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Consumer - Community Connections and Divisions of General Practice

INTRODUCTION

The Commonwealth government "is committed to encouraging a stronger, more active role for consumers at all levels of the health system."[1] Since the establishment of divisions of general practice, the Department of Health and Ageing (DoHA) has been encouraging them to actively engage with consumers – and report on their activities in this area – and divisions have been using a variety of strategies to engage with consumers and their local communities. Drawing on suggestions made by the Consumers' Health Forum, one of the principal strategies suggested by the Department is to appoint consumer representatives to divisions' boards of management. GPDV's work with its member Victorian divisions suggests that divisions generally do not think this is an effective strategy. While representation is one approach, there are a range of other effective strategies which can be, and are being used by divisions to connect with their local consumers and community.

This paper seeks to examine the issue of divisions' engagement with community/consumers in more detail:

- to briefly summarise the arguments for consumer engagement in health, review the different types of people and roles that come under the umbrella-term "consumer", and the difference between that term and one that is often used interchangeably: "community".
- to describe some of Victorian divisions' current work to engage local communities and consumers, which is not fully captured in the current reporting formats to the DoHA;
- to look at the range of potential sites for consumer/community engagement in divisions' work (organisational, health service, planning, evaluation etc.)

The paper concludes with the recommendation that desirable solutions are far more complex than simply placing consumer representatives on division boards, and suggests a focus for future action that may meet the needs of consumers, divisions of general practice and the Department of Health & Ageing, and some of the practical steps that need to be taken.

GPDV invites comments on the conclusions suggested in this paper – from our member divisions, and also from other interested stakeholders. We also hope that the Divisions' Review Panel will take the issues described here into account when formulating recommendations for divisions' action to strengthen community and consumer engagement.

CONTEXT

1. Why promote consumer participation in health?

There are many reasons for encouraging consumer engagement in health services, at an individual, health service and system-wide level. It is beyond the scope of this paper to go into detail about the theory, action and evidence underpinning consumer and community engagement in health.

[1] National Health Priorities and Quality Consumer Engagement web page at www.health.gov.au:80/pq/consumer/index.htm

At the broadest level, we can consider the Declaration of Alma-Ata[2], drawn up at the 1978 International Conference on Primary Health Care which articulates the rights of communities to participate in health.

> *The people have the right and duty to participate individually and collectively in the planning and implementation of their health care…*
> *Primary health care…*
> *…requires and promotes maximum community and individual self-reliance and participation in the planning, organiszation, operation and control of primary health care.*

The Declaration of Alma Ata has been embraced by governments and health providers in Australia and overseas and prompted a ongoing focus on achieving sustainable systems for citizens' participation in health care.

A useful (7 page) document that summarises the case for consumer participation in health was produced in 2001 by the Consumer Focus Collaboration.[3] It outlines some of the evidence for consumer participation leading to improvements in health at three distinct levels:

- Individual care
- Health services
- The health system

Individual care

The Consumer Focus Collaboration suggests that at the individual care level, active participation in decision-making leads to improvements in health outcomes, and access to quality information supports an active role in decision-making, and in consumers better managing their own health. A number of different studies are cited as evidence for shared decision-making and self-management leading to improved health outcomes.

Health services

At the health service level, understanding the views and needs of potential and actual users makes it more likely that the service will effectively target those needs.[4] The development of Aboriginal Community-Controlled Health Services in Australia represents one end of the spectrum and the Victorian community health centres set up in the 1970s were structured to make community control possible. Health services with much longer histories were not generally founded on these underlying principles of community control.

According to the document, much of the focus of research and evaluation about consumer participation in services "has been oriented to understand the value of different methods of obtaining consumer views."[4] This research and evaluation has limited value in informing divisions of general practice, as they are not health services.

The health system

Evidence cited for the third level, consumer participation in the health system, includes the development of the Australian response to HIV and AIDS, which, as the paper says, is "internationally recognised for its success in controlling the spread of HIV and minimising the impacts of diease" and which includes partnerships between governments, community-based

[2] Also the Ottawa Charter for Health Promotion, from the First International Conference on Health Promotion, Ottawa, 21 November 1986. Both documents can be downloaded from http://www.who.int/hpr/archive/docs/ , along with documents from succeeding health promotion conferences.
[3] Consumer Focus Collaboration, May 2001, *The evidence supporting consumer participation in health.* Available for download at the NRCCPH website, www.participateinhealth.org.au.
[4] Consumer Focus Collaboration, *The evidence supporting consumer participation*, p.5.

organisations, affected communities, health professionals and researchers, all informing policy development – along with bipartisan political support.[5]

Divisions of general practice may facilitate consumer participation in all three levels described by the Collaboration, but cannot be categorised as one of them. Certainly, they are not primarily health services.

2. What do we mean by consumer?

DoHA defines consumer as "people who either directly or indirectly make use of health services."[6] Even if not making use of health services at a particular time, every citizen (and indeed, every person living in a society, whether or not a legal citizen) is a consumer through their potential use. The perspective of someone who approaches the system from a user's point of view is bound to be different from that of a provider who is informed by another set of interests and experiences, and therefore can lead to a fuller discussion of issues, whether about individual care, health services or the wider system. It is widely acknowledged that consumers are diverse, but this acknowledgement alone does not help to discover who should be consulted by divisions for what input in what context. Consumers can organise in different ways. Bastian[7] suggests 6 broad strands:

1. Groups that form around ***local geographical interests***, generally in response to a single issue of local public concern
2. Groups that form among people ***sharing the same health condition or experience***
3. Groups that are forged among ***people with a shared experience of being harmed by a product*** (or by people advocating a particular treatment or practice)
4. Groups that ***protest particular practices or developments on an ideological basis***
5. Population ***groups with a shared identity*** who come together to represent their concerns and interests
6. ***Generic groups and coalitions*** that are formed to advocate on behalf of the whole population.

It is probably true to say that to date, consumer involvement in divisions of general practice has tended to be associated with the second and the last of these strands – that is, those sharing a particular health condition (especially in relation to a specific division project or program), or generic groups advocating on behalf of the whole population (as the Consumers' Health Forum does, representing Australian health service users in general).

Although there are many ways to categorise different groups of consumers, this one helps to illustrate that there is not a single consumer "voice", nor "view." In the absence of community controlled health services, a philosophical commitment to consumer participation can be difficult to put into practice. Divisions may wish to work in a way that is consistent with the principles of participation outlined in the Alma Ata Declaration, and may seek to strengthen engagement with their local communities, but face important decisions about who they want to engage with and what specific results they are seeking from the engagement (beyond satisfying the stated departmental agenda and appearing to meet requirements of consumer/community engagement).

3. Consumer or community engagement?

Divisions are not health services; they work to enhance the quality of general practice in the local area and to improve coordination between GPs and other health providers. As they have developed over the last decade, it has become clear that their local community of interest includes individual consumers,

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[5] Consumer Focus Collaboration, *The evidence supporting consumer participation*, p.7.
[6] National Health Priorities & Quality – Consumer Engagement at www.health.gov.au:80/pq/consumer/index.htm accessed June 2002.
[7] H Bastian, 1998, 'Speaking Up for Ourselves: the Evolution of Consumer Advocacy in Health Care' *International Journal of Technology Assessment in Health Care* 14 (1): 3-23. Quoted in NRCCPH, March 2002, *Consumer Participation in Australian Primary Care, A Literature Review*. pp.9-10

and consumer groups as well as a range of other groups and organisations brought together in different ways. The Access SERU suggested that "what is fundamental and unique about community liaison by divisions of general practice is that there is an opportunity to bring together consumer and community views with a more collaborative approach to taking action on health issues".[8]

GPDV developed an audit for divisions to use to examine the nature and level of their involvement with the local community. Results in 1999 and again in 2002, showed that divisions were generally very well connected with their local communities across a variety of levels.[9]

There is some tension about whether divisions should seek to engage consumers specifically – ie representatives of health service users – in their locally-based programs and their organisation; or whether the appropriate level of engagement is with the wider local community, including groups and organisations which do not identify themselves as consumer groups specifically. It is not always an open debate: many of the discussion papers and resources in circulation in the Divisions Program move between the two terms (consumer and community) interchangeably. The Access SERU called the debate about whether community participation should focus on consumers/patients or the wider community 'a stale and unrewarding argument' in 1998[10], because ultimately links are required at all levels. The SERU's CAP guide argues persuasively that perspectives of both consumers and health providers and policy makers are necessary to achieve sustained improvements. For that reason, the Access SERU made the focus of its guide community rather than just consumer liaison.[11]

GPDV would support a focus on community engagement rather than only consumer engagement for the same reasons, and also because consumer issues and perspectives arise through a range of groups with which a well-connected divisions has links (e.g. through the PCPs in Victoria, which, themselves, work towards a consumer engagement strategy).

Although the debate about consumers or community may be 'stale and unrewarding,' a lack of clarity at the policy level about exactly who divisions are trying to involve and at what level (the individual level; the service/organisation level; or the wider system) makes it difficult to outline sensible and effective strategies for strengthening community participation in divisions. While the policy level may lack clarity, divisions have been making their own decisions about what to do in terms of engagement with their local communities and how to do it.

WHAT'S BEEN HAPPENING IN DIVISIONS?

Evidence shows that Victorian divisions are involved in a wide range of strategies which connect them with their local communities. For some divisions, these strategies originate in the attempt to ensure strong engagement with the local community, developing from the work undertaken when the DoHA funded specific community liaison projects, and project officer positions, until block grant funding was introduced in 1998. For other divisions, engagement strategies arise when they seek to implement an effective program. Strategies that emerge here may or may not be reported as "community" or "consumer" engagement, since they are seen, primarily, as an implementation method for a division's program.

The range of activities includes[12]:

- establishing consumer reference/advisory groups, to advise the division board on relevant issues (members of the group may attend board meetings, and GP board members may attend group meetings)

[8] Access SERU, Centre for Health Program Evaluation, University of Melbourne, June 1998, *A Current Accepted Practice for Community Liaison Activities: a Guide for Divisions of General Practice*, Draft for Comment. p.7
[9] The final report of the audit results can be viewed at http://www.gpdv.com.au/consumers/
[10] In an early draft of the CAP Guide cited above.
[11] Access SERU, *CAP Guide*, p.7
[12] These are taken from a compilation (September 2002) by GPDV of the activities outlined in divisions' annual reports and newsletters.

- inviting consumer/community representation on steering groups for particular programs
- inviting consumer input to: development of programs, local needs assessments, development of business plans
- inviting consumer input to patient surveys for practice accreditation
- inviting consumer input to wider policy issues (e.g. national electronic health records, corporatisation of general practice)
- producing consumer information
  - on particular health issues (e.g. immunisation, farm safety, child health, postnatal depression etc.) to be used in the general practice
  - about (and promoting) general practices available in the local area
  - about communicating with your GP
- holding workshops for consumers (sometimes with GPs and sometimes separately) to identify what they seek in a good quality general practice
- working with specific sub-groups of the population in order to ensure that a program reaches its target group(s)
- obtaining consumer input for division's program of GP continuing professional development (CPD).

Reviewing this list (which is not exhaustive) reveals not only that there are a wide range of activities, but that they are quite different in what they are aiming to achieve, and whose needs they are trying to meet (e.g. promotion of general practice services compared to ensuring that the division creates programs based on community need). Some involve consumers specifically while some target the wider local community. The subject of the work ranges across different levels of health, from individual care to the health system.

Victorian audit

Experience suggested to GPDV that this range of activities and strategies did not represent the complete picture of community engagement. GPDV developed an audit to explore other facets of engagement. In 1999-2000, GPDV provided Victorian divisions with a self-audit to assist them with reviewing and reporting on the extent of their relationship with their communities, and the involvement of consumers in program planning and management generally.

In 2001, GPDV offered a second self-audit and extended its focus.[13] 23 of 31 divisions responded, and those divisions represented a cross-section of Victorian divisions in terms of size, geographical location and funding levels. Therefore responses to the survey can be seen as representative of Victorian divisions generally.

The audit questionnaire had four parts:

1. to check the extent to which the community has had input to the division's information gathering, decision-making, program delivery and evaluation for 2000-01
2. to examine the ways the division had input to other groups/organisations and activities in the local area
3. to describe in some detail the division's community advisory group (or equivalent) where it had one
4. to explore some questions about the division's consumer/community engagement policy, and allow for discussion of lessons learnt and directions for the future.

The audit found that Victorian divisions were extremely well-connected with their local communities. Major findings included:

- Victorian divisions have achieved a high level of representation on the Boards of Management of other organisations. (52% of divisions)

[13] The final report of the audit results can be viewed at http://www.gpdv.com.au/consumers/

- Victorian divisions have used the strategy of Consumer/Community Advisory Groups more than is average for divisions nationally (74% compared to national average of 37%)[14]
- Victorian divisions have provided remuneration for consumer representatives with greater frequency than the national average (76% compared to 67%)
- Divisions have made significant GP and CEO time available for direct participation in Primary Care Partnership (PCP) development.[15]

Evidence from the audit results suggests that in Victorian divisions there have been serious, sustained efforts to ensure consumer/community engagement through a wide range of activities.

Consumers on divisions' boards of management?

Divisions vary not only in their philosophical commitment to community/consumer engagement, but in their beliefs about how it can best be achieved. From time to time the strategy of compulsory board membership for a consumer representative is suggested as a way of divisions ensuring consumer engagement. The evidence suggests that in Victoria, divisions are unlikely to embrace that strategy.

The Victorian audit (2002) showed that 35% of divisions had consumer or community representatives sitting on their boards of management. This is consistent with the rate for divisions nationally.[16] The NRCPPH case study suggests that some divisions which have embraced consumer representation on their boards have only done so following the implementation of successful consumer and community engagement activities at program and project level.[17] While the Victorian audit shows 35% of divisions have consumer/community representatives on their boards, GPDV is aware that in some divisions this includes members without voting rights, who are therefore not full members of the board. The annual survey report does not make clear whether it differentiates between consumer representatives with and without voting rights.

At a statewide meeting of division CEOs in June 2002 (convened by GPDV), CEOs were asked to indicate their own board's response to the idea of having consumer representatives with full voting rights on the division's board of management. A small number of divisions supported the model; a couple were reported by CEOs to be uncertain; and the majority were opposed. To impose a model of compulsory consumer appointments to a board of management in advance of the collaborative work that allows partners to build a relationship of mutual trust not only risks tokenism, but ultimately risks damaging the chances of building a truly collaborative relationship where decision-making power may be shared.[18]

Board governance and membership

Divisions of general practice are (Commonwealth funded) companies governed by boards of management. Boards of management do not comprise individuals representing various constituencies – they stand in for all the membership (in this case, universally GPs and the practices where they work, although some divisions do have other categories of membership e.g. associate). People who accept a position on a division board of management accept the responsibility to provide policy direction for the organisation, to monitor its financial position, and report on these things back to the members. Widely

[14] The national averages are reported from the Annual Survey of Divisions. Carolyn Modra, Elizabeth Kalucy, 2002, *Practices, partnerships and population health: report on the 2000-2001 Annual Survey of Divisions of General Practice,* Primary Health Care Research & Information Service, Flinders University.

[15] The Victorian Department of Human Service funds the PCP initiative, which aims to bring together all the state-funded primary care agencies, along with general practice, to improve entry, assessment, referral, and coordination for consumers who access primary care services.

[16] 20% of divisions reported consumer representation on the board. C Modra, E Kalucy, 2002, *Practices, partnerships and population health – annual survey of divisions,* p.55.

[17] NRCCPH, June 2002, *Consumer Participation in Australian Divisions of General Practice: A case study.*

[18] For more information about building partnerships between organisations, see R Walker (2000) *Collaboration and alliances: A report to VicHealth*, VicHealth, Melbourne; R. Walker (2001) "Trust between primary health care organisations," *Health Promotion Journal of Australia* 11(1): 43-47.

accepted good governance theory[19] suggests that it is erroneous to appoint members as though they represent a particular constituency. Examples given by Carver are consumer or student representatives. Avoiding this practice is consistent with the appointment to boards of GPs who do not represent their own practice, but stand in for all the local practices; and in Victoria, appointment to the GPDV board, where members do not represent their own division but Victorian divisions as a group. Of course board members are influenced by their own skills and experience which inform their perspective, and members from a variety of backgrounds may add depth to the discussion of issues under consideration, but this does not equate to "representation." Carver[20] suggests that if there are board members from different groups, governance would work better if they were considered to be 'from' that group, rather than representing it. The appointment of a so-called "representative" does not lessen the board's obligation to actively seek to access and understand the diversity of its community of interest, and include the breadth of its concerns in a meaningful way. Yet the presence of a "representative" can often be taken as evidence of the group's inclusion, which can lessen rather than enhance the board's work in the area of community engagement.

There are a range of strategies that divisions currently use when engaging their local communities. The methods should match the purpose of the activities and the needs of the division and its community. Imposing a method which is not supported locally is likely to solidify resistance. Instead of making consumer board membership compulsory, a much better approach would be to continue to build integrated systems for consumer and community involvement in divisions and, where necessary, to assist divisions to implement these systems gradually. As Carver argues, the governance task for boards is to actively seek to access and understand the diversity of the community of interest, and the issues that arise need to be incorporated into the work of the organisation. This task is not likely to be accomplished merely by appointing a consumer "representative" on a board of management.

THE TASK

Divisions are committed to improving health through general practice and to increasing access to general practice services. CHF works to promote consumers' views in all areas of health care, and works to promote accessible, good quality, affordable and safe health care.

When we consider the stated agenda of the Consumers' Health Forum (articulated in *Consumers' Expectations of General Practice in Australia*, April 1999 and *Policy Regarding Key Issues in General Practice Financing*, April 1999[21]) there appears to be broad agreement between CHF and divisions on many issues (although they may differ about the best way to implement them). There seems to be agreement to promote:

- accreditation of general practices
- PIP to reward practice quality
- nurses working in general practice
- improved communication/coordination between general practice and other health services
- the importance of GP training
- prescribing support
- appropriate management of patient/consumer health information
- an increasing GP role in illness prevention
- recall systems in practices.

[19] Carver's approach (cited below) underpins GPDV's advice to divisions, and GPDV's program of governance training for boards (delivered by John Mero, among others).
[20] John Carver and Miriam Mayhew Carver, 1997, *Reinventing Your Board: a step-by-step guide to implementing policy governance:* Josey-Bass Publishers. pp.48-9.
[21] Available at www.chf.org.au/publications/

Many of the strategies divisions are currently working on (see p.5 above) address elements of the CHF agenda.

The broad, major areas on which there is no agreement seem to be:

- the necessity for bulkbilling
- a commitment to reduce waiting times and guarantee appointments within a certain timeframe
- what consultative mechanisms for consumer input should be in place.

Additionally, there is no agreement across divisions – let alone between divisions and other stakeholders – about which areas are the highest priority.

What should happen in divisions?

The role of divisions is not primarily to deliver health services. Divisions promote improvements to the quality of the health services delivered through general practice; and better coordination of health services between general practice and other primary care settings, and between general practice and hospitals.

There are at least two tiers to consider in the division's role in community/consumer engagement. One relates to the division as an organisation. Community/consumer input to its needs assessments, its programs and evaluation of them should help to ensure that they are consistent with local needs and are being implemented effectively. Having consumer representation on a board of management might be one of the tools for achieving this, although it is certainly not the only one, and, arguably, an ineffective one (and an unpleasant and unrewarding experience for the consumers who take part) if it does not have the support of the board of management, staff and the wider membership. (See p.6. above.)

Another tier is the end-point of the division's work: the delivery of health services to patients. These may be delivered to patients via a division's program directly, or, more usually, to patients via a general practice. When the site for service delivery is general practice, we might look at those things that support care at the individual consultation level (e.g. consumer input to CPD for GPs) and also at the practice's systems that are necessary to promote good quality care (e.g. patient surveys, meeting accreditation standards, having available good, clear, relevant health information for patients, use of interpreter services, appointment systems, recall and reminder systems).

Most of the information that has been gathered about what divisions do in relation to consumer participation, and most of the strategies recommended (by CHF and DoHA) focus on the division-level structures, rather than strategies to ensure consumer/community participation in the health service delivery level.

The clearest, recent example is a document prepared by a working group of GPPAC's Divisions' Standing Committee[22] which sought to "address a number of frequently asked questions from Divisions about consumers and their participation" and deliberately did "not address the relationship between individual general practitioners and consumers as their patients, nor the issue of participation in general practices".

Over the last two years, the Annual Survey of Divisions (undertaken by the PHCRIS at Flinders Uni) has included more questions about consumer/community involvement, informed by the GPDV audit, and partly as a result of GPDV having provided the representative for SBOs on the PHCRIS advisory group that helped to revise the questionnaire. Richer information is now available through the annual survey, but there is further work to be done looking not only at the levels of activity, but their results.

However, comments made by two guest speakers at the National Divisions Forum in 2002, Kathy Mott and Michael Greco, support the need for much more attention to be paid to practice-centred consumer engagement activities, supported by the division. Such activities have great potential impact on

[22] *Consumer Participation In Divisions*, undated but circulated in draft form in late 2001.

consumers as users of general practice services. Speaking on 'Engaging the Community' as a consumer advocate, Kathy Mott argued that consumer input at the general practice level is a fundamental area that has been consistently overlooked in discussions about divisions, community engagement and consumer involvement. Citing John Oldham's work which suggests that patient engagement at the practice level as part of a continuous quality improvement (CQI) process can lead to more efficiency, better patient satisfaction and to some extent better outcomes, Kathy Mott claimed that the challenge for divisions of general practice now is to support practices to better engage with their patients.

Michael Greco is Head of Patient and Public Involvement, National Primary Care Development Team and National Clinical Governance Support Team, which are both located in the NHS Moderisation Agency in the UK. At the ADGP Forum, he argued that GPs are more likely to be responsive to feedback from their own patients than to feedback from consumers not connected with their practice.[23] In an article in Australian Family Physician,[24] Dr Greco identified the need for future research to explore how practices act on the results of patient feedback; and which practice-based strategies are more effective in raising standards of care from a patient's perspective.

This focus on the practice level is echoed by some divisions. The CEO of one of the divisions which has adopted a range of strategies for consumer participation (including at board level) has stated that the next logical step for the division's Community Action Forum to encourage GPs to have consumer input at the practice level.[25]

Existing resources to strengthen consumer/community engagement

At a national Improving Health Services through Consumer Participation conference in May 2001, Brian Johnson, CEO of the Australian Council on Health Care Standards described Australian frameworks for consumer participation in the acute sector as still "immature."

If consumer participation frameworks are immature in the acute sector, then they are even more so in divisions and in general practice as little national investment of resources has been made in collaboration to develop or evaluate sustainable, workable frameworks for divisions. Some of the valuable, recent work carried out by the DoHA-funded Consumer Focus Collaboration, and by the NRCCPH, has provided resources – to which divisions are referred by the GPPAC paper and the DoHA – but they are geared to promoting consumer participation in health services.[26] They may be extremely useful for community health services (where general practice services may or may not be a component) but not for divisions, which, as discussed above, generally operate at a step removed from health service delivery.

General practices are the patient service delivery sites and divisions work with their member practices to support continuous quality improvement activities which affect that service delivery but which are generally implemented by the practice, not the division. This fundamental organisational difference has limited the usefulness and applicability of such resources to divisions. They do highlight, however, the fact that for consumers it is the relationship with the health provider that is the important one.

One of GPDV's consistent observations has been that GPs have found it difficult to relate to policy directions around consumer involvement in divisions. When a patient enters a public hospital as a public or private patient they receive a large number of services from providers with whom they have no ongoing relationship and who they have not chosen to care for them. Nurses, radiologists, cleaners,

[23] Powerpoint presentation can be downloaded from www.adgp.com.au/site/index.cfm?display=766

[24] M Greco, K Sweeney, A Brownlea, J McGovern, November 2001, "The practice accreditation and improvement survey (PAIS) – what patients think" in *Australian Family Physician*, Vo. 30, No. 11 1096-1100.

[25] NRCCPH, June 2002, *Consumer Participation in Australian Divisions of General Practice: A case study*,p.20.

[26] Recent examples include the Consumer Focus Collaboration's *Improving health services through consumer pariticpation – a resource guide for organisations;* the NRCCPH's (May 2002) *Primary Care Self Assessment Tool for Community and Consumer Participation*, V1.0, as well as the GPPAC document cited above, which bases its recommendations on literature related to consumer participation in health services. The NRCPPH is aware of this problem and is currently working on a revised version of the *Primary Care Self Assessment Tool* specifically for the use of organisations such as divisions.

ward clerks, allied health staff, catering staff and so on all contribute to the patient experience of hospital care and mechanisms are important for hearing and acting on the quality of these experiences from a patient perspective. But in general practice patients generally know and have personally chosen the GP who is providing their care. What is more, they are more likely than not to have an ongoing care relationship with their chosen GP. In this situation, GPs commonly report that resources and policy directions useful in hospital settings are not relevant to their private practice setting.

GPDV has identified the need for further research and resource development in the area of GP/consumer/community engagement which is firmly grounded in the realities of that engagement from both the GP and consumer perspectives.

CONCLUSION

Divisions' engagement with their communities

GPDV recognises that divisions' engagement with their local communities is essential to fulfil their functions of improving the quality of general practice services, and better coordinating consumers' care (between GPs and other primary care providers and between GPs and hospitals). Divisions need to be well-connected to their communities if they are to be effective; and need to clearly define their community of interest. Divisions are not community controlled organisations, but are, by definition, controlled by GPs. There are many areas of agreement between consumer groups and divisions of general practice which can continue to be identified and progressed by divisions.

GPDV recognises that there are a range of strategies divisions use to achieve engagement with their local communities, some of which are outlined above in this paper.

GPDV believes that focusing solely on a single structural or organisational strategy such as placing a consumer representative on the board runs the risk of tokenism. GPDV opposes the imposition by DoHA of a requirement upon divisions to appoint a consumer representative to their board.

GPDV believes that Victorian divisions are well-connected with their local communities (based on the audit conducted in 2001). GPDV supports principles of continuous quality improvement in all areas and believes there is room to further develop divisions' community engagement.

Future focus

GPDV suggests that a useful focus in the area of community/consumer engagement is on consumer input to health services (bearing in mind that in the divisions' context, health services are most commonly delivered through general practices). Strategies include:

- Ensuring division programs are consistent with the needs of the local population (through consultation, needs assessment, joint work with other groups in the community, PCPs etc.)
- Increasing access for disadvantaged groups of consumers. Ensuring that disadvantaged groups within the local area are identified for divisions' programs that adopt Commonwealth health priorities (e.g. ensuring that a Heart Health Program is made available in an appropriate form to a local Aboriginal community)
- Incorporating consumer views into the development of continuing professional development programs for GPs to further GP knowledge about consumers' experience of general practice and their views on quality improvement
- Promoting and facilitating consumer input to general practice, through the accreditation processes.

What is needed to further develop divisions' engagement with their communities?

Resources

Divisions need resources that address the realities of general practice and of divisions, and are clear about the difference between them, and seek to offer guidance on more than structural issues (e.g. establishment of advisory committee/additional board member).

GPDV has advocated for and welcomes the development of an additional version of the NRCPPH Primary Care Self-Assessment Tool for Community and Consumer Participation that will meet divisions' needs (as distinct from the needs of health services, for which the first version was designed).

Useful strategies may be provided by the NRCPPH's current work-in-progress to assist divisions to work with consumer and community organisations and GPs to improve management of chronic conditions.

Other resources may need to be adapted to address consumer engagement at the practice level. For example, consideration could be given to implementing nationally some of the NHS practice-based strategies, such as the Improving Practice Questionnaire (IPQ) toolkit and establishment of Critical Friends Groups (CFGs).[27]

Training for consumers / community representatives

GPDV proposes that training in negotiation/advocacy skills, which is a stated need of consumer/community representatives, would be most appropriately provided through the TAFE system, to nationally agreed standards. It is appropriate for divisions and their support organisations to provide organisational orientation for representatives, but it would be inappropriate for divisions to provide skills training to independent representatives of other groups. (It appears that some community health service advisory boards are using this type of model, by offering training to independent community representatives, that will be provided through the TAFE sector.)

Orientation to divisions of general practice

GPDV will continue to provide orientation to the Divisions of General Practice Program for consumer/community representatives, through regular, statewide workshops. These aim to provide community/consumer representatives with the knowledge about general practice issues and the policy context that they need to work in partnership with divisions. They do not aim to develop participants' skills.

Evaluation

The Victorian audit of divisions' engagement with their local communities and the PHCRIS's Annual Survey of Divisions measure levels of activity between divisions and their local communities. More rigorous evaluation is needed to measure the results of the engagement, in order to inform future direction. Evaluation that is grounded in theoretical frameworks about intersectoral collaboration and its components could help to give divisions a detailed picture of what they need to do, and how, in order to achieve results that will meet the needs of divisions of general practice and their communities.

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[27] NHS Modernisation Agency website, *Involving Patients and carers,* www.modern.nhs.uk/improvementguides/patients/5_6.html. See also the Client-Focused Evaluation Program (CFEG) website at http://latis.ex.ac.uk/cfep/ http://latis.ex.ac.uk/cfep/ for more information about IPQs and CFGs, and further publications.

Draft Recommendations

- That ADGP, GPPAC and DoHA develop consistent policies that focus on promotion by divisions of consumer engagement at the general practice level. This is likely to be of interest to GPs, who can see the relevance of enhancements at the general practice level, and has been repeatedly identified by consumer advocates as a central area of concern (most recently by Kathy Mott at the 2002 ADGP Forum).

- That ADGP, GPPAC and DoHA resist the development of policies that seek to impose particular organisational structures (such as consumer "representatives" on boards), which are likely to alienate divisions, require considerable time and effort, and run the risk of being ineffective and tokenistic.

- That ADGP work with RACGP, AGPAL & NRCCPH on a nationally consistent set of tools and incentives to be used through the accreditation process, drawing on the work done in the UK by Michael Greco and others; and to work to further the incorporation of patient feedback into a CQI cycle in general practices.

- That all players recognise that the central task for divisions of engagement with their communities is challenging and complex; and that DoHA support divisions in that task by investing in evaluation.

- That the development of skills training for community representatives to nationally agreed competencies be supported. Representatives of Commonwealth and State health departments would need to work together with consumer groups to develop these opportunities. Provision of training by a provider external to the Divisions Program (e.g. TAFE) would facilitate the participation of consumer/community representatives on equal terms. Provision of such training by divisions would not fulfil the same function.

GPDV invites feedback on this discussion paper, and in particular on the conclusion and the draft recommendations. GPDV board will consider Victorian divisions' responses before formally adopting the position outlined in the conclusion of the paper.

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