Activities developed by Divisions (n=20)

Immunisation activity type	No. Divisions developing this activity type	Total no. activities developed
Practice Visit	14	23
CME session	12	21
Workshop / Seminar	9	13
CME Session; Workshop / Seminar	3	3
CME Session; Practice visit	2	2
Workshop / Seminar; Practice visit	2	2
CME session; Workshop/Seminar/Practice visit	1	1
Other	1	1

5.16 Target groups for immunisation activities (n=23)

Target group for immunisation activities	Number of resources
GPs; Practice Nurses; Practice Managers	27
GPs	13
GPs; Practice Nurses	10
GPs; Practice Managers	4
GPs; Practice Nurses; LGA	3
Practice Nurses; Practice Managers	3
GPs; Practice Nurses; Practice Managers; LGA	2
Practice Managers	2

6. DATA FROM THE LOCAL GOVERNMENT IMMUNISATION COORDINATOR QUESTIONNAIRE

6.1. Profile of responding Local Governments

Fifty-seven Local Government Immunisation Coordinators responded to the questionnaire, giving a response rate of 73%.

Of the 53 who responded to the question on location, 32 (60%) were from rural Victoria and the remaining 21 (40%) from metropolitan Victoria.

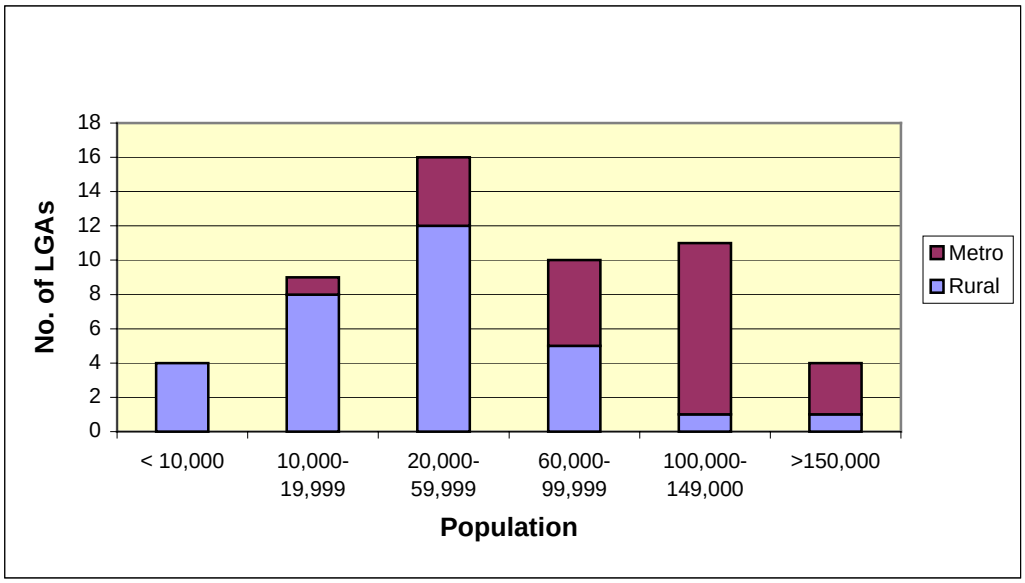
The number of Divisions of General Practice that were situated in each Local Government Area (LGA) ranged from one to seven (see Table 6.1). Sixty per cent of the rural LGAs (19) had one Division of General Practice, compared to 43% (9) of the metropolitan LGAs. One metropolitan LGA had seven Divisions.

Table 6.1: Number of Divisions of General Practice located within each Local Government Area

No. of Divisions	Rural LGAs		Metro LGAs		Total	
	n	%	n	%	n	%
1	19	*60*	9	*43*	28	*53*
2	10	*31*	10	*47*	20	*38*
3	3	*9*	9	*1*	12	*7*
7	0	*0*	1	*5*	1	*2*
Total	32	*100*	21	*100*	53	*100*

Twenty-four of the 29 LGAs (83%) with a population less than 60,000 were located in rural Victoria. Eighteen of the 25 LGAs (72%) with a population greater than 60,000 were located in metropolitan Victoria (see Figure 6.1).

Figure 6.1: Local Government Population Estimates (n=57)



Most respondents (78%) reported that their Health Department had the primary responsibility for the delivery of their immunisation service. Thirteen percent reported their Maternal and Child Health Service delivered immunisation for their Local Government (see Table 6.2).

Table 6.2: Organisation responsible for the delivery of immunisation in each LGA

Organisation	LGA	
	Frequency	Percentage
Local Government Health Department	44	78
Maternal and Child Health Service	7	13
Local Government Family Services	2	3
GPs	2	3
Other (Contracted out – not specified)	2	3
Total	57	100

6.2. Collaboration with Divisions of General Practice

Forty-seven (84%) respondents reported that they were involved in collaborative activities with Divisions of General Practice. Twenty-nine respondents (62%) claimed that these collaborative activities did not exist prior to GPII and 11 (23%) were unsure. Twenty-six respondents (57%) reported collaborating with at least one Division of General Practice, with seven respondents (13%) collaborating with three or more Divisions (see Table 6.3).

Table 6.3: The number of Divisions that Local Government collaborated with

No. Divisions collaborated with	LGA	
	Frequency	Percentage
1	26	57
2	13	28
3	5	11
4	1	2
7	1	2
Total	46	100

6.2.1. Nature of the collaboration

The most commonly reported collaborative activities that occurred between Local Government and Divisions were data cleaning (92%), sharing of information (72%) and attendance at regular meetings (63%) (see Table 6.4).

Table 6.4: Collaborative activities between Local Government and Divisions of General Practice (n=47) (More than one response was allowed)

Collaborative Activities	LGA	
	Frequency	Percentage
Data cleaning	43	92
Sharing information	34	72
Regular meetings	29	62
Joint initiatives / projects	25	53
Sharing resources	12	26

6.2.2. Focus of collaboration

When asked specifically about the focus of their collaborative activities with Divisions, many respondents reported ACIR issues / data cleaning issues (87%), local immunisation issues (66%) and joint projects/activities (43%). Fewer used this collaboration to provide updates on recent activities (26%), State Government issues (26%) or Commonwealth Government issues (13%) (see Table 6.5).

Table 6.5: Focus of collaborative activities between Local Government and Divisions of General Practice (n=47) (More than one response was allowed)

Focus of collaborative activities	LGA	
	Frequency	Percentage
ACIR / data cleaning issues	41	87
Local immunisation issues	31	66
Joint projects / activities	20	43
Updates on recent activities	12	26
State Government issues	12	26
Commonwealth Government issues	6	13

6.2.3. Impact of collaboration

The majority of respondents reported that the overall impact of collaboration between Local Government and Divisions was an increase in immunisation coverage. Many also reported an increase in communication and information sharing between providers and an increase in the accuracy of the data reported to the ACIR. Several mentioned that collaboration had enabled a better understanding of the issues faced by other providers. Below are some of the comments received about the impact of collaboration:

> *Increased joint initiatives, increased information sharing, working as a group to increase immunisation awareness and coverage rates. No longer 'us against them'.*

> *Very, very positive impact in many ways. I believe it will boost community confidence in immunisation and give Divisions and Councils a better understanding of each other's service needs and delivery. Better immunisation rates.*

Better communication overall leading to better data records for overall coverage.

6.2.4. Barriers to collaboration

The great majority of respondents had not experienced any barriers in efforts to collaborate with Divisions. A small proportion reported initial resistance or misconceptions but now had positive working relationships. A number commented on the accessibility of Divisional Immunisation Coordinators who only worked part-time as a barrier to collaborative efforts. One respondent maintained that she had not identified a need to collaborate with Divisions while another reported personnel issues as a barrier. Below are some of the comments received about the barriers to collaboration:

Initially some misconceptions by doctors in the area who saw Local Government as in competition with them instead of working together. Communication / education has overcome this. The Division itself was excellent.

The only barriers have been the resistance of some GPs, GPs having a lack of knowledge of the immunisation schedule and not putting records to ACIR. Our Division only has a two-day per week Immunisation Coordinator, which can be awkward.

There were personality clashes as well as a mutual suspicion regarding competitive programs.

6.3. Immunisation Coordinators in Divisions of General Practice

When asked specifically about Divisional Immunisation Coordinators, 38 (68%) respondents reported that Divisional Immunisation Coordinators assisted their Local Government while 12 (21%) reported that they did not (see Figure 6.2). The most common activities that Divisional Immunisation Coordinators undertook to assist Local Government were data cleaning (76%), information sharing (76%) and provision of information to GPs (53%) (see Table 6.6).

Figure 6.2: Do Divisional Immunisation Coordinators assist your Local Government? (n=57)

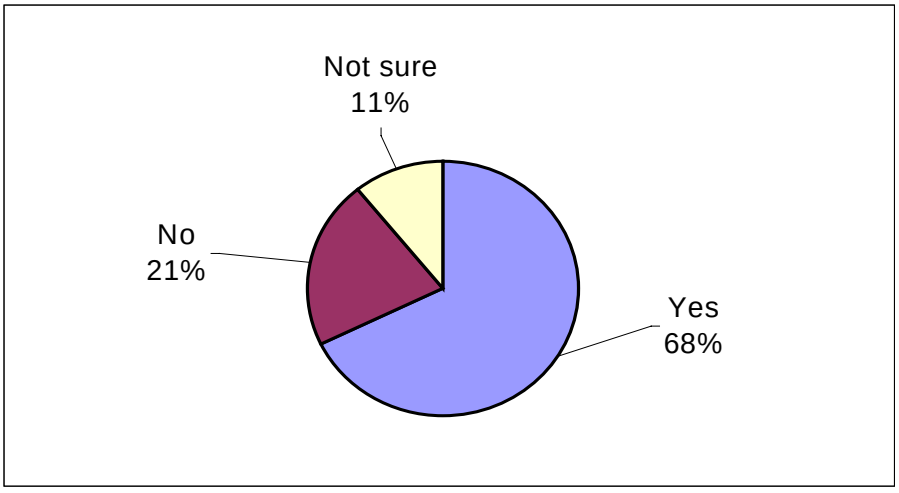


Table 6.6: How Divisional Immunisation Coordinators assisted Local Government (n=38) (More than one response was allowed)

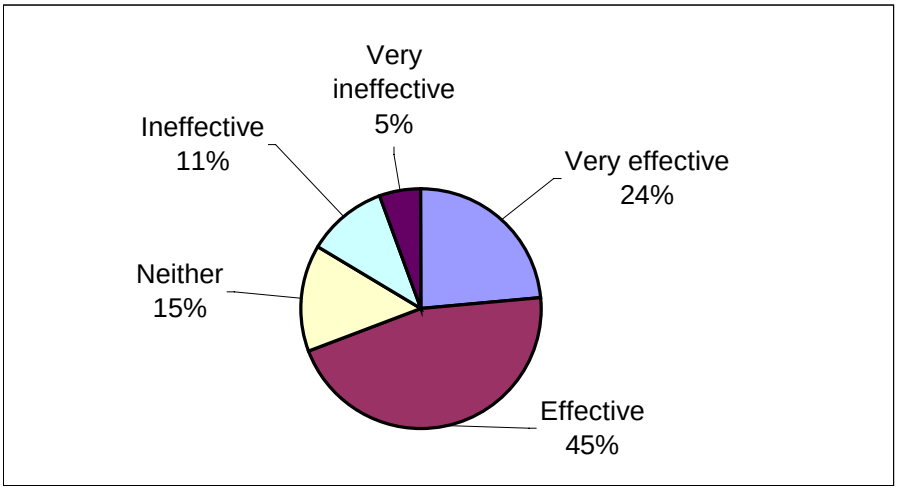
Type of assistance to Local Government	LGA	
	Frequency	Percentage
Undertake data cleaning	29	76
Share information	29	76
Provide information to GPs	20	53
Joint projects/initiatives	16	42
Cold chain audits	9	24
Share resources	6	16
Provide training	4	11
Run local campaigns	3	8
Bring two groups together	1	3
Attend regional meetings	1	3

Local Governments were asked to comment on the effectiveness of Divisional Immunisation Coordinators in improving collaboration between immunisation providers.

Sixty-nine percent of respondents reported that they had been either effective or very effective in improving collaboration, while 16% reported they had been ineffective or very ineffective (see Figure 6.3). A number of respondents commented that there was little or no collaboration prior to the appointment of Divisional Immunisation Coordinators. A few respondents reported being unaware of a Divisional Immunisation Coordinator.

> *Depends solely on the individual and their respective personal skills.*
>
> *I am not aware if such an appointment has been made in this Division. If it has, then my lack of awareness of it supports my answer of 'very ineffective'.*
>
> *This should be a full time position to all Divisions of General Practice.*

Figure 6.3: Effectiveness of Divisional Immunisation Coordinators in improving collaboration (n=55)



6.4. Impact of the GPII scheme

Twenty-five respondents (44%) reported that their Local Government immunisation service had changed since the introduction of the GPII scheme, while 23 (40%) reported no change and eight (14%) remained unsure. When asked specifically about how their service had changed, the majority of respondents reported a decrease in numbers of people attending sessions. Many reported offering a wider range of vaccines and services to compete with GPs, while a smaller number reported changing immunisation session venues as a result of either decreased numbers or to improve customer satisfaction with Local Government services.

> *General practitioners vaccinating means the load is shared with local Council. Sessions more manageable. We are still having to send data to ACIR for some general practitioners which takes up a lot of admin time.*
>
> *Number of children attending sessions makes the sessions economically difficult to sustain.*
>
> *Reduction in immunisation session attendances which decreases funding from subsidies. Certain sessions have been scaled down either by reducing their length or reducing staffing levels.*

Respondents were requested to comment specifically on why they felt these changes had occurred. The most common responses were that as a result of the incentive payments more GPs were vaccinating, and that more parents were choosing to go to GPs for vaccination.

> *Funding incentives to GP practices have encouraged GP practices to promote immunisation services that they operate rather than refer client to a Council session.*
>
> *Because of incentives more GPs are vaccinating making Council sessions not as chaotic. I believe that it is good to give the community the choice to be vaccinated with the service providers of their choice.*

6.4.1. Effect of the GPII scheme on Local Government

The main reported effect of the GPII scheme on Local Government was the decrease in numbers of people attending their sessions. Several respondents noted the inadequate financial incentives that were available to Local Government and a smaller proportion commented on reduced economic viability of Local Government immunisation sessions.

> *Our number of clients may have dropped. GPs are probably more pro-active as far as immunisations are concerned.*
>
> *GPII has assisted with overall increase in immunisation coverage rates, however Local Government has either reduced services or is absorbing increased expenditure costs due to reduction in payments.*
>
> *Limited to slight increase in immunisation coverage. The same could have been achieved at lower cost by provision of some incentive based funding to*

Local Government. The current system is discriminatory in favour of GPs. Sessions operated by Council now require greater subsidy from Council.

Respondents commented on increased immunisation rates, the provision of more accurate data to the ACIR and changes to Local Government services to improve customer satisfaction. A small proportion believed that GPII had had little effect on Local Government.

It has made Local Government become more customer focused and in my opinion improved services.

I don't believe that GPII has had any impact on the immunisation services provided in this area. Initially GPs tried to encourage patients to immunise their children at their services but this is no longer an issue.

A few respondents acknowledged improved relationships between immunisation providers, while one respondent claimed that despite the financial incentives, vulnerable families were still being missed.

6.4.2. Effect of the GPII scheme on Victorian immunisation providers

When asked about the effect of the GPII scheme on Victorian immunisation providers in general, the majority of respondents commented on the increase in immunisation rates and the funding inequities that existed between Local Government and GPs.

I think it has enabled Local Government and Divisions to work together to meet one objective – increased coverage rates.

It has re-prioritised immunisation for GPs, the extra payments have made it cost-effective for GPs to follow up patients' immunisation status.

The Victorian model of immunisation is very effective. Federal Government should have benchmarked States to see what was working well and complemented our model of service rather than competed with it.

Other suggested effects of the GPII scheme included an increase in the awareness of immunisation by GPs; increased collaboration between providers which had resulted in initiatives, such as data cleaning; and a consistency in immunisation service provision and messages across the state.

I think that generally, it has improved a sense amongst providers that children will inevitably be immunised, if not at GPs then at the myriad of other providers which exist – this is a good thing.

More collaboration and sharing of ideas and practices which gives the community greater confidence if we are united in the message we are giving to the public.

A small number of respondents noted an increased workload for GPs and another described the GPII scheme as promoting competition between immunisation providers.

6.4.3. Effect of the Regional Data Quality Officer position

Twenty (36%) respondents believed that the appointment of the RDQO would change the relationship between Local Government and Divisions, 18 (33%) reported that the appointment would have no impact and 17 (31%) remained unsure. Some hoped that the position would improve communication between Local Government and Divisions, raise awareness of the role of Local Government, and increase collaborative projects across a range of public health issues. One respondent commented that the RDQO would need to be an unbiased advocate of all providers, not just GPs.

6.5. Future of the GPII scheme

The main comments regarding the future of the GPII scheme called for an increase in financial incentives to Local Government or the provision of equal subsidies for Local Government and GPs.

> *It is imperative that Local Government remains a strong player in immunisation if for no other reason than to keep us there for mass campaigns. A more equitable subsidy with GPs would help this. The very cost-effective nature of Local Government should be recognised.*
>
> *Local Government is concerned that over time it will dismantle its immunisation services because of the lack of funding. Can this be picked up by GPs? Also if the incentive funding is removed will GPs continue to immunise or submit ACIR records at the current rates and does that mean Local Government has to rebuild their immunisation services?*
>
> *Ensure that some of the funding is directed back to Local Government so as to ensure a system of choice between public and private providers of immunisation service.*

Several respondents felt that the immunisation rates could still be increased and would like to have more contact with Divisional Immunisation Coordinators. Only a few respondents commented that the GPII scheme should be maintained in the future and one felt that the scheme had been of little benefit to rural Victoria.

7. MAIN POINTS FROM THE KEY STAKEHOLDERS INTERVIEWS

7.1. Introduction

Seven people with considerable experience in the immunisation field and representing a range of organisations were interviewed. The organisations represented were Divisions, GPDV, DHS, Local Government and the MAV. The data presented below is a summary of the key points made during the interviews.

7.2. Impact of collaboration

All those interviewed agreed that collaboration between Divisions and Local Government was valuable, particularly the sharing of resources. It was felt that collaboration led to improved understanding of the issues faced by other providers. One person suggested that collaboration was useful in identifying gaps and ensuring services complemented each other.

> *I see opportunities for helping each other with areas of difficulty. They can phone one another if they know each other. So much can be learnt just from breaking down those barriers…….*

Several people raised the point that collaboration would not have taken place without Divisional Immunisation Coordinators.

One interviewee commented that there had always been collaboration between Local Government and Divisions in her Local Government Area. She reported that the only effect of the GPII scheme was increased liaison with the Divisional Immunisation Coordinator which had improved information sharing.

> *It's a two way street. We are only too willing to help each other. I just ring her up if I need something.*

Another respondent commented that collaboration resulted in consistency in immunisation practice and led to parents getting the same message from providers.

7.3. Barriers to collaboration

Several people commented on the lack of financial incentives for Local Government as a barrier to collaboration. One person felt that collaboration was easier now than it had been in the early days of the GPII scheme because some of the Local Government staff who had blocked collaboration no longer worked there.

Funding and personality issues, as well as differing perspectives on public health were raised as barriers to collaboration. There was also the view that Local Government had not been given any acknowledgment by the Commonwealth Government of their substantial role in immunisation in Victoria.

Other suggested barriers to collaboration included distrust and scepticism about the GP agenda. This was thought to be due to a lack of understanding between the organisations.

> *Cultural barriers, sometimes they are talking two different languages.*

7.4. Facilitators to collaboration

Interviewees reported that staff working for the two organisations often facilitated collaboration, for example, GPs working in Local Government as MOHs and belonging to Divisions. To a lesser extent, nurses working as immunisers in Local Government who were also employed as Divisional Immunisation Coordinators played a similar role in facilitation. Another suggestion was that merely having people employed in Divisions focused on immunisation, who could reach out and bring people together, facilitated collaboration.

Trust and positive attitude were also thought to facilitate collaboration. This involved keeping in mind that both organisations were working for the community with the same goal of improving immunisation rates.

> *It doesn't matter who does it as long as it gets done. It is not a competition.*
>
> *It is about understanding each other's agendas and also having some goals we are working on for the benefit of the community, rather than being overwhelmed by the structures.*

7.5. Impact of the GPII scheme

There was general agreement that the GPII scheme had improved the quality of immunisation services delivered through general practice. This was mainly the result of GP education on vaccine administration and storage provided by Divisions. It was felt that the GPII scheme had also raised awareness of immunisation amongst GPs and improved reporting procedures.

The GPII scheme was seen as having a very positive impact on Divisions. Interviewees reported that the scheme demonstrated that Divisions could provide high levels of support to general practices and achieve results on population health issues. It also gave Divisions credibility and a 'foot in the door' with GPs.

> *Fantastic for the Commonwealth to work through Divisions to achieve significant changes in health status……. Served as an example to validate the whole existence of Divisions as being able to achieve outcomes - that's the example, GPII did it first.*

Other suggested benefits of the GPII scheme were that it provided a sense of shared agenda between public and private providers, and increased the numbers involved in immunisation.

One person commented that data cleaning would not have taken place without the GPII scheme because it gave GPs the financial imperative to improve data quality, and Divisional Immunisation Coordinators could assist them in doing this. Another pointed out the influence of the GPII scheme on the development of the State Government funded data cleaning initiative. The database used for data cleaning was initially developed by a Victorian Division. GPDV in consultation with DHS further developed the database and held workshops for Divisional Immunisation Coordinators on how to help practices check their data. The work through Divisions demonstrated that there was incorrect or missing data in both Local Government and GP records. State Government collaborated with GPDV in developing a state wide approach to data cleaning, and then provided funding to ensure systematic take up of the scheme.

There were a range of views when respondents were asked about the impact of the GPII scheme on Local Government. One person felt that there had been no effect whereas two commented on increased costs to Local Government due to decreased attendance at immunisation sessions. One respondent felt that this had been negative, but another reported that reduced numbers had improved their Local Government service by providing a more pleasant environment for staff and clients.

The overall impact of the GPII scheme on Victorian immunisation service infrastructure was described by one respondent as fantastic, because it provided more choice for parents. The impact of the scheme on State Government was seen as very positive because it meant that DHS had an additional 31 people working for them in the community, in the form of Divisional Immunisation Coordinators.

7.6. Future of the GPII scheme

Most respondents believed that all three components of the GPII scheme were necessary for its success. There was general agreement that there was an on-going need for GP education, and that Divisional staff were best placed to provide it.

> *If it* (practice support) *is done by anyone who is more external than Divisions, GPs see it as a threat and turn off and they close up and won't be responsive.*

One person commented that this need would fluctuate depending on whether there were immunisation schedule changes or other new initiatives. Another view was that if Divisional Immunisation Coordinators were no longer funded by the Commonwealth Government, State Government would have to fund positions in each Division or across several Divisions.

There was support amongst respondents for incentives for Local Government. One person suggested that these incentives would enable Local Government to be more proactive in their response to immunisation. A divergent view was that encouraging GPs to immunise by providing incentives was an inappropriate use of their time, and that immunisation could be delivered more cost-effectively through Local Government.

One respondent commented that there was a need for a long-term commitment to the GPII scheme and that immunisation should be recognised as an on-going health need affecting general practice.

8. CONCLUSION AND RECOMMENDATIONS

8.1. GPII funding to Divisions

Not all Divisional immunisation activities were completely funded by the GPII scheme. In most Divisions, over 75% of immunisation activities and resources were funded by GPII. This is in keeping with the national evaluation of the GPII scheme (KPMG Consulting, 2000) which reported that an average of 80% of immunisation activities within Australian Divisions were funded through the scheme.

There was considerable variation amongst Divisions regarding the proportion of the Divisional Immunisation Coordinators' salary covered by the GPII scheme. In 35% of Divisions less than half of the salary was funded by the scheme, but in a further 35% more than 90% of the salary was covered. There was also considerable variation in the number of hours Divisional Immunisation Coordinators were employed to work on immunisation, ranging from 5 - 25 hours per week.

8.2. Role of Divisional Immunisation Coordinators

8.2.1. Dissemination of information

Divisional Immunisation Coordinators played an important role in keeping GPs and practice staff informed of current immunisation procedures. Most Divisional Immunisation Coordinators disseminated information and conducted practice visits. In the early stages of the GPII scheme, much of the Divisional Immunisation Coordinators' time was spent in the development of resources. This activity appears to have been replaced by data cleaning and associated activities - IT support and collaboration with non-GP immunisation providers.

While the need to educate GPs and practice staff about basic immunisation practice has decreased with time, there will always be a need for Divisional Immunisation Coordinators to train new staff and provide updates in a constantly changing field. Major changes to the immunisation schedule, as well as the release of a new edition of the NHMRC Immunisation Handbook, take place approximately every two years, with significant smaller changes often occurring more frequently. Divisional Immunisation Coordinators play a key role in educating GPs about these changes. In addition, infectious disease outbreaks occur from time to time and GPs need to be informed of these outbreaks as soon as possible. Divisional Immunisation Coordinators assist DHS in conveying information to GPs. The employment of Immunisation Coordinators in Divisions means that information is more likely to reach the majority of GPs.

Whilst funding for Divisions is expected to continue beyond June 2002, there is, at the time of writing this report, no written assurance that GPII funding to Divisions will continue beyond June 2002. If Divisional Immunisation Coordinators were no longer funded by the GPII scheme, DHS would have to review how it disseminates information to GPs.

Recommendation: With the possibility that GPII Divisional infrastructure funding may cease, DHS should consider making contingency plans to ensure continued effective communication with GPs. This could take the form of State Government funded Divisional Immunisation Coordinators, or possibly regional Immunisation Coordinators located in Divisions.

As well as disseminating information to GPs, almost all of the responding Divisional Immunisation Coordinators disseminated information and resources to other organisations. Local Government, in particular, has benefited from GPII funding to Divisions. The majority of Local Government Immunisation Coordinators reported that Divisional Immunisation Coordinators assisted their Local Government. The most common forms of assistance were data cleaning, sharing of information, joint projects and cold chain audits. The education of GPs undertaken by Divisional Immunisation Coordinators also assisted Local Government as it promoted the proper administration of vaccines and improved reporting to the ACIR.

The national evaluation of the GPII scheme (KPMG Consulting, 2000) found there was strong support for the effectiveness of Divisional Immunisation Coordinators in contributing to the GPII scheme and recommended that Divisional Immunisation Coordinator roles and funding be retained. In particular, the national evaluation found that Divisional Immunisation Coordinators were crucial in:

- Facilitating GPs' initial uptake of the scheme
- Educating GPs and practice staff about the various components of the scheme and their operation
- Promoting good practice in immunisation among practices
- Keeping GPs informed about ongoing developments, such as schedule changes and new forms
- Supporting GPs and practice staff in their efforts to increase coverage.

Recommendation: The position of Immunisation Coordinator should be retained in Divisions. This position has changed considerably since the introduction of the GPII scheme and is likely to continue to change in response to new initiatives. On-going review of the time required to undertake this role is recommended.

8.2.2. Collaboration with other providers

There was general agreement amongst both Local Government and Divisional staff that collaboration between the two organisations was beneficial. Some respondents believed that collaboration brought an increased understanding of the issues faced by other providers. Others commented that it meant that the two organisations could work together on their common goal of achieving increased immunisation rates. The national evaluation (KPMG Consulting, 2000) found that one of the attributes common to Divisions that had obtained high coverage levels was a desire and commitment to work closely with all immunisation providers to raise coverage levels.

In Victoria, collaboration between Divisions and non-GP immunisation providers is particularly important, as Local Government provide half of all the immunisations in the state. It would be extremely difficult to reach high levels of coverage without cooperation between the two main providers. This was recognised by the Victorian SBOIC who liaised with the MAV and promoted the importance of collaboration to Divisional Immunisation Coordinators.

Very little collaboration on immunisation issues between Divisions and Local Government took place prior to the introduction of the GPII scheme. In most cases, Divisional Immunisation Coordinators appeared to have initiated this collaboration and were seen by the majority of respondents as effective in improving collaboration.

The Victorian State Government funded initiative of data cleaning has also been important in promoting collaboration. It should be acknowledged that GPII

infrastructure funding was instrumental in the development and implementation of this initiative.

A limitation of the current study is the inability to distinguish between the direct effects of the GPII scheme on collaboration and those related to the data cleaning initiative. Some Divisional Immunisation Coordinators reported that they were collaborating with Local Government prior to the initiative, while others reported that they came together for the first time to work on data cleaning.

Regardless of the impetus, collaboration between Divisions and Local Government on immunisation issues has increased, with 96% of Divisional Immunisation Coordinators and 84% of Local Government Immunisation Coordinators currently reporting involvement in collaborative activities. Most of this collaboration involves data cleaning. It is anticipated that once data cleaning systems have been established, this task will become much less labour intensive. One of the anticipated outcomes of data cleaning was promotion of on-going collaboration. It will be of interest to see if the level of collaboration continues without the need to work on data cleaning. However it should be noted that local immunisation issues were also a major focus for collaborative activities for both Local Government and Divisions and this may facilitate continued collaboration.

Most of the Divisions' collaborative activities took place with Local Government. Relatively little collaboration took place with MCHNs. Thirteen per cent of Local Government immunisation services were delivered by MCHNs, and all MCHNs are required to discuss immunisation with parents on several occasions (as outlined in the DHS Child Health Record). Therefore it is crucial that Divisions recognise MCHNs as key players in immunisation and collaborate with them as much as possible. It should be noted that some respondents may have included MCHNs within Local Government, even though the questionnaire made a distinction between the two organisations.

Recommendation: Divisions should include MCHNs in collaborative activities.

Another area where it appears that collaboration could be improved is training. Only six Divisions shared training with Local Government, two with hospitals and one with MCHNs. If Divisions are conducting immunisation training it seems that, in most instances, it would be beneficial (and inexpensive) to invite other interested local professionals to attend.

Recommendation: Divisions should invite local non-GP professionals involved in immunisation to any relevant training they provide for GPs and practice staff.

8.2.3. Barriers to collaboration

A greater proportion of Immunisation Coordinators from Divisions had experienced barriers to collaboration, compared to those from Local Government. One of the main barriers to collaboration for Divisions was the resentment felt by some Local Government staff due to the inequity in financial reward for immunisation between Local Government and GPs.

A factor which may have contributed to this resentment was the misconception that GPs received additional funding for administering immunisations. However GPII payments only became available as a result of funds being re-directed from the traditional fee-for-service model to incentive payments for improved outcomes.

Dissemination of this information, particularly to Local Government, at the time that the GPII scheme was introduced may have reduced misunderstandings.

Another barrier to collaboration was the differing levels of available resources between the two organisations, with some Local Governments not having the resources to work on joint projects with Divisions.

Most Divisional Immunisation Coordinators were aware that the GPII scheme had had a negative effect in some Local Governments and were supportive of financial incentives for Local Government. GPDV, in its submission to the national evaluation of the GPII scheme, expressed concern about the sustainability of Victorian immunisation services, given that only half the service system was rewarded under the GPII scheme, and that it threatened to weaken the Local Government system. There is no assurance that GPII funding will continue beyond 2003. If funding ceases there is the possibility that fewer GPs will continue to immunise. If the Local Government system has been reduced so that it cannot quickly respond to this shift, there is the potential for immunisation coverage in Victoria to drop considerably.

Recommendation: If DHS wishes to maintain the current Victorian immunisation system, which offers the choice of public or private providers, it should ensure the viability of Local Government immunisation programs.

Other impediments to collaboration were the part-time nature of the Divisional Immunisation Coordinators' position and the lack of congruence between Divisional and Local Government boundaries. A third of responding Divisional Immunisation Coordinators worked one day or less per week. This may be inadequate to perform the key tasks of supporting GPs and practice staff, as well as collaborating with a number of Local Governments and other organisations involved in immunisation. This is particularly true in rural Victoria where most Divisions cover more than three Local Governments Areas, and staff often have to drive long distances to meet with other organisations.

Divisional Immunisation Coordinators provided a contact point and source of information for other organisations, and in doing so raised the profile of Divisions. It is important that they are present at the Division for a reasonable period of time so that it is feasible for other organisations to contact them. This does not necessarily mean that they should only be working on immunisation during that time.

8.2.4. Facilitators to collaboration

One of the factors that facilitated collaboration was the employment of staff, such as MOHs or nurse immunisers, who worked in both Local Government and Divisions. Another factor considered to be important was the attitude of the individuals involved in collaboration. Collaborations worked well when individuals trusted one another, understood the issues each other faced, and worked together towards the common goal of increasing immunisation rates.

The commitment to collaboration by GPDV appears to have greatly influenced Divisions and resulted in high levels of collaboration in Victoria. The SBOIC helped Divisional Immunisation Coordinators to understand that collaboration was part of their role and promoted collaborative activities. The major facilitators of collaboration were the Divisional Immunisation Coordinators themselves who had the support and resources to establish collaborative activities.

8.3. State Based Organisation Immunisation Coordinator Position

The great majority of Divisional Immunisation Coordinators believed that the SBOIC supported their work, with some commenting that she held the network together. The SBOIC facilitated communication between Divisions, promoted best practice and guided the Divisional Immunisation Coordinators in their work.

Recommendation: The position of State Based Organisation Immunisation Coordinator should be retained.

8.4. Impact of the GPII scheme in Victoria

Most respondents believed that the GPII scheme had increased immunisation rates, increased awareness and knowledge of immunisation amongst GPs and promoted a consistency of service provision across the state. Another reported benefit was improved collaboration between Divisions and Local Government, involving the sharing of information, resources and expertise. For Divisions, the GPII scheme had increased their profile as a source of information. The impact on Local Government was mixed. Due to decreased attendance at immunisation sessions, some Local Governments were forced to reduce their services in order to remain financially viable. In contrast, a few reported that decreased attendance had resulted in improved services.

8.5. Other issues emerging from this project

Most Divisions received information about the same immunisation issue from multiple sources, most commonly DHS and GPDV. DHAC and ADGP were also popular sources. It is recognised that some information has to be disseminated by DHS because it relates to State issues and that it is preferable for Divisions to receive too much information rather than not enough. However it appears that there is duplication of information and this may be an inefficient use of resources.

One of the reported roles of Divisional Immunisation Coordinators was to translate information coming from State or Commonwealth Governments into a form that was more user-friendly for GPs. This task is time consuming and may result in inconsistency of information. Resources could be conserved if the information was written in an appropriate form for its target audience at source. This may mean distributing information in its current detailed form, as well as distributing an abbreviated form suitable for GPs.

Recommendation: A GP communication strategy, which reduces duplication and ensures consistency of information, should be jointly developed by GPDV and DHS.

8.6. Limitations of this project

This project is limited by several factors. The questionnaire data represents the views of 77% of Immunisation Coordinators from Divisions and 73% of those from Local Government. Rural Divisions were slightly under-represented in the questionnaire data and slightly over-represented in the group interview and focus group data. The data was self-reported and has not been verified.

As mentioned earlier, not all of the activities undertaken by Divisional Immunisation Coordinators described in this report were completely funded by the GPII scheme.

It should be recognised that the State Government funded data cleaning initiative may have been the incentive to collaborate for some Divisions and Local Governments, not the GPII scheme.

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