VICTORIAN GENERAL PRACTICE

Number 1. November 1999

QUARTERLY DIVISIONS

Challenges for GPs and divisions

Bob Douglas

The purpose of divisions

Liz Furler

Expectations and reality

Views of some 'founding fathers'

In brief:

Brian Howe
Michael Bollen
Paul Mara

FIRST ISSUE – TAKING STOCK

QUARTERLY DIVISIONS

GPDV is a state based organisation of divisions of general practice owned by all the 31 divisions in Victoria. It is funded by DH&AC to provide support to Victorian divisions, to develop policy and to represent and advocate for divisions and for general practice.

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General Practice Divisions – Victoria Ltd
1st Floor, 458 Swanston St
CARLTON VIC 3053

Ph: (03) 9341 5200
Fax: (03) 9348 1375
Email: gpdv@gpdv.com.au
Website: www.gpdv.com.au

GPDV
GENERAL PRACTICE DIVISIONS
VICTORIA

The Divisions' Quarterly is a journal produced by General Practice Divisions Victoria to enable all Victorian divisions and their members to participate in discussion about the changes in general practice that divisions are funded to implement. Others associated with the Divisions' Program including consumers are also invited to contribute.
All articles submitted for inclusion in the Divisions' Quarterly are subjected to a review process by the Editorial Committee prior to publication. The Committee may request changes be made to the article before publication. All changes will be sent to authors for approval before printing if possible. The Editorial Committee cannot promise that all contributions will be automatically printed in the journal.
Divisions' Quarterly will not usually reprint articles that have been submitted to other journals.
Please send your article in either Word 97 or earlier version or Rich Text Format to the following address:

c.macdonald@gpdv.com.au

If you do not have email facilities, then send a disk copy in one of the formats previously mentioned. If this is not possible, send us a typed copy of your article to:

Christine Macdonald
GPDV
1st Floor
458 Swanston Street
CARLTON 3053

Feature Articles
Feature articles are approximately 1500 to 2500 words long. Please adhere to this length.
Ideally, a Divisions' Quarterly article will meet as many as possible of the following criteria

- generate debate about the theme;
- promote analysis of issues
- inform others about issues in the Divisions' Program
- promote and affirm divisions and their work
- contribute to setting the research agenda for the Divisions' Program.
- have state-wide relevance

The Next Edition
The second edition is scheduled for March 2000.
The theme will be Practice Support. It will include articles on the following issues:

What forms of practice support should the Divisions' Program provide?
What forms of practice support have been most effective in IT? health promotion? practice management? immunisation?

We seek contributions on practice support issues associated with accreditation, amalgamation and the Practice Incentives Program.
Deadline for contributions: Friday 21st January

Letters to the Editor
Divisions' Quarterly seeks letters from GPs and others on the content of the first edition. As part of the purpose of the journal is to generate debate and discussion within the Program, the Letters to the Editor section will be a significant feature of each subsequent edition. Letters of more than 300 words may be edited to that maximum.

Address letters to:

The Editor
Divisions Quarterly
1st Floor
458 Swanston Street
CARLTON 3053
Fax: 03 9348 1375
Email: c.macdonald@gpdv.com.au

QUARTERLY DIVISIONS

CONTENTS

Introducing the journal

Dr Julie Thompson, Chair, GPDV

The Divisions' Quarterly is being launched as a vehicle to enable all Victorian divisions and their GP members to participate in discussion about the changes in general practice that divisions are funded to implement.

Each edition of the journal will generate debate about a key issue or theme; it will also

- promote analysis of issues
- inform others about issues in the Divisions' Program
- promote and affirm divisions and their work
- contribute to setting the research agenda in relation to the strengths and weaknesses of the Divisions' Program.

The Quarterly will not include Program news as division newsletters provide that service to their members.

The theme of the first edition is "Taking Stock" – taking stock of the Divisions' Program, considering whether it has achieved its aims, whether it has changed direction, whether Commonwealth views of the purpose of divisions match GP hopes and expectations.

Future editions will address more concrete themes, the second edition being focused on issues associated with providing practice support. However, each edition will include some analysis of the overall direction of Program activities as they relate to the particular theme.

We have launched the journal by inviting leading GPs and policy makers to reflect on divisions – past, present and future. We would welcome comments in the form of letters to the editor and we strongly encourage contributions in the form of articles for the next and future editions.

We see the journal as one way of ensuring that all Victorian divisions have the opportunity to reflect on the overall direction of the Program – and the implications for general practice – and to influence directions by expressing their views.

Julie Thompson

IT IS AN APPROPRIATE TIME TO LOOK BACK TO SEE WHETHER THE DIVISIONS PROGRAM HAS DONE WHAT WAS EXPECTED, HOPED OR FEARED WHEN IT WAS FIRST PROPOSED

Overview: taking stock

Bill Newton

Bill Newton is the editor of the Divisions' Quarterly and CEO of General Practice Divisions – Victoria. In this overview he introduces the themes and issues explored in this first edition of the journal.

Introduction

The theme of the first edition is taking stock of the Divisions' Program: what was it intended to do, how has it measured up against those expectations and what is its future.

We have gathered the recollections of some of the major players in the development of the ideas that led to the Program and asked them to comment on its achievements. We have sought the views of some of the "founding fathers" of divisions in Victoria (and apart from one who is now overseas they were all men) about what they hoped to achieve and whether they think they succeeded. We have asked Liz Furler, First Assistant Secretary of the Health Services Division of the Department of Health & Aged Care (DH&AC) to set out the Commonwealth's view of the purpose of divisions and how this view may have changed since 1992.

The need for review

It is an appropriate time to look back to see whether the Divisions' Program has done what was expected, hoped or feared when it was first proposed. The Program is well established with divisions operating on a three-year funding contract, the major change to its structure brought by Outcomes-Based Funding (OBF) is now in place and DH&AC sees the Program as a major vehicle for health system change.

Liz Furler's article, and her presentation at the National Divisions Forum in August, show that DH&AC has clear ideas about the future directions of the Program and its key role in bringing important improvements to the health system. While these ideas have been in common currency at least since the publication in 1992 of the National Health Strategy Paper No 3, *The Future of General Practice,* the questions that arise from the proposed changes have not really been debated within the Divisions' Program in any systematic way.

Taking stock enables the debate to be put into the context of what GPs were led to expect from the Program when it was set up. How far has DH&AC moved from the original aims? How well do the current directions of the Program match the profession's promotion of divisions as a way to address well-documented concerns of GPs set out in the 1991 Report: *W(h)ither Australian General Practice?*

The purpose of divisions

The Divisions' Program, and the whole GP Strategy of which it is a part, was introduced with the explicit aim of changing general practice. As the comments here by Paul Mara and Michael Bollen show, this aim was supported by GP representatives at the time, although not always by the health department. The department's original opposition to the Divisions' Program, mentioned by both Michael Bollen and Paul Mara, may have been caused by the political failure to introduce a co-payment for GP services and the consequent loss of the expected $696.5 million in savings that the 1991 budget predicted for 1994/95.

Bob Douglas refers to the "urgent need to stop the dangerous game of federal/state cost-shifting" – the practice of the states trying to make the Commonwealth pay for state services and vice versa. Divisions will agree. The short-term projects of the early years of the Program have been described here as a waste of money (Mukesh Haikerwal) or as opportunities missed (Leon Massage): whichever they were – probably a bit of both – the approval of projects was heavily influenced by cost-shifting issues. These continue to obstruct the integration of services and to dominate the debate about whether divisions should use their funds for service delivery.

Of course, the real test of a serious desire to create an integrated health system will be the willingness of the states to move funds out of the acute care system and into primary care. Brian Howe says he saw this in 1992. Needless to say he did not have any more success in winkling the funds out of the hospitals for the Divisions' Program than did his predecessor who developed the Community Health Program, with very similar objectives to the Divisions' Program, in 1973. Instead Howe's successors tried to claw back some of the cost by reducing the increase in Medicare rebates for GP services, thereby giving rise to the ill-founded and destructive belief that the whole GP Strategy is funded by cuts to the rebates.

Reducing GP isolation

The reduction of the isolation of GPs was an objective of the Program from the start. It is generally regarded as the major achievement of divisions. All the GPs interviewed by Tattam say that divisions have been successful in reducing the isolation of GPs and no one involved in the Program seriously challenges that view. Divisions may have been more successful in bringing GPs together with each other than with other health professionals and other parts of the health system, and some GPs, as Bob Douglas says, are still not part of the new togetherness, but the change is still impressive.

A common theme running through Liz Furler's look at the future is the need for GPs to become more involved with other parts of the health system and to avoid taking a "mono-disciplinary view of the world". Brian Howe refers to his plea to GPs in 1992 to "cease to be so insular and recognise the great opportunities

that lie with looking outwards". The same theme is implicit in the current DHS desire to involve GPs in the Victorian Primary Health and Community Support (PHACS) restructure and in the creation by the Commonwealth of new Medicare Benefits Schedule (MBS) items to enable GPs to be remunerated for case conferencing and care planning with other health professionals. Bob Douglas thinks that the ability of divisions and state-based organisations of divisions (SBOs) to provide the conduit for this involvement with other players is one of the important changes brought about by the Program.

This all indicates a reassuring view of general practice as essential to the effective functioning of the health system. It may also suggest that governments are giving general practice this opportunity to remain at the centre of primary care and to help design a better system, but that GPs need to use their present strong position to become fully involved or else the opportunity will pass them by.

Of course, it is not as simple as that and the responsibility cannot all be on general practice. Bob Douglas has referred to GP disappointment with the ACT Co-ordinated Care trial that failed to involve them effectively. GP comments on other trials have characterised the attitude to GPs as tokenistic and similar comments have been made about the Victorian Post-Acute Care projects. The development of a fully integrated health system will require culture change in other health professionals and agencies as well as in general practice.

Support for GPs

The interviews by Amanda Tattam of GPs involved in setting up divisions suggest that support for GPs was, and still is, seen as the major role of divisions in the future. This is a widespread view among GPs and the provision of services to GPs by divisions is one of the four quadrants, or areas of activity, required by DH&AC in the funding contract under OBF. There is less unanimity about what supporting GPs means. To some it means activities to benefit GPs as individuals in their practices by, for example, providing financial management skills, addressing remuneration issues or attending to doctor health. Others see support for GPs more as helping them to improve clinical skills and practice management, by the provision of CME or expert advice on specific priorities such as immunisation; Bob Douglas refers to the importance of helping GPs to make use of the opportunities offered by information technology (IT). Still others think that support to GPs means helping them to develop systems and skills in the context of programs to improve population health outcomes.

Examination of the meaning of "support for GPs" is relevant to the future because the Divisions' Program is not an end in itself; it is one of the means to an improvement in the health system. Support for GPs is an important part of the process, but Liz Furler's article shows that the Commonwealth is determined that activities of divisions in support of GPs must also help to improve health outcomes for all Australians. This is not incompatible with direct support for GPs, as John Menzies says, but it is important to be clear that the use of public funds always brings with it a responsibility to do things that are of benefit to the public.

GPs and population health

There is an increasing emphasis in comment about the Divisions' Program on the involvement of GPs in population health. Liz Furler suggests in her article, and said at the National Divisions' Forum in August, that GPs will need to develop population health skills. Bob Douglas includes the opportunity to work in population health as one of the six main changes to general practice brought about by the Divisions' Program. He also concedes that not all GPs agree that the change has been positive and Hersh Cohen may well speak for many GPs when he says that GPs should retain their traditional focus on individuals and families and not be heavily focused on population-based health promotion activities.

GPs should not be surprised at the proliferating references to population health. It is not something that has been suddenly foisted on the Program but was included as one of the four quadrants of OBF from the very start of the discussion about changes to the funding of divisions. Nevertheless GPs can be excused for feeling confused about the meaning of population health in the general practice context, especially in light of the very loose use of the terms population health, public health, health promotion and illness prevention as though they were synonyms. We hope that the issues paper on general practice and population health that is being redrafted by DH&AC as we go to print will help clarify the matter for GPs.

Whose agenda?

The rapid rate of change in the Divisions' Program may lead some to question how far divisions, SBOs and Australian Divisions of General Practice (ADGP) can or should go as agents of the department in leading GPs in directions suggested by government or by fashionable overseas trends. The other side of the coin is to ask how far publicly funded organisations can go in opposing government policy. These are really questions about providing leadership (by which governments and departments often mean persuading the membership to do what the government wants), about the respective roles of divisions (and their peak organisations) and the AMA and other membership-funded organisations, and about the accountability of organisations using public funds. That they were raised by several of the "founding fathers" interviewed by Tattam, as well as by Michael Bollen and Paul Mara shows that they are not only academic issues.

Who represents GPs?

The recent negotiations over the Memorandum of Understanding (MoU) gave force to Paul Mara's comments about the fears of the AMA and RACGP in 1992 about the possibility of eroded roles, and the loss of political power and membership to divisions. As it turns out those fears were not justified, but the difference of opinion about the appropriate role of ADGP in the MoU negotiations is wide. This arises because there are at least two ways in which the MoU will affect GPs. Those aspects of the

MoU that affect the workings of the health system are issues of public concern in which divisions and their peak organisations can – indeed, must – take part. The effect of the MoU on the personal businesses of GPs is more properly dealt with by organisations funded by their members, rather than the taxpayer. Mark Robinson's comment that ADGP and GPDV cannot effectively represent the interests of grassroots GPs is well made. Representing the interests of grassroots GPs is not the business of publicly-funded organisations, but should be left to member-funded political organisations like the RDAA, as he says. The debate over the role of divisions and ADGP in negotiations of this sort is long overdue, as is the clarification of their role compared with that of the AMA and RDAA.

The need for evaluation

Also long overdue is a significant evaluation of the Program. Without this, assertions of the value of the Program are anecdotal and impressionistic, with no evidence about the extent and impact of the changes it has brought. It remains vulnerable to its critics, irrespective of encouraging statements from Canberra about divisions being a fixture in the health infrastructure.

An evaluation would also tell us whether this is still a national program or a series of state-based programs. The devolution of the administration of the Program to the state offices of DH&AC increases the danger of the program fragmenting. There are worrying parallels with the Community Health Program (CHP) here. Whatever GPs may have thought about the CHP in the 1970s and 1980s, there are strong similarities with the Divisions' Program: the CHP started as a national initiative and quickly became state-based without strong policy co-ordination at the national level; it undertook significant work but with variable quality; it was criticised but never evaluated in any meaningful way, so that when it was challenged at the political level there was no basis for its defence. Divisions will be just as vulnerable unless they make a commitment to maintaining the national character of the Program and insist on a serious evaluation of the Program.

Too much bureaucracy?

Bob Douglas comments that general practice now has a corporate face that is more effectively represented by divisions than by any other body and that gives general practice a structure for working with governments, departments and regional authorities. Elsewhere Paul Mara, Michael Bollen and some of the "founding fathers" comment about the development of bureaucracies at division, state and national level. "Bureaucracy" is a pejorative when used by GPs, but the representation of the views of 20,000 GPs is impossible without organisations and structures, which was why divisions were created. Even divisions need structures through which their views can be represented at state and national level: DH&AC will not discuss policy with 123 divisions; nor, at the Victorian level, is it practicable for DHS to negotiate with 31. Nevertheless, divisions, SBOs and ADGP need to be very sensitive to the concerns expressed by GPs about "bureaucratisation" if they are to continue to carry their constituency with them. It will be useful to have a fuller debate about "bureaucratisation" and what that means – perhaps in a future issue of this journal.

GENERAL PRACTICE NOW HAS A CORPORATE FACE THAT IS MORE EFFECTIVELY REPRESENTED BY DIVISIONS THAN BY ANY OTHER BODY

What did the profession want from divisions of general practice?

Michael Bollen and Paul Mara were asked to address the following questions:

What were you hoping to achieve for general practice through the establishment of divisions?

Did the original joint statement (The Future of General Practice) include all that you hoped to achieve?

Did you have to compromise on any issues? If so, what were the compromises?

Were you satisfied with the results?

Michael Bollen

Michael Bollen was honorary treasurer of RACGP from 1991-92 and represented the college in the negotiations that led to divisions of general practice. He now works as a consultant to the health system.

During the negotiations about the reforms being proposed for General Practice, the RACGP and the AMA spent significant time considering ways of addressing the isolation inherent in the way in which general practitioners work and general practices are run. In particular we believed it was important to find ways to enable us as GPs to work together more effectively, whilst still retaining our individuality and independence. We recognised that not everybody wished to work in larger group practices. Even those GPs working in group practices often did not wish their practices to become larger for fear of becoming impersonal or for many other good personal reasons.

The idea of having divisions of general practice was very much that of the profession. The concept of funding divisions as part of the general practice reforms was vigorously opposed by the Department of Health which could see no benefit in such a proposal. However the Minister was eventually persuaded to support provision of funding for piloting ten divisions of general practice. The agreement was subject to a requirement that divisions would be active participants in implementing the process of accreditation of general practices.

Roles proposed for divisions of general practice by the negotiators included:

- Maintaining and improving the standards of general practice in the area, including coordination of care between general practitioners and other service providers for the benefit of patients.
- Providing an interface to improve communication between general practitioners, hospital and community health services and other services at a local level and with the local community.
- Improving and facilitating information transfer between hospitals, community health services and GPs.
- Negotiating, developing and implementing QA (including peer review) and CME for members of the division.
- Providing opportunities for upgrading and maintaining GP skills and for undergraduate education and vocational training with general practice.
- Supporting and undertaking research in general practice.
- Involving GPs in population health preventive activities in their practices.
- Enhancing and improving the efficiency of practice management.
- Assisting in the development and implementation of appropriate IM/IT.

The joint statement eventually encompassed these objectives and the number of divisions reflects the acceptance of the concept by significant numbers of Australian GPs. Not all GPs have accepted divisions of general practice as an integral part of their general practices. For many GPs, divisions mainly represent access to continuing education to fulfil a requirement for remaining on the vocational register.

In recent times divisions have taken a major role in introducing and improving information management in general practices.

Some GPs see divisions as their medico-political organisation. Despite being largely government funded, these GPs expect divisions at a local, state and national level to be in a position to negotiate on their behalf with the very government that provides the funds. Such negotiations will only be seen to be credible if GPs themselves are prepared to assume virtually full responsibility for funding their divisions and not rely on government handouts.

Only relatively few GPs see the division as a means of supporting population health activities and research.

Most divisions are much larger than was originally proposed. Some are seen as just as remote as the organisations which originated divisions. However throughout Australia some divisions have accomplished most if not all of the original vision of the negotiators. Some GPs are now seeing the benefits to themselves and to their patients in working together rather than in competition with another.

GPs ALSO HAD SIGNIFICANT CONCERNS WITH FALLING REAL INCOMES, DECLINING STATUS AND RELEVANCE IN THE HEALTH SYSTEM

Paul Mara

Paul Mara is a practicing rural GP and was the first director of general practice at the AMA. He was closely involved in the negotiations that lead to divisions of general practice.

Establishing divisions of general practice was a key strategy of the GP representative organisations in negotiations surrounding the so-called restructuring of general practice in 1991.

The motivation for discussing general practice reform came from both the government and GPs. At the time there was concern in government that a rapidly rising increase in the number of GPs had seen a parallel rise in costs. The expenditure on GP services was uncontrolled and the benefits or health outcomes undefined and often unmeasurable.

GPs also had significant concerns with falling real incomes, declining status and relevance in the health system, professional isolation and the difficulty in attracting doctors to rural and remote areas.

There was an argument from both GPs and others that quality care was not helped by an open-ended funding system (Medicare with bulkbilling) with perverse incentives for turnover.

A number of key areas was targeted during the 1991 Commonwealth budget including:

- workforce measures to resolve the geographical maldistribution of GPs,
- strengthening of the vocational training and vocational registration schemes,
- proposals for an accreditation system,
- proposals such as budget holding to improve prescribing, and use of pathology and radiology services by GPs.

The governmental motivation for all these initiatives was to gain some control over general practice, especially financial control. It was also to improve integration of general practice with other areas of the health system, to better define and reward quality care and establish a framework for targeted funding in general practice.

The profession's response to these measures was to argue that there was no structural framework for these initiatives and that the concept of local professionally controlled networks of GPs or divisions which were trialed in the previous year in 12 areas could form the focus for these. The government had not put extension of these on the agenda. The professional motivation was to establish a process for reform in general practice over which GPs had, through divisions, some local control. There was considerable initial resistance from government fearful of the power divisions could provide GPs and then there was resistance from within general practice itself.

Divisions had major dangers for the larger GP organisations, particularly the AMA and RACGP and there were real concerns about eroded roles, loss of political power and membership.

Today divisions are really only just beginning to impact on the day-to-day professional lives of GPs. Many would say they are too intrusive, others would say they do not do enough to justify their existence. There will inevitably be tension between the support role played by divisions and the program monitoring and implementation roles as they become a focus for funding, standards implementation and practice development.

One real problem with divisions is that potentially they could become too bureaucratic and they could ultimately control GPs rather than give them more opportunities. The development of powerful and remote state and national based groups was not initially envisaged and the large government funding of these poses significant issues with government funded organisations negotiating for GPs at the same table as other groups. The natural history of member-based organisations is that while initially they are established by and for the members eventually they become internally focused and act to strengthen the organisation and executive rather than the concerns of the members. With divisions this evolution could be accelerated because the funding is not based on member subscriptions.

GPs will establish their own benchmarks on whether divisions are worthwhile but inevitably the value for GPs is dependent on their involvement.

Expectations and reality: the views of some 'founding fathers'

Amanda Tattam

In 1992-93 there were ten demonstration divisions in Australia but none of these operated in Victoria. Consequently, when the Divisions' Program began in earnest in 1993/94 all Victorian divisions opened their doors at roughly the same time in the last quarter of 1993. Exactly six years on, we commissioned a freelance journalist to interview some of those who were closely involved in setting up divisions in Victoria, to reflect on their early expectations and fears and their views of the achievements of divisions so far.

The 'founding fathers' are

Dr Dominic Barbaro – Executive Director, Northern Melbourne Division 1993 – present

Dr Hersh Cohen – Chair, Inner South East Melbourne Division, 1993 – present

Dr Mukesh Haikerwal – Chair, Westgate Division, 1993 – 97

Dr Paul Hemming – Executive Director, Ballarat Division, 1993 – 1998

Dr Geoff MacFarlane – Chair, East Gippsland Division, 1993 – 97

Dr Peter MacIsaac – Medical Director, Westvic Division, 1993 – 1998

Dr Leon Massage – Executive Director Greater South Eastern Division, 1993 – present

Dr John Menzies – Chair, Otway Division 1994–present, Board member, 1993 – present

Dr Mark Robinson – Executive Director, North East Victoria, 1993 – present

The state of general practice

In 1992, prior to the introduction of divisions, general practice was in "a deep malaise" according to Paul Hemming, the first Executive Director of Ballarat Division and until recently Chair of GPDV. GPs were demoralised, frustrated and every practice was working in its own "cocoon". John Menzies, Medical Director of the Otway Division, agrees general practice was in the doldrums. In Menzies' view, general practice was a "fragmented cottage industry" in desperate need of some kind of rejuvenation. GPs, he says, were a "teeth-gnashing group of people on the periphery of things."

These strong views were reflected in the results of a nation-wide GP survey conducted in 1991 by Bob Douglas at the National Centre for Epidemiology and Population Health (NCEPH) and published in the influential paper *W(h)ither Australian General Practice?* The NCEPH survey found that GP dissatisfaction was very high, with the most significant causes being excess doctor numbers, professional isolation, competition and alienation from community health professionals and low remuneration.

The idea of divisions

The idea of divisions was promoted as "Departments of General Practice" in *W(h)ither Australian General Practice?* but it took second place to other reforms already proposed in the 1991/92 budget. In 1991/92, Budget Paper No 9 expressed the government's concerns about the quality and cost-effectiveness of general practice and foreshadowed discussion with the profession. The General Practice Consultative Committee(GPCC), a partnership between the AMA, RACGP and Department of Health Housing and Community Services, was established in 1991 to consider the problems of general practice in the health system.

In July 1992 the GPCC released *The Future of General Practice: a strategy for the Nineties and Beyond.* It focused on wide-ranging reforms in general practice of which divisions were only one component. Despite the intensity of planning and review among GP and academic organisations, it took considerable time for the idea to filter through to grass roots GPs. Many GPs, such as Geoff MacFarlane, founding Chair of East Gippsland Division, first discovered the idea when an advertisement calling for expressions of interest appeared in the Saturday papers in 1993.

Other GPs first heard of divisions when Dr Paul Mara from Gundagai, NSW, who worked with the Commonwealth to develop the idea of divisions, did the rounds in a series of meetings to promote divisions as a positive development for general practice. John Menzies recalls first hearing about the concept at a conference in the early 1990s. Paul Mara sold the idea well, he says. "It was a GP initiative which the Commonwealth responded to. That is why it has been blessed with a reasonable rite of passage because it could be sold as a doctor-initiated plan to enhance primary care."

GP fears

One of the ironies of the divisions' movement is that although it was the profession that advocated for divisions and, according to them, had to persuade the government to agree, the rank and file tended to perceive divisions as a deep threat to their autonomy.

John Menzies initially feared the Commonwealth's moti-

vation for funding divisions and suspected they wanted to exercise control. He is now more philosophical. "We have to balance paranoia with optimism. When you are promised something and you are used to being bottom of the heap, you are by nature suspicious," he said. At the time, there was reform in the UK and New Zealand, namely "purchaser/provider" models of health care, which it was feared might be replicated in Australia.

Geoff MacFarlane feared that divisions would be "choked by bureaucracy" and that a large part of the budget would go to non-GP infrastructure. While he describes himself as "apolitical" and does not air a strong opinion about allocation of funds, he insists rural medicine is still losing out. "Everyone knows that rural health professionals are there because of their background, the lifestyle. They practice autonomously with dedication and devotion. My fear was that the 'money men' would exploit this altruism. They have."

Despite the fears, clearly many GPs perceived divisions as offering opportunities for general practice as the membership rate right from the start was well over fifty per cent and in some places, higher.

What did Victorian GPs hope for or expect?

Geoff MacFarlane had firm ideas about what he expected divisions to do:

- establish the central role of GPs in health care;
- recognise the skills and competence of rural GPs and that the maintenance of these skills was vital to rural communities;
- make it easier for rural GPs to maintain their skills;
- bring GPs together through educational projects (as distinct from research ones, which he regards as divisive)
- improve the manpower situation
- be autonomous within reason and have a global budget.

Dominic Barbaro, Executive Director of the Northern Melbourne Division, felt it was important for GPs to be aware of the potential for divisions, rather than reject them out of hand as a government initiative. "I felt that if GPs did not take it up themselves, there would be directives from the government. I wanted to be part of it, rather than being dictated to."

For Paul Hemming the idea of developing a cohesive network was an attraction. "I saw divisions as an excellent way to bring GPs together in a more focused way to better deliver and coordinate care, and to develop infrastructure to support GPs."

For some GPs, the formalisation of GP networks was recognition of an already informal process, rather than a completely new invention. Indeed, some argue the concept of a network to support GPs goes back twenty years or more.

Hersh Cohen, founding Chair of the Inner South East Melbourne Division, says the model set up in the 1970s by 112 GPs in the inner southern suburbs of Melbourne, was in many ways better than the current division structure. Hersh Cohen set up a formal collaboration with the Southern Memorial Hospital in 1970. "We had bed rights in the hospital, there was a department of family medicine. As family physicians we had an executive role," he says. The hospital also provided education sessions for GPs. "When the division structure came it was just a matter of sticking it onto that process," said Hersh Cohen. "I had the wish that we have a similar model to Caulfield. That would have been a much nicer system."

Achievements

Reducing professional isolation

For those who hoped that divisions would provide a cohesive network for GPs, the Program has been a resounding success.

All those interviewed agreed that divisions have reduced the isolation felt by GPs, many of whom still work in solo practices. For Mukesh Haikerwal, founding Chair of Westgate Division and current Vice-Chair of the Victorian AMA, it is the "network" potential of divisions that he is most enthusiastic about. "Being able to know my peers, professionally and socially, is the single biggest achievement." Having contact reduces competition and suspicion among GPs, which was a problem before.

This reduction in professional isolation seemed to be felt most keenly in rural areas, but even in metropolitan areas GPs can, through divisions, operate as a force for change. In the Northern Melbourne and Westgate Divisions, for example, GPs have developed constructive relationships with local hospitals. "We have been able to talk to various heads of departments about notifications of admissions to hospital and discharge. I am not saying the division has made a significant difference, but we have started a dialogue," said Dominic Barbaro. Mukesh Haikerwal says it has taken many years of work by the division, but hospitals now realise the importance of including GPs in the information loop.

Support to GPs

The provision of support to GPs has been a significant achievement of divisions. "Divisions have been good at dissemination of information," says John Menzies. Divisions have also developed the resources to help GPs make better use of information technology. The greater use of IT in general practice (mainly as a management tool) has seen the creation of division staff devoted to IT - nearly all have IT project officers who can help GPs with training and support. This is one way that divisions have changed since their inception.

GP management development

Divisions have also been responsible for some unintended positive developments. For example, Peter MacIsaac, first Medical Director of Westvic Division, noted that one of the unexpected positive achievements of divisions was the development of GPs as leaders and managers in forums outside traditional organisations such as the RACGP and AMA. "Divisions have been the management training schools for GPs. Never before had doctors been obliged to write up a

proposal for a project, outline its aims, devise a budget and then run the project," said Peter MacIsaac, who now works as a Senior Medical Adviser for the Pharmaceutical Benefits Branch, Department of Health & Aged Care. He points out that a number of colleagues working at Commonwealth government level have a background in divisions.

Catalyst for change

One of the problems with referring to the achievements of divisions is that it is often difficult to separate the impact of divisions from those of many other influences on general practice, such as the Better Practice Program, Rural Incentives Program, Vocational Registration and Practice Accreditation.

Paul Hemming argues that many of the positive spin-offs of changes in general practice would have passed GPs by if they had not had a formal organisation to take advantage of them. "It would have been hard to advance them. Divisions acted as a catalyst." Bringing GPs together in an organised way to undertake research, for example, is helped by the presence of divisions. Ballarat Division has a project on blood pressure monitoring. "It would not have been possible without a formal network," says Hemming.

Room for improvement

While many GP leaders are positive about divisions, they are also realistic about the failures.

Supporting the right GP role

Hersh Cohen argues that divisions have failed to define the nature of general practice and are therefore focusing on matters outside the scope of the ideal general practice role. He believes that instead of a focus on population-based health promotion initiatives, doctors should concentrate on individuals and families. He acknowledges that his opinion is not shared by many of his colleagues at the Inner South East Division, with the diverging views reflected in the Division's mission statement, which is " to improve the health outcomes of the individual and populations."

The legacy of projects

According to Mukesh Haikerwal, the system of project-based funding was a mistake. "There was a lot of money wasted. It seemed that there were projects for projects' sake. The move to three-year funding and the move to outcomes-based funding has some positive aspects to it," he says.

For Leon Massage, founding Executive Director of Greater South Eastern Division (GSED), the project-based funding had its pitfalls and created many "bureaucratic hurdles" to overcome. At GSED a project involving diabetes nurse practitioners and educators was "extremely popular" with doctors and patients. But when the money ran out, the project stopped. Even though some of the work is continuing, the original essence of the project has been lost. "Two years down the track we are still getting requests for the service, but we can never re-create what we had before," he said.

The value of membership fees

Ensuring the true commitment of members to the division was another recurring theme in these discussions, with many GPs arguing that it is essential for divisions to be clear about who is really a member. This view implies a criticism of those divisions that hand membership to local GPs without requiring a membership fee. Leon Massage says that just asking GPs to tick a box to opt into membership is not enough. "Divisions cannot truly represent people unless they have choice about whether they are a member."

There are other reasons why divisions should charge for membership, according to division leaders. Peter MacIsaac admits some fees are quite low and that they are more "token", but having to pay a fee makes doctors think more actively about opting into the division and whether they are getting value for money. "It means divisions have to earn their stripes," he says.

Recognising limits

Some of the ongoing concerns facing general practice are beyond the scope of divisions. For example, the rural medical workforce crisis is such a "huge" problem that divisions alone could not fix it, according to Paul Hemming. "We all had great expectations that the development of divisions would help resolve this. There has been progress but it has been minimal. We need a multi-pronged approach," he says. Governments are aware of this too. Earlier this year the Victorian State Government, via the Rural Workforce Agency of Victoria, launched a high profile recruitment drive to attract overseas doctors to rural Victoria. Over 800 applications were received.

While Paul Hemming admits there are still other problems affecting GPs: "At least doctors have somewhere to take their whinges now and there is the possibility of doing something about it."

The future role of divisions

In the light of early expectations and achievements, what do these GP leaders see as the critical issues and directions for the future?

Support to GPs

The core business of divisions will continue to be support for GPs, according to division leaders.

Leon Massage says the form of support will vary from one division to another and may change over time in any given division, depending on local GP need. "It will vary - from IT support to practice management support and that means everything from how to run your practice, to appointing staff and billing." Divisions have different strengths, he says. While some are more research-orientated or academically orientated, others like to focus on management issues.

An important component of GP support is the education and training done by divisions, which provide CME programs based on the needs of GP members. Despite the RACGP's pre-eminence in education and the need

"BEING ABLE TO KNOW MY PEERS, PROFESSIONALLY AND SOCIALLY, IS THE SINGLE BIGGEST ACHIEVEMENT"

for an arbiter on academic standards, divisions will still have a role in training, according to Leon Massage. "Division courses are offered at little or no cost....The College has become very bureaucratic...we are more responsive to our members because we communicate with them more regularly," he says.

Improving community health

While the GP leaders focus on support to GPs as the core role for divisions, the General Practice Strategy Review Group, in its 1998 Report *General Practice: Changing the Future Through Partnerships*, gave considerable emphasis to improving health outcomes for the local population. The two areas need not be mutually exclusive as John Menzies notes: "Divisions really need to work towards improving the health of the community and go beyond serving doctors." Paul Hemming believes that there is no reason why divisions could not take the lead on public health initiatives such as immunisation.

Hemming suggests that in the interests of improving community health another major focus for the future will be links with other agencies, such as local government, community-based organisations and health agencies. "Divisions are going to make a big difference if they collaborate with other community groups instead of trying to do things on their own all the time," he says.

Voice of general practice

According to Geoff MacFarlane, divisions should strengthen their role as "a conduit of information and policy proposals to government, the college, community groups and organisations such as the AMA, RACGP, RDAV and to have ownership and control of that information." Views differ about the issues on which divisions can appropriately speak (see panel), but few reject the role.

From impression to documentation

There was little hint, in these discussions, of the "deep malaise" of the early 1990s although many of the problems that gave rise to divisions and the GP Strategy remain. Perhaps the professional networking among GPs inspires greater confidence in addressing problems, or the wide-ranging professional activities that divisions have funded has led to the rejuvenation that John Menzies said the profession so badly needed. The difficulty is that without evaluation there is no reliable way of knowing how widespread the thoughts expressed here are. To what extent have divisions reduced GP isolation? How many practices receive divisional support? How relevant are divisions to most GPs?

GP leaders in Victoria suggest that divisions have made some significant differences to general practice at the local level. In particular, they seem to have provided a voice and a network for general practice as the basis for taking action on other GP problems. Formal program evaluation would help clarify the real impact of the Program and provide a clearer basis for future directions.

The voice of general practice

One of the main motivating factors in the creation of divisions was to enable the unfiltered voice of general practice to reach the government.

So are divisions an effective voice for general practice?

Speaking generally Geoff MacFarlane argues that divisions have been effective in raising the profile of GPs. "Prior to divisions, there was no effective voice. Certainly not the RACGP or AMA. The strength of the AMA is that it provides a forum for all doctors. Its weakness is that it can never be seen by all sectional interests, at all times on all issues, to represent everyone adequately and equally." He argues that the AMA provides the best compromise, the best overview and the best avenue of communication to members of the profession as a whole.

When it comes to being "the voice" at a local level, GP leaders suggest that divisions are often seen by the media as the peak body within the local community. While they are unlikely to be called on for comment in the same way as the AMA, media coverage of divisional activities is more common in local papers. Outside the Melbourne metropolitan area divisions can have an even more powerful voice, according to Paul Hemming. "When I was head of the local division we got calls, sometimes two or three times a day, from either print media, TV or radio." Dr Hemming suggests doing live talk-back about health issues raises the profile of GPs in the community. "That would never have happened 10 years ago," he says.

Having a "critical mass" of GPs at a local level gives them a much louder voice, in a decentralised professional forum. The AMA is not organised like divisions. One or two GPs raising a local issue at a state-wide level would be voices in the wilderness – they are much more likely to be listened to by a division, according to Dr Hemming.

The views expressed by divisions can, at times, be influenced by the source of their funding, argues Mukesh Haikerwal. This is why he supports divisions having membership fees, because they can raise their own revenue for activities that may not be wholeheartedly supported by government and can represent the views of GPs more effectively. "Divisions are greatly influenced by the government, but there are still some good independent voices in the divisions' movement," he says.

The role of divisions and their peak organisations as the voice of general practice was an issue during the negotiations over the recent Memorandum of Understanding (MoU) with the Federal Government. Some division leaders believe that it is not the role of the peak division organisations to be the chief voice of general practice on these sorts of issues. Dr Mark Robinson, Executive Director of the North East Victorian Division, says the ADGP and GPDV are "deluding" themselves if they believe they can represent the interests of grassroots GPs, especially in rural areas. "The Rural Doctors Association of Victoria would have a much better handle about what is going on," says Dr Robinson who is National Secretary of the Rural Doctors Association of Australia.

The consultation with division members over the MoU was not done properly says Mukesh Haikerwal, who believes that divisions should not be claiming to represent a broad cross-section of GPs at the table with government over such issues. "They are paid for by government and are negotiating with that same government. I am a great champion of divisions at the local level, but when they negotiate with government on behalf of all GPs they should discharge their pecuniary interest with government," he said, adding that processes for surveying members must "stand up to scrutiny."

Hersh Cohen believes that throughout the negotiations, all organisations were on the back foot. "The government left them for dead," he said. "Divisions were able to provide rapid collective input on the views of their members to the MoU which means they were very effective communication tool," he says, "but the MoU question about rebates was woeful".

The divisional leaders' reservations about becoming involved in areas in which divisions have little expertise were an echo of those expressed in 1997 by Dr Brian Bowring, the then interim chairman of the Australian Divisions of General Practice (ADGP). Commenting on a survey of GPs that found that four out of five think that there are too many GP organisations and want a united umbrella organisation speak for them, he said the ADGP was not suited to being the umbrella organisation. The strength of divisions, he said, was to present GPs' views to the major organisations and to provide infrastructure to support general practice.

It seems that the effectiveness of divisions as the voice of general practice may depend on the topic.

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Challenges for GPs and divisions in the next century

Professor Bob Douglas

Professor Douglas is the Director of the National Centre for Epidemiology and Population Health, (NCEPH) at the Australian National University in Canberra. Over the last decade, he has played a leading role in the debate about directions in general practice with a series of influential discussion papers as well as surveys designed to assess the mood of general practice. This article is an abridged version of his keynote address to the GPDV 1999 conference: Achievements and Directions.

As we approach the new millennium, big questions are being asked about the future of the human species. These questions raise concerns about environmental sustainability, globalisation and the relevance of modern economic thinking to the sustainability of good health.[1]

Australian general practitioners cannot afford to ignore these big questions as they look to their own future within the Australian health care system. In this paper, I would like to focus first upon changing views of health. I will then look back over the past ten years and attempt an appraisal of some of the things divisions of general practice have accomplished. I will attempt to identify some parameters around which the future of Australian general practice will need to be developed and I will refer particularly to changes in funding, information technology and the planning and coordination of care which I think are inevitable. I will conclude with the suggestion that the divisions' movement should grasp these three nettles firmly from a position of strength, in which all GPs are actively involved on the divisional payroll.

Changing views about health and illness

Most of us in the medical profession derive our views of health and illness from the reductionist model in which we were trained, which views human beings as complex machines.[2] Understand the operation of the machine at the biomolecular level, and you can best determine how to fix it when it goes wrong. Modern technology, pharmacology and vaccinology have enabled us to become more and more precise about which parts of the machine to oil or medicate - when, and how.

In medicine, we have always paid lip-service to the view that humans are social beings and an integral part of a complex ecosystem that conforms to the principles of systems theory and chaos theory. But it has been largely lip-service, and the 'man as a machine' paradigm still rules supreme in our medical psyche. Now, however, we are being forced to look more seriously at the social and environmental determinants of health, as increasingly we recognise that system factors set the thermostat for the operation of the machine. Social and environmental factors are all pervasive in their impact on health.[3] They influence the entire spectrum of health and illness and although we are not sure of the causal pathways whereby they alter immunologic and endocrine function, there are consistent patterns of health disadvantage that go with socioeconomic status, education, occupational prestige and the lived environment. Fixing a sick environment is probably more important in the long run for sick individuals than a focus on the sickness itself. Doctors are now beginning to understand this, and to recognise the need for population-wide strategies that can change the collective thermostat. But the craft is still in its infancy.

Synchronously with this recognition of the vital importance of system factors, we are also seeing the flowering of biomolecular medicine through such stunning enterprises as the human genome project. So generalists are now pulled both ways: by the system issues on the one hand, and by the movements of modern technology on the other.

Another social movement that is changing the way we think about medicine and health care is the evidence-based medicine movement.[4] The effort to synthesise what we know and ensure confidence in what we know are major challenges to the generalist. Accessing and responding to the evidence puts new pressures on the GP.

And to make matters even more complicated, doctors are increasingly being accused of ignoring the wellbeing side of the health equation. It is being suggested that by focusing exclusively on illness management and virtually ignoring the promotion of wellbeing (which is not the same as the absence of disease), we may be doing some of our patients a serious disservice.[5]

Add to all of these factors the growing technological capacity of health care and the need for us to make choices that inevitably have opportunity costs. If we spend all our health dollars on the treatment of the terminally ill, we won't have enough left to prevent the young from becoming ill in the first place.

Finally, in this changing kaleidoscope of what health is about, we have the economists pointing to the importance of different financial incentives operating on both consumers and providers of health care and health seeking behaviour.[6]

It is not surprising in the face of these mounting and diverse pressures, that GPs in the front line of our health

care system are often jaded, confused and feel put upon by a health care system that undervalues the contribution they are called upon to make.

What have divisions accomplished?

In the seven short years since divisions of general practice appeared on the Australian scene, I think we can say unequivocally that they have altered the general practice climate. Not all GPs would agree that it has been in a positive direction but most do agree that there have been significant changes. I suggest there have been six main alterations.

- The first is that the general practice industry in Australia now has a corporate face that is more effectively represented by divisions than by any other body.
- Next, although this divisional movement has not yet ended the isolation for some GPs (which was one of its reasons for existence), it is certainly offering new opportunities for many GPs who, prior to the divisions, often did not get too much outside their consulting rooms.
- Divisions now also offer a geographic coherence and an interface for general practitioners to work with other players in the local health care system. At last, State and Commonwealth health departments, as well as regional government authorities, have a group with whom they can interact and discuss health care issues in population groups.
- The fourth thing that has happened is that general practitioners now have the opportunity to think about constructive promotion of the health of the population as a whole; not just the individual patients who walk through the consulting room door.
- That possibility is leading to new activities by divisions. The population health opportunities are also creating new experiences in health administration for GPs who work in administrative positions in their divisions. In the last few years, we have seen some highly talented GP administrators emerge, who are excited by the population health opportunities that exist for GPs and are beginning to deliver initiatives to special disadvantaged and handicapped groups in the community.
- Finally, and perhaps most importantly, the emergence of divisions has produced a counterbalancing force within our medical care system which was becoming dominated by specialists' interests within the system.

Future of the Australian GP

Let me now try to hazard a guess at some of the forces which will operate on Australian general practice in the coming decades.

- As health care becomes more complex in its technology and in its level of specialisation, people in the community are going to need, more than ever, interpretive generalists to whom they can relate and whom they trust.
- Secondly, the community is going to seek a form of primary care that encompasses the full range of changing views on health about which I spoke earlier.
- Third, GPs who are not currently particularly happy with their role in the system will have to go on adjusting to change that will continue at a frenetic pace in the early years of the new century. Many are already frustrated by their vulnerability to litigation, their sense of loss of control over their own future, and by the competitive pressures that come from entrepreneurial practices and rising numbers of GPs in the cities. These pressures will almost certainly increase, and it will be partly the responsibility of the divisions to protect their members from the more toxic aspects of these changes.
- From the government perspective, health ministers will continue to grapple with the maldistribution of general practice in rural areas and with the need for better integration of the range of professions working in primary care.
- Finally, the community will insist on a system of care that is sustainable, and affordable in an era of rising pressures, expectations and vested interests.

So, how will these pressures change what GPs will do in ten years time in Australia and how will they impact on the activities of divisions? I think much of the answer to this depends upon GPs and divisions themselves.

If divisions can help the profession to respond to these imperatives and to the challenges of fund management, information technology, and planning and coordination, that lie ahead, then they will have served GPs, as well as the nation, very well indeed.

Funding challenges

I agree with the Prime Minister that we have one of the better health systems in the world. But there are some problems, and they are growing.

- The first is a serious mismatch in resource distribution for specialists versus their GP colleagues.
- The second is that we do not have a system of rationing that can optimise quality of care, and our rationing procedures are being managed as very blunt instruments, often with little in the way of professional input.
- The third is that we have built our system too heavily around the fee-for-service approach. We have still not blended various payment options to improve incentives for the various actors in the system.

Doctors have, understandably, wanted to stay away from the resource allocation process, believing correctly that it was their role to get the best deal possible for their patients. But absence of professional involvement in the rationing process has meant a degree of inequity of access to limited resources sometimes for those who deserve them most. How general practitioners will deal with the possibility of being involved in resource allocation remains to be seen. The challenge to become

IT IS NOT SURPRISING THAT GPs ARE OFTEN JADED, CONFUSED AND FEEL PUT UPON

involved will not go away. As technology advances and as the pressure to ration increases, the need for medical input will become more acute.

I perceive the division as an appropriate agency through which GPs can participate in the resource allocation process without compromising their primary allegiance to their individual patients. I am well aware that 'budget-holding' and 'managed care' have become emotive words on the Australian medical scene, representing, as they do, the British and American efforts to institute a form of rationing and efficiency into the allocative process. I am also aware that most GPs in Australia do not enjoy the prospect of becoming actively involved in the rationing process. But if technological capacity continues to expand faster than the growth in available resources, as is manifestly the case, priorities must be set somewhere and a form of rationing that accords both with medical need and with those priorities, must be developed. If GPs do not become involved in a serious way in this process, some other agency or group will have to.

There is growing experience in New Zealand where the equivalent of Australian divisions (Independent Practitioner Associations) are playing a constructive role in budget-holding to make savings to develop new and better services.[7] The opportunity to develop our own Australian approach to purchasing and allocation that addresses Australian needs, must, in my view, actively involve divisions as the corporate face for the general practitioner. To make a constructive relationship possible, state-based divisional organisations would need to work closely with health purchasing authorities to develop new accounting and information systems, and to ensure that GPs in their daily decisions are appropriately trained and informed about the resource implications of those decisions.

IT challenges

Health care in Australia is well behind the electronic eight ball. The travel and banking industries have turned the information revolution to their advantage in a way that health care has barely begun to explore. Our health system suffers seriously from the lack of an integrated health record and information system.[8] But there are signs that things are about to change, and that the GP will be at the heart of the change.

Certainly, all the ingredients are now available for us to move rapidly to an electronic clinical record that will be the building block for our national health information system. Technically, it is both possible and highly desirable.

There are issues of access, security, privacy and utility to be resolved and we need a shared national vision about where health informatics is going to lead us. In my judgement the GP has an absolutely pivotal role to play in this development and divisions must be at the forefront of involvement in our future electronic health information system.

In the first instance, the divisions should provide technical and professional support to their members, as many of them make the difficult transition from paper-based to electronic prescribing and electronic record keeping. The culture change is a difficult one, but inevitable, and appropriate networking across the entire health system is likely within the next ten years.

Planning and coordination of care

Funding and IT challenges come together in the planning and coordination of care for heavy users of the Australian health care system. We are nearing the end of phase one of the coordinated care trials[9] and new trials are being proposed.

We are still on a steep learning curve about the process of planning and coordination of care. What role should the GP play and how can the division most effectively contribute to this process which will inevitably demand continuing efforts from all players in the health system? There are equity and ethical issues for local populations and there is an urgent need to stop the dangerous game of federal/state cost shifting. We need also to make prevention and the promotion of wellbeing a more serious part of the planning process and that means courageous experiments and evaluation to discover how these can best be accomplished.

Our early experience of coordinated care in the ACT has not been a positive one for the members of the ACT Division. GPs enjoyed the care planning process, but little else in the system changed. There is evidence that those managing the trial were not successful in involving GPs in the broader issues and objectives of the trial, and that the system-wide elements of smart purchasing were not available to enable planning to translate into improved resource efficiency. Our evaluation team concluded that future trials of coordinated care will need to make greater efforts to involve grass roots primary care practitioners (GPs, as well as those from the other professional domains) in shared ownership with their patients of the coordination task. If divisions are to be active in coordinated care, they need to see themselves as partners with other primary care providers.

How might the next phase of divisional activity evolve?

I continue to believe that divisions got off to the wrong start. They will not reach their potential until every GP in the country has the opportunity to spend at least a half day paid session per week working with his or her division in ongoing divisional programs.[10] While the short-term project mentality continues to affect divisional activity, and while spurious efforts to force the system to an 'outcomes' approach continue to operate, we will not see the broad change in the culture of Australian general practice that many of us believed would be a consequence of the divisions development.

Until general practice divisions are to general practitioners what hospitals are to their specialist colleagues, we will not see a shared commitment to population health and to primary care in its broadest sense.

I am certain that there is a potential future role for divisions in rationing of health services, in the

THE VISION FOR GENERAL PRACTICE
INTO THE 21ST CENTURY

Reprinted from: *General Practice: Changing the Future through Partnerships.*
Report of the General Practice Strategy Review Group, 1998

General practitioners will

- be unified in their purpose of providing quality medical care to individuals, families and the community
- have partnerships with patients and carers that promote maximum independence, self-care and self-responsibility for health
- be assisted in the care of patients through utilising advanced technology, electronic communication links with providers of health services, and information systems to guide best practice
- be able to develop initiatives in primary health care and create opportunities for better patient care as a result of the shift of resources from hospitals to communities
- be actively involved in research, evaluation and teaching and be appropriately remunerated for these activities
- acknowledge the diversity of their profession and show respect and open-mindedness in dealing with each other and other health professionals
- embrace the team approach that ensures their central role in the coordination and integration of health care
- be recognised for their essential role in health care delivery through appropriate remuneration and support
- be proud to work in general practice

General practice will

- provide a well-trained workforce that operates within a recognised discipline of knowledge and skills supported by systems designed to ensure that skills are maintained and developed
- remain the prime entry point to specialists and other medical services
- have a variety of practice models to meet differing community needs and settings that support professional independence in the interests of quality care
- play a pivotal role in the management of chronic illness in the community
- ensure that medical schools provide a strong focus on primary health care in medical curricula and provide inspirational general practice teachers and role models
- have an accreditation process that is supported by patients, the community and general practitioners
- have clear well-developed mechanisms for consultation with consumers, governments and others who impact on primary health
- have a recognised role in the planning and development of health services and be an active participant in the ongoing evaluation of the effects of policy implementation
- be positioned at the heart of the health care system through collaborative efforts with consumers, Divisions of general Practice and other groups, enabling patients and communities to receive seamless delivery of their health care

THAT VISION SEEMS TO ME TO BE WORTHY OF FRAMING, AND ON THE WALL OF EVERY GP OFFICE IN THE COUNTRY

development of an effective national information technology system and in coordination of care. Divisions must grasp the breadth of the health care model to which I have alluded earlier, and enter into productive partnerships with other primary care actors, to ensure that Australians are dealt with not just as machines and as social beings, but that wellbeing and ecological sustainability are also addressed as integral parts of the health equation.

Now that state-based organisations are in place and capable of interacting with the primary actors in the delivery of health care systems, we need visionary leadership in the divisions movement which is willing to look forwards and not backwards to what many in general practice still perceive as "the good old days". There is also a need for the visionaries in the divisional system to recognise the real stresses that their colleagues in the consulting rooms are under, and to ensure that they are not moving so far in front that they lose touch with the realities of day-to-day practice.

I have been careful to keep my comments general, and to identify the broad territory in which change seems most imminent. There is much room for debate and diversity in each of the issues on which I have concentrated. Specific responses to each of these issues need to be hammered out, within the divisional framework, and soon.

If GPs are not to be marginalised, they will need quickly to use their divisional platform to move the Australian health care debate forwards, around all of the issues identified as the Vision for General Practice into the 21st Century by the Report of The General Practice Strategy Review Group last year.[11] That vision seems to me to be worthy of framing, and on the wall of every GP office in the country.

We live in an era of rapid and often traumatic change. Adjusting to change comes easier to some than others. For general practitioners previously isolated from the rest of the health care system and focused mainly on management of illness in individual patients, the new opportunities offered to them through divisions are daunting and stressful for many. If divisions cannot help the members to adjust to new challenges, both they and their members will become increasingly irrelevant. If, on the other hand, they can assist their members to grasp and develop the opportunities that now lie before them, I believe we will see a resurgence of general practice as the centrepiece of the Australian health care system.

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The Next Edition

The second edition is scheduled for March 2000.
The theme will be Practice Support.
It will include articles on the following issues:

What forms of practice support should the Divisions' Program provide?
What forms of practice support have been most effective in IT?
health promotion? practice management? immunisation?

We seek contributions on practice support issues associated with accreditation, amalgamation and the Practice Incentives Program.

Deadline for contributions: Friday 21st January

The purpose of divisions: The Commonwealth view

Liz Furler

Liz Furler is First Assistant Secretary, Health Services Division, Department of Health and Aged Care. She oversees a number of branches in the Department including the GP Branch, which manages the Divisions' Program.

This article briefly explains what the Commonwealth hopes to achieve for the health system by continuing to fund divisions of general practice. It argues that the three most important outcomes are improvements in population health, especially in preventable illness, improvements in the quality of care and in cost-effectiveness. In the box opposite, Brian Howe, the minister responsible for introducing divisions, explains the governments' original intentions.

'In the beginning'

The Commonwealth Government decided to fund divisions of general practice in 1992. GP representatives (in the AMA and RACGP) first proposed the idea of divisions as a way to address problems that included GP isolation, low levels of remuneration compared with their specialist colleagues and low morale. The Commonwealth hoped that divisions would enable GPs to participate in the health system in new ways.

Both the Commonwealth and the GP representatives saw that divisions of general practice could provide a unified voice for grass roots GPs at a local level. Through divisions, the Commonwealth hoped that there would be a structure through which GPs would relate collectively to governments, hospitals, other health professionals, and community and consumer groups to enhance patient care within the Australian community.

Divisions were deliberately established as autonomous organisations, incorporated either as companies or associations of general practitioners. The initial idea was that the government would provide a base grant for organisational costs and divisions would then obtain additional funding from other sources. When the Divisions Projects Grants Program first commenced, funding was provided on an annual basis to meet divisions' organisational costs, and additional project funding for specific activities was made available through a competitive pool.

Current situation

The Divisions' Program (with 123 divisions established and covering the entire country) has been continually developing and evolving. Following several years of divisions' functioning, the Commonwealth has modified some of its views about the role of divisions. However, it still believes that it is important for divisions to have a strong membership base and for divisions to be aware of the needs of a wide range of stakeholders at the local, state and national levels. It also believes that divisions have an important role to play in supporting GPs, who in turn have an important role to play in shaping local health policy and delivery of health services.

The Commonwealth's changing views about the role of divisions are reflected in the Program's most significant change – the shift from project-based funding to block grant funding. Block grant funding, with its three year timeframe, demonstrates the strength of the Commonwealth's commitment to the idea of divisions. Three year funding provides divisions with security and with considerable flexibility to determine their own activities. However, there is a quid pro quo. Divisions must achieve broad objectives agreed to by the Commonwealth, which is seeking the support of divisions to improve health outcomes within their communities.

Implications for the future

There are three key implications for GPs and divisions in the pursuit of better health outcomes for the community.

Population health

First, GPs through divisions need to develop an increased capacity to think and act according to a population health approach – being able to use and draw on epidemiological approaches, social and behavioural sciences as well as clinical paradigms and skills.

While acknowledging the importance of improving the GP capacity to address population health, it is also important to recognise that much of the debate about the best role for GPs in population health is being driven by anecdote and assertion. It is necessary to clarify what is the most cost-effective contribution general practice can make. The Joint Advisory Group (JAG) of General Practice Partnerships Advisory Council (GPPAC) and the National Public Health Partnership is working on this. Once that potential contribution has been agreed the next task will be to determine what

must be done to encourage and enable GPs to put it into practice.

Links with stakeholders

The second major implication for GPs and divisions in the pursuit of better health outcomes for the community is the need to maintain and strengthen links with stakeholders. Divisions have done a great deal to establish links between GPs and others. In developing better health outcomes, they need to continue to show a willingness and ability to work in partnership with other agencies, professions and disciplines as well as with communities and consumers. In particular GPs should be rewarded for working with others in planning, setting priorities, taking action and monitoring, evaluating and reporting on problems and achievements.

Health promotion/illness prevention

Third is the need to strengthen the emphasis on health promotion and illness prevention. Just as we made use of the scientific evidence about traditional lifestyle risk factors such as tobacco, alcohol, diet, physical activity and sexual practices, we should also be starting to take seriously the empirical evidence emerging on the link between poverty and health. We need to know how we can intervene effectively in the Australian setting to lessen the adverse impact of social and economic disadvantage on health outcomes for particular communities.

Those working in and with divisions need to be abreast of the evolving science, theory and practice, of effective health care in the Australian setting if the divisions' movement is going to survive and grow in influence and not be seen as self-serving.

Three strategic directions

The Commonwealth believes that there are three critical directions that need to be pursued in order to make a difference and warrant the investment being made in the Program.

Improving population health

The first is the need for leadership at the national, state and local levels concerning the action required to improve poor health outcomes and reduce the burden of preventable injury, illness, suffering and early death experienced unevenly in our population.

Quality

The second strategic direction which the divisions' movement must embrace is that of quality – of taking a keen interest in systematically uncovering what is best practice and how to achieve it and maintain it in everyday policy and practice in the Australian setting.

Under the next phase of the National Health Priority Areas' initiative the Department is working towards a more tightly managed, systematic national program of applied research and development on 'best practice' in cardiovascular health, mental health, injury prevention, asthma, diabetes, and several cancers. National information and guidelines

Doctors need to look out(wards) !!

Brian Howe

Brian Howe was the Minister responsible for introducing the General Practice Strategy and the Divisions' Program into the Australian health system. He is currently Professorial Associate, Centre for Public Policy, University of Melbourne.

Brian Howe was asked:

> ***What was your main purpose in supporting the establishment of divisions of general practice? It has been said that your main aim was to abolish solo practice. Is that true? What were you trying to achieve in the negotiations? Were you satisfied with the results?***

I intended to use the National Health Strategy papers oversighted by Jenny Macklin as the basis of reform in health.

I saw general practice as one of the most critical areas for reform and a possible approach was outlined in the Issues Paper No 3 *The Future of General Practice* which was published in March 1992. The further development of the early departments or divisions was supported in this paper with an emphasis on an area rather than a hospital focus. I thought the concept was exciting for several reasons.

It seemed to me that the focus of care was increasingly likely to shift from acute to primary care which in turn would be less centred on institutions and much more focused on communities and regions. Rather than care being organised on the basis of case work it seemed to me that increasingly at the community level there would be a greater need to get coordination between a whole range of different providers each of whom would be making a contribution to patient wellbeing. In the consultations on the future of general practice I emphasised the need for GPs to see reform as an opportunity not a threat. However in future they would need to have a less individualistic focus and not just think of themselves as case workers.

I recall putting these ideas to a local GP who was appalled. He felt that his skill in diagnosis would be compromised by any move away from casework. The notion that his case records might help to shape a broader picture of the state of health in the community left him unimpressed.

As earlier discharge of patients becomes possible, co-ordination between the hospital and general practice becomes more and more important. Clearer communication between different professionals seemed to suggest greater computerisation of records and communication. Of course the one-to-one doctor/patient relationship is very important but it is also a priority that there be opportunities for peer review, for the exchange of information and the discussion of the latest treatments.

For these reasons I was sceptical about the efficacy of solo practices. However my main plea to doctors was that they cease to be so insular and recognise the great opportunities that lie with looking outwards. I supported the divisions because they will facilitate a changing culture in general practice.

need to be debated locally (preferably with others who have an interest, such as consumers and allied health professionals and managers). Guidelines have to be adapted to local circumstances, be 'owned' and supported and be seen as relevant by the key groups. Locally meaningful benchmarks and performance measures have to be established and efforts made locally to disseminate and promote best practice. The Commonwealth through divisions must then monitor their uptake and impact on local policy, practice and health outcomes. Finally, we need to report back to the players and the public on our progress.

Cost-effectiveness through primary care

The third strategic direction for the divisions' movement is the pursuit of a more cost-effective health system. We need to ensure that the funds being spent on health are going towards things that cannot be prevented or dealt with in a less expensive and yet just as effective manner. One of the approaches to this is to build and maintain a more robust and effective primary health system. Problems commonly experienced in the community should be dealt with as early as possible and not make their way into the more expensive secondary and tertiary levels of the system. There is a need to provide the one-to-one primary care and treatment locally, integrated with local efforts at preventive health promotion.

The primary level of our health system has become quite weak and patchy in Australia. The last 20 years has been a period of increased resources for the acute hospital sector, with little going to primary care. The Commonwealth has tended to focus on only a few elements of the primary health level of the health system, with general practice and the Home and Community Care Program being the two most significant examples. Both state and Commonwealth governments are starting to take action to strengthen primary health and community care now. Victoria, South Australia and the Northern Territory are making progress in this area and the Commonwealth signalled an interest in pursuing this strategic direction through its commitment to the Enhanced Primary Health Care Package in the last budget. *(This package includes provision for the new MBS items – Ed)*

The Commonwealth will soon start discussions with divisions on a national policy and organisational framework for primary health and community care, and how it might be developed over the next 12 months. The rural health initiative and the next phase of the coordinated care trials will all see a heavy emphasis on primary health care in action.

The Minister has asked the General Practice Partnership Advisory Council (GPPAC) to advise him on the implementation of new Medicare Benefit Schedule elements of the Enhanced Primary Health Care Package. The divisional movement also needs to seek a prominent role in shaping this national action to revitalise Primary Health and Community Care in Australia. It would be destructive for the debate to be cast as an adversarial one with general practice on one side and other primary health care providers on the other.

There is growing evidence that general practice cannot be cost-effective without ready access to the wider fabric of primary health care support infrastructure. Therefore, the divisional movement needs to seek key involvement, if not a leadership role, in this process of national policy development concerning primary health care. Divisions should be sensitive to how they can provide support for the wider primary health care policy development and planning challenge we face in this area. It would be counter-productive for divisions to take a mono-disciplinary view of the health world.

Implementing the three strategies

Information management and information technology (IM/IT) are going to be crucial in the implementation of the three strategies – improving population health and clinical outcomes, improving quality, and building primary health care networks which include general practitioners. As IT/IM systems are developed, divisions must retain awareness of their purpose and not allow the technology to drive the exercise.

Participation in health trials in recent times such as the coordinated care trials is proving to be an excellent way of researching better ways to deliver primary health care. The Department and the divisional movement will continue to collaboratively trial better ways of delivering health care in Australia and, to this end, divisions need to position themselves fully in this health service reform by being involved in trials over the next few years.

Ensuring the future of divisions

Evidence of the benefits to the health system of funding for divisions will be vital for the long-term future of the Divisions' Program. DH&AC is interested in developing a system to enable it to monitor the achievements of divisions against agreed indicators. It is reviewing the evaluation process and will revisit divisions' contracts to include outcomes about population health.

Given the potential for better quality and cost-effectiveness, divisions of general practice must be seen as a fixture in the health infrastructure. Their role in the facilitation of desired change will be critical, both in promoting the implementation of change and also in ensuring that new proposals are developed with the consultation with general practice that is essential to make the changes effective.

In summary challenges for the Divisions' Program will be:

1 – to continue to actively engage GP membership;

2 – to actively participate in the shift to community-based effective health care;

3 – to demonstrate an ability to provide quality services within a competitive market and;

4– to work strategically with governments and other health care providers as part of a multidisciplinary health care system to maximise health care provided to the Australian population.

GPDV

GENERAL PRACTICE DIVISIONS

VICTORIA