

A quality framework for Australian general practice

Background paper July 2005



THE ROYAL AUSTRALIAN
COLLEGE OF
GENERAL PRACTITIONERS

Suggested reference for this guide:

Booth B, Snowdon T, Lees C. A quality framework for Australian general practice: Background paper.
Melbourne: The Royal Australian College of General Practitioners, 2005.

Acknowledgments:

Dr Shiong Tan, Dr Karda Cavanagh, Ian Watts, Rachel Portelli, Jane London

Contents

1	Introduction	1
1.1	Project method	1
2	Quality in health care	2
2.1	Concepts of quality	2
2.2	Definition of quality	3
2.3	Quality and risk	4
2.4	Understanding and analysing quality	4
2.5	Quality improvement in general practice	5
2.6	Strategies for change and improvement	8
2.7	Theoretical basis for quality improvement strategies	8
3	Quality frameworks in health care	14
3.1	International quality frameworks	14
3.2	Quality frameworks in Australia	20
3.3	Quality frameworks in general practice	25
4	Barriers that affect quality in general practice	29
5	Quality general practitioners	30
5.1	Routes to Fellowship of the RACGP	30
5.2	Routes to Fellowship of the ACRRM	31
5.3	Vocational training	31
5.4	Ensuring the quality of vocational training	34
5.5	Vocational registration	35
5.6	Continuing professional development	36
5.7	International medical graduates	37
5.8	Workforce factors	38
6	Quality general practices	39
6.1	Standards and accreditation for general practices	39
6.2	Practice accreditation	40
6.3	Standards for medical deputising services	41
6.4	The role of general practice nurses	42
6.5	The role of practice managers	43
6.6	Information management and information technology	44
7	Quality initiatives in Australian general practice	45
7.1	Quality care for consumers	45
7.2	General practitioner and patient partnership	46
7.3	State government health departments	47
7.4	Divisions of general practice	47
7.5	Faculties of the Royal Australian College of General Practitioners	51
7.6	Quality initiatives at the national level	52
7.7	Key stakeholders	57

7.8	General practice representative groups	59
7.9	Organisations impacting on quality of care in general practice	62
7.10	Health care funding in Australia	66
7.11	National guidelines and resources	70
7.12	Where to from here?	72
8	Conclusion	73
8.1	Next steps	74
8.2	Comments	74
9	References	75

Introduction

A quality framework is a tool to facilitate the systematic analysis of the general practice environment in terms of the quality of care – current status, activities for enhancement, barriers to achievement and initiatives for future improvement. A quality framework is an evolving entity that can be extended and improved over time and has the potential to be used as a model, a reference, a plan, a source of ideas and a benchmark to review progress and identify quality improvement program gaps. The key to the usefulness of any quality framework is its adaptability to local structures, environments and needs.

The Royal Australian College of General Practitioners (RACGP) has produced this background paper in a bid to discuss key ideas in quality and take stock of the quality frameworks currently used in health care and general practice. This document supports the development of an indicative quality framework in consultation with a Quality in General Practice Committee (QGPC), and other key stakeholders. This background paper is not exhaustive. The intention is to provide a descriptive snapshot-in-time and to draw attention to some of the key issues that could impact on quality in general practice. The report is intended to promote discussion, rather than being a definitive statement.

1.1 Project method

The RACGP will conduct a thorough stakeholder consultation process for the development of the quality framework. Engagement strategies will include face-to-face meetings, electronic contact through *FridayFax* and teleconferencing as appropriate. This consultation will include the RACGP's faculties hosting a series of state based quality framework consultations, involving GPs, associated practice staff and organisations. RACGP clinicians and national managers will facilitate the consultations. The consultations will:

- review the indicative quality framework to identify gaps, opportunities and barriers
- develop an understanding of quality, quality improvement from a practitioner perspective and build on past and current college experience in standards, systems thinking, accreditation and quality activities such as the General Practice: Building on Quality Program
- identify what is feasible and acceptable for a quality framework
- build clinician leadership and support for a quality framework.

The results of the consultations will be analysed and compared with international evidence (moderated by Australian environmental factors) to produce a draft quality framework for final consideration by the QGPC and the RACGP's National Standing Committee for Quality Care and Council. The college will produce a 'gap analysis' together with any recommendation/s for priority action. Thereafter, the quality framework will be presented to the Commonwealth Department of Health and Ageing.

Quality in health care

There are varying definitions of quality that come from different disciplines. This section provides a brief overview of quality in general and of quality in health care and considers how quality is analysed in health care.

2.1 Concepts of quality

On a US physicians chat site, a contributor compared quality health care to pornography: most doctors 'can't define (the ingredients), but they know it when they see it'.¹

The management gurus, however, believe they know quality when they see it. Traditionally, business quality is conceived in terms of decisions and goals. A business makes a decision about the 'level of quality' of its products and consequently the position of those products in the marketplace. For products and services, decisions about quality are most often associated with measurement, determining the level of defects that will be acceptable in a sample of products or services. Quality goals are measured in a range of ways including satisfaction, waiting times or complaints. Consumers often link price and quality, and ascribe differing expectations based on the price of the product. Taguchi², using a loss function measurement of quality, hypothesises that the customer becomes increasingly dissatisfied as performance deviates from the expected target. The curve, represented below, charts upper and lower levels of customer tolerance, allowing a business to focus on consumer response within given constraints.

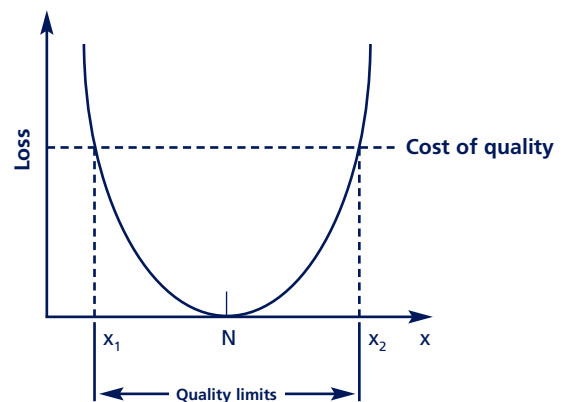


Figure 1. Levels of customer tolerance

There are three sequentially developing overarching themes around quality: static, systems and disruptive change. In the first, the static model, the focus is on the practitioner and centring quality through the assurance, training and regulation of the individual.

The second model (and current dominant theme of quality improvement) derived from management theory that evolved as a response to the challenges that arose from industrialisation and mass production in the late 19th and 20th centuries. Frederick Taylor introduced the idea of studying work processes to organise for better efficiency. The human relations movement introduced concepts such as the needs of workers, job satisfaction, leadership, group dynamics and teamwork, and information and communication management.

These management developments were taken to a new level by seminal authors Deming and Senge. Deming's authority came from his work in Japan and the reorganisation of Japanese industry after World War II. W Edward Deming developed notions about quality management and control that are encapsulated in 14 objectives:

- create consistency of purpose towards improvement of product and service
- awaken to the challenges of the new economic age and adopt a new philosophy
- cease dependency on inspection to achieve quality
- stop awarding business on the basis of price
- institute training on the job
- institute leadership
- drive out fear

- break down barriers between departments
- eliminate slogans, exhortations, and targets aimed at zero defects and new levels of productivity
- eliminate quotas on the factory floor
- remove barriers that rob people of the right to pride of workmanship
- institute a vigorous program of education and self improvement
- put everybody in the company to work on accomplishing the transformation.³

Peter Senge⁴ popularised the concepts of ‘the learning organisation’ to direct management to quality outcomes in the changing environment of the latter 20th century. His influential work on leadership and management identified learning organisations as incorporating five ‘disciplines’:

- systems thinking; a conceptual cornerstone that underpins other disciplines. Systems thinking involves reflecting on interdependences within and between systems
- personal mastery; the discipline of continually clarifying your vision, focusing energy, developing patience and seeking reality objectively
- mental models; examining generalisations, assumptions and influencers of behaviour to better understand the environment
- shared vision; this discipline explores common identity, what binds people together, the development of a shared vision and future
- team learning; this is the discipline of group interaction where combined energies and actions are used to achieve agreed and common goals.

Authors such as Reason,⁵ Amoore and Ingram⁶ signal the changing view around quality assurance or improvement. They exemplify the move from discrete, compartmentalised, ad hoc, and person focused approaches to quality improvement, to a systems approach to quality assurance and improvement.

The third model centres on the concept of quality within disruptive change. Examples of disruptive change include the emergence of digital photography, use of broadband, and genetic screening. Gilbert, Bowers and others^{7,8} argue that new strategies are required when industries and organisations face disruptive change that leads to paradigm shifts. This model focuses on framing change challenges as threats or opportunities and using that perception to navigate into new business models through staged commitment. Key components in the disruptive change model involve building separate organisations, reframing change as an opportunity, funding new businesses in stages, and continuing to pay attention to the existing business.

2.2 Definition of quality

Quality in health care, and more specifically quality in general practice, operates within a business environment. The cultural milieu of general practice, the education, training and aspirations of general practitioners, and a highly regulated marketplace temper that environment. The ‘fit’ is not always a comfortable one.

The Institute of Medicine defines quality as:

“...the degree to which health services for individuals and the population increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

The World Organisation of Family Doctors (WONCA) defines quality as:

“The best outcomes possible given available resources and the preferences and values of patients.”

The Australian Council of Safety and Quality in Health Care defines quality as:

“The extent to which the properties of a service or product produces a desired outcome.”⁹

Don Berwick, from the Institute of Healthcare Improvement defines quality as:

“The dimensions of performance of a system that the people who depend on that system care about.”

2.3 Quality and risk

Another way of looking at quality in health care is to consider failures of quality or errors or the risk of errors. The Australian Council for Safety and Quality in Health Care (ACSQHC) defines risk as ‘the chance of something happening that will have an impact on objectives. It is measured in terms of consequences and likelihood.’⁹ The ACSQHC defines risk management as ‘the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.’⁹ Nisselle concludes that ‘medical practice requires quality assurance and risk management. It also requires organisational governance – management of personnel, financial efficiency, and so on – as much as clinical governance. All the various components of practice governance need to be managed. Focusing on any one component to the detriment of the others leads to a mismanaged practice. It is not a choice between risk management and quality assurance, we need both.’¹⁰

2.4 Understanding and analysing quality

Donabedian¹¹ argues that ‘every health care practitioner and every health care institution has two major objectives: (1) to provide care of the highest possible quality, and (2) to provide care at the lowest possible cost.’ He identifies three components:

- structures: material resources, facilities, equipment and the range of services at the practice level
- processes: what is done in giving and receiving care
- outcomes: the effects of care on the health status of the patient and the community.¹²

Ferlie and Shortell¹³ took an independent look at the quality strategies in the United Kingdom and the United States. They argue that the quality strategies in these two countries will fail to realise their potential unless both policy makers and practitioners consider and implement a more comprehensive, multi level approach to change. They argue that most efforts to date have relied on narrow, single level programmatic change strategies that have been largely unsuccessful, and that initiatives to improve quality should proceed on four levels:

- individual practitioner
- group or team
- organisation
- system.

Furthermore, they identify organisational dimensions or ‘domains’ (leadership, culture, team development, and information technology) that will play a crucial role.¹⁴ Similarly, the World Organisation of Family Doctors¹⁵ proposed a framework to help design activities to enhance quality. They identify levels for quality improvement such as:

- individual GP
- practice
- local or regional level
- national or policy level.

They also identify important stakeholder perspectives on quality:

- patient
- doctor/medical stakeholder
- funder
- policy maker.

The various stakeholders involved in health care differ in their concepts and understanding of quality. For example, patients and consumers value the process of the general practice encounter. They acknowledge open communication, appropriate and high quality information, and affordable and equitable access, as key components of quality. While GPs stress consumer identified issues and technical clinical competence as highly valued. A health care funder may define quality as value for investment.^{16,17} GroL and Wensing identify six levels of barriers and incentives that impact on quality.¹⁸

Table 1. Barriers and incentives that impact on quality

Level	Barrier/Incentive
Innovation	Advantages in practice, feasibility, credibility, accessibility, attractiveness
Individual Professional	Awareness, knowledge, attitude, motivation to change, behavioural routines
Patient	Knowledge, skills, attitude, compliance
Social context	Opinion of colleagues, culture of the network, collaboration, leadership
Organisational Context	Organisation of care processes, staff, capacities, resources, structures
Economic and political context	Financial arrangements, regulations, policies

2.5 Quality improvement in general practice

The challenge of quality in general practice is demonstrated by the gap between what is known to be best practice care and the delivery of care to the Australian population, variation that is outside that explicable by patient factors, increasing costs of health care and the need for efficiency, surveys of practice against standards and medical errors. There is a variable and often unpredictable time lag between research results that demonstrate benefit and those insights being implemented at the practice level. Variation within a system is accepted and to be expected. However, numerous examples of variable patient care suggest that care is not being provided consistently to all patients. For example:

International

- In a study of 4000 patients in 11 European countries, on average only 46% of patients were given recommended beta blockers¹⁹
- The Dutch College of General Practice found that on average guidelines are followed in 67% of cases.²⁰

Australia

- the National Health and Medical Research Council (NHMRC) guidelines for the management of diabetes identify that HbA1c, weight (BMI), blood pressure (BP), and foot care should be assessed at least 6 monthly. Lipids and urinary microalbumin every 12 months, retinal examination every 2 years. The aim is for HbA1c to be within 1% of upper limit of normal (ULN), ie. <7%, BP <130/85, total cholesterol <4 and LDL <2.5. The Divisions Diabetes and Cardiovascular Quality Improvement Program (DDCQIP) found that:
 - 61% of patients within 1% of upper limit of normal for HbA1c. Using Medicare data, only 27% of people with diabetes met the minimum testing frequency for HbA1c²¹
 - 26% of patients within target for BP
 - 16% of patients within target for BMI
 - 52% of patients within target for total cholesterol
- only 25% of patients with cardiovascular disease (CVD) were within lipid targets, 6 months after hospitalisation in Victoria²²
- general practitioners identify approximately 65% of patients who smoke and provide cessation advice to less than half of these patients.²³ Smoking cessation advice was provided to just over one-quarter of women smokers who were 30 weeks pregnant and had had contact with a health provider²⁴

- the British Heart Foundation recommends that patients should receive thrombolytic therapy within 90 minutes of calling for medical assistance. A pilot study in western Melbourne found this critical service was only being met in 64% of eligible cases.²⁵

Although Mott, Kidd and Weller²⁶ provide an overview of quality related issues in general practice, their work does not focus on exploring the existing level of quality provided by GPs. Fletcher²⁷ reviews the current issues and future directions of health care in Australia and suggests there is little data on the quality of health care in the primary care setting. He cites a study by Bhasale et al involving 324 Australian GPs, in which 805 incidents were reported, of which 76% were considered preventable, and 27% had potential for severe harm. The major contributing factors were considered to be poor communication with patients, actions of others and errors of judgment.

In addition to errors, or 'active' failures, latent deficiencies in service organisation and delivery of care (latent failures) can also impair the quality of care.²⁸ The rate of omissions created by such 'systems failures' is probably an important area of focus. A recent study by Makeham, Dovey, Country and Kidd²⁹ 'indicates that errors are likely to affect primary care patients in similar ways in countries with similar primary health care systems.' Errors were categorised as process (eg. office administration, investigation, treatment, communication, payment, health care workforce management) or knowledge and skill based (eg. execution of clinical task, diagnosis, wrong treatment decision with right diagnosis).

Britt et al (1997) examined adverse events in Australian general practice through a General Practice Sentinel Network monitoring program.³⁰ These researchers found that the highest incident rates were for pharmaceutical prescribing (52 per 100 incidents), nonpharmacological management (37 per 100 incidents) followed by diagnosis related incidents (28 per 100 incidents). Diagnostic incidents, which accounted for over one-quarter of the incidents in this study, are a particularly common reason for litigation.³¹ The proportion of diagnostic errors resulting in adverse patient outcomes of moderate severity or greater was 44% for immediate events and 31% for long term events. Of the diagnostic incidents examined 11% resulted in the death of the patient. This proportion was relatively consistent for both immediate (11%) and long term (13%) diagnostic adverse events. This research does however confirm the findings observed within the hospital setting from the Quality in Australian Health Care Study (QAHCS) that when adverse events arise in clinical practice they are often serious in nature. Common causes for errors in primary care management resulting in adverse events are summarised in *Table 2* as a proportion of diagnostic incidents that were observed.

Consistent with the results of the QAHCS a high proportion of the incidents examined by Britt et al (76%) were considered preventable.³⁰ Many of the common contributing factors relate to inadequate communication by practitioners with and about patients. Poor communication between patient and health professionals (23%) and poor communication between health professionals (21%) account for a large proportion of errors. If failure to recognise symptoms was also considered this proportion might be even higher. Evaluation of common causes of errors suggests that quality initiatives designed to evaluate practitioner communication skills in general practice may minimise potential adverse events. Common themes underlying the contributory factors included lack of coordinated care, failures in medical record keeping, illegible prescriptions, and lack of access to resources in rural regions.

Most data regarding the need for quality improvement in health care comes from individual studies or localised systematic data collections such as those referred to above. However, routinely available national or regional data on the quality of the health care system is not available for general practice in Australia through routinely collected quality indicators.

Table 2. Contributing factors – rate per 100 incidents (n=500)³⁰

Contributing factor	Rate per 100 incidents*
Poor communication between patient and health professionals	26
Error in judgment	24
Action of others (ie. not general practitioner or patient)	24
Poor communication between health professionals	20
Patient consulted other medical officer	16
Failure to recognise signs and symptoms	14
Patient's history not adequately reviewed	11
Omission of checking procedure	11
General practitioner tired, rushed or running late	10
Patient misunderstood their problem or treatment	8
Administrative inadequacies	7
Inadequate patient assessment	7
Patient not adequately followed up	7
Poor choice of medication	7
Patient's poor psychological condition	6
Patient's poor physical condition	5
General practitioner's limited knowledge of the situation	5
Patient delayed presentation or follow up	5
General practitioner's limited experience of the situation	4
Access to health services delayed	3
Routine tests not conducted	3
Hospital admission delayed	3
Distraction during consultation	3
Memory lapse	2
Stressful situation	2
Test results not available	1
Poor choice of medication regimen	0

Smith³² reports on projects in the UK and USA that have focused on enhancing practice systems to improve care. These included better planning of the workflow in the practice and the roles of professionals within the practice. She reports that:

“Using these methods some practices have, eg. seen their proportions of diabetic patients who have had their eyes examined rise from 65% to 85% and their glycosylated haemoglobin measured from 47% to 80%. And among the first wave practices in the UK collaborative the percentage prescribing aspirin for over 80% of their patients with coronary heart disease, has increased from 23% last July to 50% this April.”

Other reports from similar work by the Institute for Healthcare Improvement³³ report that sites saw:

- the percentage of diabetic patients with HbA1c less than or equal to 7.5 increase from 65.6% in 1999 to 91% in 2000
- the percentage of hypertensive patients with BP less than or equal to 140/86 increase from 67% to 95% in 2000
- the percentage of patients with LDL less than 100 increase from 64% in 1999 to 90% in 2000.

In the United Kingdom, the National Primary Care Collaborative has engaged 200 practices, covering 11.5 million patients. Using the collaborative methodology the average waiting time for an appointment with a GP has been reduced by 60%.³⁴

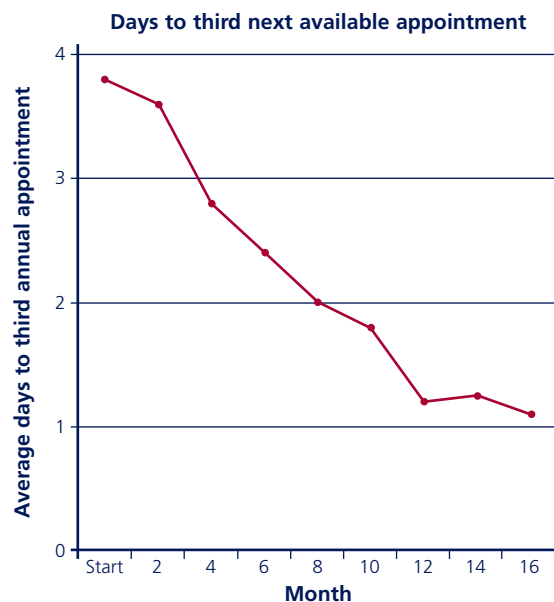


Figure 2. Average waiting time for a general practitioner in United Kingdom over time

When considering solutions it is necessary to be mindful of current and future constraints at the practitioner, the practice and the health system levels. A recent US study calculated that US doctors would need to spend an additional 7.4 hours per day with patients to provide the recommended evidence based guidelines (USPSTF).^{35,36} Haines estimated that a doctor would need to read 19 articles each day to keep up to date.²⁰

2.6 Strategies for change and improvement

As the barriers to health care quality are complex and multifaceted, the implementation of successful strategies for consistent quality improvement requires action at multiple levels and in multiple areas. A recent edition of the *American Journal of Public Health*,³⁷ suggested that in Canada, France, Germany and the United Kingdom, the cost containment approach seems increasingly insufficient to counter the fundamental challenges these nations face – growing and aging populations, technological progress, inflation, wage pressures, and rising popular expectations.

While the focus in the past has been on constraining growth in the cost of care, new emphasis is being given to improving the quality and outcomes of care. This is in large part due to advances in health service research, which has demonstrated wide variation in both process and outcomes of care even in the most technologically advanced countries.¹³ While variation in complex systems is inevitable, those funding the health care system often consider the current wide variation, to be evidence of inappropriate care and errors. Another mobilising factor has been a high profile incidence of gross medical errors in the UK (Bristol Royal Infirmary) and the US, and the evidence of adverse events shown in the Quality of Australian Health Care Study (QAHCS).³⁸

2.7 Theoretical basis for quality improvement strategies

Knowledge about effective implementation strategies is growing. Traditional focus has been on the practitioner and the patient and consequent interaction, eg. focus on patient motivation, practitioner education. More recently implementation or 'translational science' has examined the context and systems within which the practitioner and patient interaction takes place. This has led to a review of the role of the practitioner, the practice, the training and supports, the motivation, the culture, the specifics of the intervention, and the interplay between these and the wider context. This broadening enriches understanding through exposure to other disciplines and thought processes. For example:

- an education approach rests on the internal motivation of individuals to achieve optimal competence. Consequently strategies centre on everyday practice and problem based learning. Common general practice education approach includes the FRACGP examination, training programs, and ongoing professional development

- an epidemiological approach is based on rational argument and decision making. Therefore practitioner change is predicated on providing the most convincing argument based on the scientific literature and evidence based guidelines. Common general practice examples are exemplified through evidence based medicine and guidelines movements
- a marketing approach emphasises the development and dissemination of proposals for change that meet the needs of the target group. A strategy is adapted to local needs
- external influences are a component of learning theory. Behaviour can be influenced by external factors such as incentives or information. This theory leads to the provision of feedback comparison, recalls and sanctions. Common general practice examples include feedback, benchmarking and quality indicators
- social interaction approaches focus on the impact of person interaction and approval for defining behaviour. Strategies include use of opinion leaders, practice visits, peer assessment. Common general practice examples are academic detailing, small group learning
- a managerial approach focuses on the organisational conditions that support change and the development of a systems approach. Strategies include process redesign, role and task delineation, cultural change and continuous improvement. Common general practice examples include the collaborative methodology
- control and compulsion is based on external control and demand for performance. Strategies include legislation, regulation, accreditation, budgets, and complaints management.²⁰ Common general practice examples include standards and accreditation.

Grol argues 'the problem is that as far as optimising patient care is concerned, there is no convincing evidence that any one of the described approaches is more effective in a given situation than another.'²⁰ He suggests the integration of these various approaches into a coherent framework is required. As an example of changing clinical practice, Grol offers the following analysis in *Table 3*.³⁹

Furthermore, Grol argues that different interventions are required depending on the purpose of behaviour change:

- marketing and social interaction approaches may be more beneficial for the adoption phase
- behavioural and organisational approaches for implementation phase
- educational, epidemiological and marketing for dissemination phase
- organisational and coercive approaches for maintenance of performance phase.

Grimshaw, at the 2004 Chris Silagy Memorial Lecture, proposed that different theories and approaches also applied at other levels of the health care system. For example social interaction strategies translate to peer review and academic detailing at the practitioner and practice level but manifest quite differently at the national, state or territory level.

Rhydderch suggests that, 'a strategic framework for quality improvement should achieve a balance of activity by considering five factors: nature of competence; level at which information is required; maturity of health system; centralisation of health system; and existing balance.'⁴⁰ He argues that, while the systems approach predominates it will only serve to 'fix' the current system. Rhydderch claims that, 'akin to driving through the rear view mirror...there is a balance to be struck between this approach and a more futures-focused approach, anticipating and making sense of likely changes.'⁴⁰ This draws us back to the disruptive change models considered earlier. Bradley et al found that success and speed of adoption and diffusion depended on:

- the roles of senior management and clinical leadership
- the generation of credible supportive data
- an infrastructure dedicated to translating the innovation from research into practice
- the extent to which changes in organisational culture are required
- the amount of coordination needed across departments of disciplines.

The characteristics and resources of the organisation and the degree to which the innovation was seen to respond to immediate or significant needs were also important.⁴¹

Table 3. Changing clinical practice – an analysis by Richard Grol

Approach	Theories	Focus	Interventions, strategy
Focus on internal processes			
Educational	Adult learning theories	Intrinsic motivation of professionals	Bottom up, local consensus development Small group interactive learning Problem based learning
Epidemiological	Cognitive theories	Rational information seeking and decision making	Evidence based guideline development Disseminating research findings through courses, mailing, journal
Marketing	Health promotion, innovation and social marketing theories	Attractive product adapted to needs of target audience	Needs assessment adapting change proposals to local needs Stepwise approach Various channels for dissemination (mass media and personal)
Focus on external influences			
Behavioural	Learning theory	Controlling performance by external stimuli	Audit and feedback, quality indicators Reminder systems, monitoring Economic incentives, sanctions
Social interaction	Social learning and innovation theories, social influence/ power theories	Social influence of significant peers/role models Peer review in local networks	Outreach visits, individual instruction Opinion leader Influencing key people in social networks Patient mediated interventions
Organisational	Management theories, system theories	Creating structural and organisational conditions to improve care	Re-engineering care process Total quality management/ continuous quality improvement approaches Team building Enhancing leadership Changing structures, tasks
Coercive	Economic power and learning theories	Control and pressure, external motivation	Regulation, laws Budgeting, contracting Licensing, accreditation Complaints/legal procedures

2.7.1 Individual change model

The best known of the individual behaviour change theory is the Stages of Change model (Di Clemente and Prochaska) (Figure 3) often used to involve patients or practice teams in determining goals, barriers and strategies for implementation. The model identifies five phases in the change process:

- not convinced of the need for change (precontemplation)
- willing to make a change but not confident about your ability to succeed (contemplation)
- ready to make a change but not sure how to best go about it (determination)
- in the process of trying to make a change (action)
- trying to sustain a change that you have already made (maintenance).

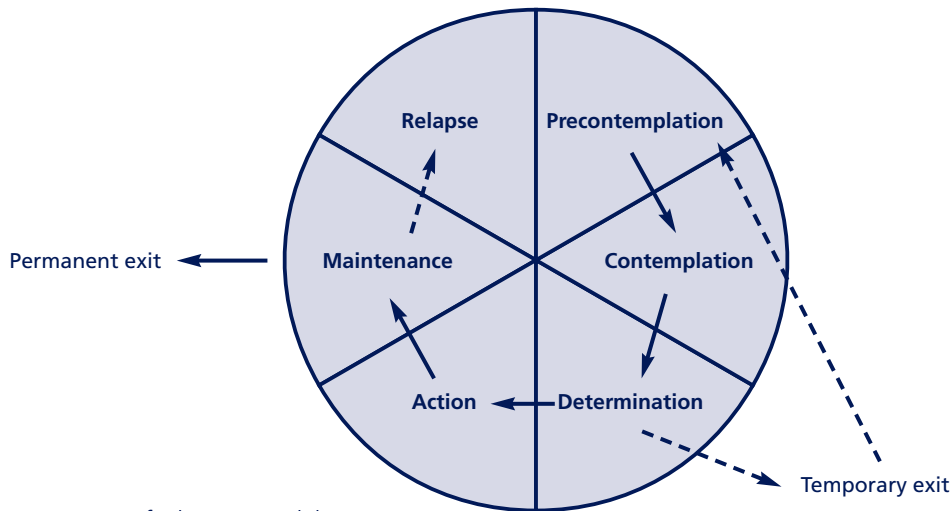


Figure 3. Stages of Change model

Applying this model at the practitioner level, Grol and Wensing have devised a 10-step approach to practitioner and practice based change.

Orientation

1. Promote awareness of innovation: level of interest in reading and continuous education.
2. Stimulate interest and involvement: degree of contact with colleagues; experience of need for innovation.

Insight

3. Create understanding: available knowledge and skills, ability to remember information.
4. Develop insight into own routines: attitude (open minded or defensive), willingness to acknowledge gaps in performance.

Acceptance

5. Develop positive attitude to change: ability to perceive advantages of change, opinion of scientific merit of change, opinion of credibility of innovation source, degree of involvement in development process.
6. Create positive intentions/decisions to change: perception of self efficacy, degree of confidence in own skills, perception about potential problems of putting change into practice.

Change

7. Try out change in practice: perception of practical barriers (time, staff, money), opportunity to try change on small scale.
8. Confirm value of change: whether first experiences positive or negative, degree of cooperation experienced and reaction of patients and colleagues, side effects (eg. higher or lower costs).

Maintenance

9. Integrate new practice into routines: willingness and ability to redesign processes.
10. Embed new practice in organisation: whether procedures in place for constant reminding, availability of support resources, degree of support from management.¹⁸

2.7.2 Systems based approaches

There is a gap between knowledge of best practice approaches to quality and the ability to implement those approaches. Grimshaw, Grol and Bero internationally and Schattner in Australia have drawn on diverse theories of learning and change and applied these to health care.

Rhydderch, Elyn, Marshall and Grol,⁴⁰ eg. draw on four theories to better understand how indicators work to support quality improvement. These are: systems theory, organisational development, social world's theory and complexity theory. Schattner⁴² uses social, behavioural and organisational theories to explore options for continuing education and guideline implementation. The strength of these theories impacts on the type of strategy chosen.

Grol and Wensing argue that in order to develop a successful change strategy it is necessary to understand: the problem that is being addressed, the target group, the setting and or context and barriers to change.¹⁸ Grol³⁹ noted that depending on whether the outcome is to promote adoption, implementation, maintenance or dissemination of a behaviour change, differing approaches are required.

In relation to guidelines Grol, Wensing and Eccles identify the importance of knowing how guidelines will be implemented, understanding the target group and seeing the development and implementation process from their perspective, identifying barriers and developing an intervention strategy and careful evaluation of outcomes.²⁰

Grol and Grimshaw suggest that change is possible if a comprehensive approach is taken that accommodates different levels and is tailored to the specific setting and target group.⁴³

As evidence of the rapid growth of knowledge in this field, Grimshaw⁴⁴ has recently overturned a common orthodoxy that academic detailing (practice visiting) is the most effective strategy for behaviour change. Through a close review of the literature he has found that, when taking account of the investment required, education and dissemination of information is comparatively effective.

Grimshaw suggested that different theories about change work at different levels. This brings us back to the work of Ferlie and Shortell and WONCA. Personal behaviour change impact at the clinician level, organisational theories at the practice and regional levels and social world and macroeconomic theory, at the national level.

A well known systems model currently in vogue in parts of Europe, the US and the UK is the 'collaborative'. This is a strategy for achieving rapid improvement in clinical outcomes by bringing teams together to address common problems using existing evidence of best practice. Clinicians share and learn through workshops. Australia will trial the collaborative strategy in 2005.⁴⁵ Improvement is centred on the plan-do-study-act cycle (*Figure 4*).⁴⁶

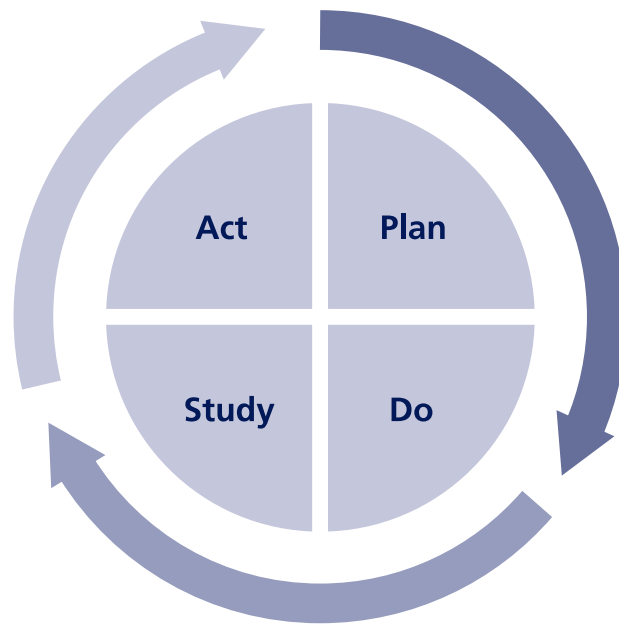


Figure 4. The plan, do, study, act model

In summary

- quality operates at varying levels and there are different perceptions of quality depending on your position in a system (ie. as a consumer, practitioner, funding body)
- quality can rest in the individual, the system and/or the process
- quality and risk are related but not synonymous concepts
- quality can be analysed in different ways; structure, process, outcome; individual, organisation, community
- there is room for improvement in health care for Australians as evidence suggests that some do not receive best practice care, there is significant variability, and there is evidence of medical errors and latent failures
- deliberate programs that target the individual and system have demonstrated improvement in health outcomes for patients. However, in a resource constrained health system, it is necessary to make choices in relation to targets and strategies
- improvement strategies come from many disciplines, are based on differing and sometimes conflicting theories. Strategies for success vary with the purpose of the improvement
- it is essential to understand the target group, the context and the barriers in developing a quality improvement strategy.

Quality frameworks in health care

The General Practice Strategy Review first considered the need for a quality framework. This section provides a selection of quality frameworks and identifies their common aspects.

While quality is perceived as a broad, generic and sometimes subjective concept, a quality framework is more objective, applicable and measurable within a particular discipline or setting. The intent of a quality framework is not to regulate or sanction but to support visibility, transparency, understanding and confidence in services and structures. As quality is an end product, a service and a process, it can be considered from a technical, user and provider perspective. Consequently the development of a quality framework serves multiple purposes.

The benefit of a quality framework is that it provides confidence to users. A quality framework identifies positive high quality and gaps in service. It contributes to the development of critical evaluation capacity and can promote standardisation and interoperability where desirable. A health service quality framework is a tool that enables a systematic analysis of the current quality within a health service environment. Depending on the quality, maturity and progress of an individual health service program, a quality framework can be applied as a model. It can be used as a reference or for planning quality initiatives in response to an environmental analysis, or used to evaluate the effects of new activities. A quality framework is an evolving entity that will be extended and improved over time.

3.1 International quality frameworks

This section outlines selected international examples of quality frameworks in the health sector.

3.1.1 World Health Organisation (WHO)

*The World Health Report 2000: Health Systems Improving Performance*⁴⁷ states that the objectives of a health service are goodness or the best attainable average level of health and fairness, or the smallest feasible difference between individuals and groups. Consequently health system performance goals are:

- good health
- responsiveness to the expectations of the population served, and
- fairness of financial contributions.

The Health For All policy outlined a quality framework for advancement of health promotion internationally. Colloquially known as the Ottawa Charter, the framework identifies a series of principles and strategies. The principles are:

- the prerequisites for health such as peace, shelter, education, food, income, stable ecosystem, sustainable resources, social justice and equity
- advocacy within political, economic, social, cultural, environmental, behavioural and biological systems
- enable equity in health care for all, and
- coordinated action by all concerned to promote health.

The strategies are:

- building healthy public policy
- creating supportive environments
- strengthening community action
- developing personal skills, and
- reorienting health services.⁴⁸

The Jakarta Declaration on Leading Health Promotion into the 21st century confirmed the Ottawa Charter strategies. The declaration acknowledged there is evidence that, 'comprehensive approaches to health development are the most effective ... particular settings offer practical opportunities for the implementation of comprehensive strategies ... participation is essential to sustain efforts ... (and) health learning fosters participation.'⁴⁹

To address emerging threats to health and in light of the evidence, the Jakarta Declaration identified new priorities for this century as: promoting social responsibility for health, increasing investments for health development, consolidating and expanding partnerships for health, increasing community capacity and empowering the individual, and securing an infrastructure for health promotion.

While the Ottawa and Jakarta Declarations outline a whole-of-government approach to health promotion, Christel Woodward,⁵⁰ in a discussion paper for the WHO, examines the context in which health care is provided. Woodward's paper proposes a framework that reflects a systematic approach to allow for sustained and multi level approach to supporting the provision of high quality care to communities.

Table 4. Quality improvement strategies

Individual level: Changing the clinical behaviour of health care professionals regarding specific patient care decisions and interventions		
Predisposing: Helping move practitioners from contemplation towards action	Enabling: Environmental changes that facilitate use of new behaviour or allow skills to be practiced	Reinforcing: Helping maintain a new behaviour, ie. Offers positive rewards
Education material Conferences Academic detailing Local opinion leaders Self assessment	Practice rehearsal Clinical guidelines Care maps and practice algorithms Reminders Patient mediated interventions Decision support software	Audit and feedback Peer review Enabling strategies can also be used for reinforcement
Practice/health facility: Strategies used at the team or local health facility to improve the quality of practice		
Quality improvement teams Employee suggestion programs Hospital committees Guidelines and care maps Management and clinical information systems Utilisation management		Release time for continuing education In house formal continuing education On the job training Performance review Outcomes measurement Total quality management
Regional/national level: Approaches to assuring, controlling or improving quality		
Strategies aimed at improving the education of health care personnel	Strategies aimed at facilities which employ health care personnel	Strategies aimed at controlling the quality of individual health care personnel
Legislation governing educational institutions for health care professionals Accreditation of health education facilities Voluntary self-assessment by educational institutions Codifying curriculum for health personnel in legislation	Legislation to govern hospitals and other health care facilities Accreditation of hospitals and other health care facilities Inspection of hospitals and facilities Creating data systems that monitor health facilities standards outside an accreditation structure	Credentialing Licensing Development of public complaints, dispute resolution and disciplinary processes Initiatives to support better distribution of health personnel and facilities Management information systems Creating structures and processes to facilitate quality improvement

3.1.2 National Health Service

In the United Kingdom, the National Health Service (NHS) system wide quality reforms have centred on the concept of 'clinical governance'. The World Health Organisation defines the components of clinical governance as:

- professional performance (technical quality)
- resource use (efficiency)
- risk management (the risk of injury or illness associated with the service provided), and
- patients' satisfaction with the service provided.⁵¹

The NHS definition however is 'a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.'⁵¹ The current model is represented at the national level in *Figure 5*.⁵¹

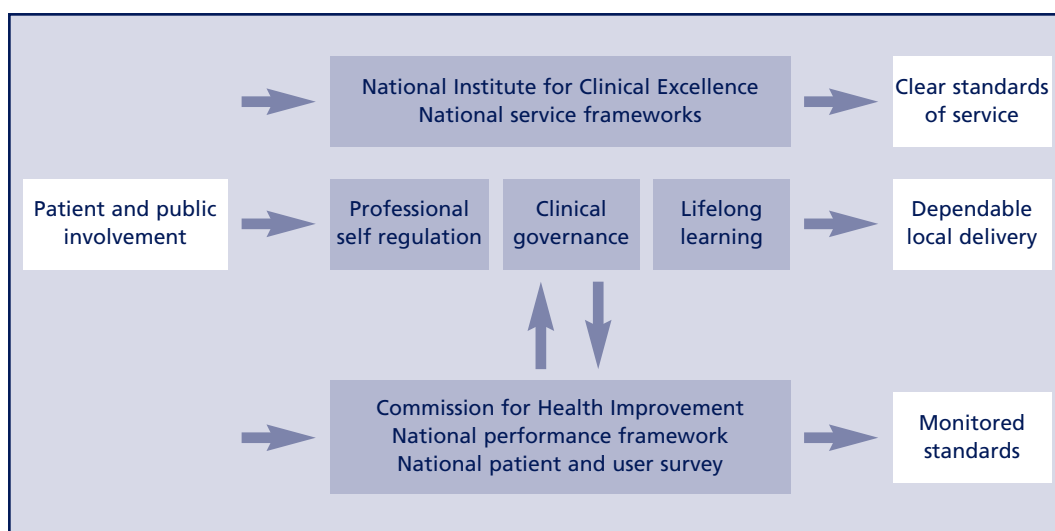


Figure 5. National Health Service Quality Framework

The four main elements of the model are:

- accountability and responsibility for overall quality of clinical care
- risk management policies
- procedures for all professional groups to identify and resolve poor clinical performance
- a comprehensive suite of quality improvement processes including clinical audit, evidence based practice, clinical guidelines, continuing professional development, monitoring of clinical care and effective research and development.

The key features of the model are:

- patient centred care needs are at the heart of every NHS organisation. This means that patients are kept well informed and are given the opportunity to participate in their care
- good information about the quality of services is available to those providing the services as well as to patients and the public
- variations in the process, outcomes and access to health care are greatly reduced
- the NHS organisations and partners work together to provide quality assured services and drive forward continuous improvement
- doctors, nurses and other health professionals work in teams to a consistently high standard and identify ways to provide safer and even better care for their patients
- risks and hazards to patients are reduced to as low a level as possible, creating a safety culture throughout the NHS
- good practice and research evidence is systematically adopted.

In Walshe's *Clinical governance: from policy to practice report 2000* the importance of the philosophy – patient centred, safety conscious and multi disciplinary in delivery – is emphasised along with the methods to be used such as continuous improvement at a number of organisational levels. This approach involved putting systems in place to fairly assess quality eg. supporting the 'right' culture, providing clinical and managerial leadership, and investing in functions that support quality. Such things could be clinical audit, risk management, and complaints, establishing processes at the managerial and the workplace level, measuring and celebrating progress, and having external reviews.⁵²

Walshe found five factors that positively contributed to changing behaviour and practice systems:

- how professional and community attitudes in relation to accountability of professions are aligned
- to what extent politicians and health decisions makers have made clinical accountability a priority
- whether there has been a sustained policy direction over 5 years
- whether that policy direction is perceived to be part of a much wider policy of performance management and monitoring
- the degree of focus on implementation and follow up.

However, Degeling⁵³ in 2004 expressed clinician concern that the current model was management based and remote from the daily concerns of front line NHS staff.

3.1.3 US Department of Veterans Affairs

In the United States, the Department of Veterans Affairs underwent a major transformation in the 1990s, moving from an inpatient subspecialty based system to a 'full service' integrated system that is committed to health promotion, disease prevention and care coordination. Two overarching strategies were used; an overhaul of service delivery and the creation of a culture of quality, including systematic and rigorous evaluation of care. Creating a culture of quality involved uniform data collection supported by electronic medical records systems, a systematic application of quality standards, externally monitored local area networks, evaluation of care quality and research into quality care.⁵⁴ Using a total systems approach, Veterans Affairs identified 12 dimensions of a VHA Health Care Quality Framework, which are illustrated in *Table 5*.

Table 5. The 12 dimensions of the Veteran Affairs Health Quality Care Framework

Credentialing and privileging	Board certification, Licensure
Accreditation	JCAHO, CARF, NCQA; others such as American College of Surgeons, College of American Pathologists, College of Radiologists, American Association of Blood Banks, Nuclear Regulatory Commission
Clinical care strategies	Primary care; clinical practice guidelines/clinical pathways; shared decision making; palliative care; telephone linked care; case management; provider profiling; decision support aides; community based services; contract specifications
Performance indicators	Chronic disease index; prevention index; surgical mortality and morbidity rates; medical cohort survival rates; end-of-life planning; functional outcomes (SF-36, FIM, ASI); long term care minimum data set; readmission rates; mental health performance indicators; case registries (eg. cancer, spinal cord injury, AIDS)
Internal review	Morbidity and mortality conferences; clinical pathology conferences; ad hoc review teams; process action teams; Bioethics Committee
External/independent review	Contracted external peer review; Medical Inspector; Office of Inspector General; General Accounting Office; Congress; press/media; veterans' service organisations
Customer feedback	Patient focus groups; patient satisfaction surveys; patient complaint tracking; patient advocates; service evaluation and action teams
Continuous quality improvement activities	360 degree personnel evaluations; employee satisfaction surveys; Baldrige strategic planning; awards and recognition; National Quality Council
Risk management	Adverse Event Registry; focused reviews/boards of investigation; root cause analysis; tort claims analysis; morbidity and mortality conferences; occupational health and safety
Education and training	Health professional training; workforce development; organisational education
Research	Health services studies; clinical care studies; biomedical studies; technology assessment
Change management and organisational learning	Executive performance agreement; resource allocation strategy; standardisation of language; integrated collaborative planning

This was made operational with four broad quality management areas: risk management, oversight review, quality assessment and improvement, data validation and management and utilisation review. Each of these areas contains a series of discrete activities or functions. Each activity has an agreed responsible office.⁵⁵ For example risk management includes the following activities:

- occurrence screening
- patient incident review
- patient representation program
- patient satisfaction survey
- suicide monitoring
- surgical complication and morbidity
- tort claim analysis system
- credentialing and privilege
- resident supervision
- infection control
- adverse drug events monitoring
- drug accountability
- cardiac surgery monitoring
- national surgical risk assessment study.

A 2003 study by Jha et al found that on a broad range of quality indicators ‘the percentage of patients receiving appropriate care was 90% or greater for nine of 17 quality-of-care indicators and exceeded 70% for 13 of 17 indicators (over a Medicare fee for service program). There were statistically significant improvements in quality from 1994–1995 through 2000 for all nine indicators that were collected in all years. As compared with the Medicare fee-for-service program, the VA performed significantly better on all 11 similar quality indicators for the period from 1997–1999. In 2000, the VA outperformed Medicare on 12 of 13 indicators.’⁵⁶

3.1.4 European Academy of Teachers of General Practice

The European Academy of Teachers in General Practice (EURACT) aims to foster and maintain high standards of general practice through promoting learning and teaching in the discipline of general practice. This model is centred on the practitioner, rather than the previous models that are dynamic system models.

The European definition of general practice seeks to define general practice through a consideration of the tasks undertaken by a GP and the principles that underpin general practice as a discipline. The model recognises that the patient and the health care system influence principles and tasks (Figure 6).⁵⁷

Within this model, the practitioners’ competency is considered within three levels: ‘knows’ (basic facts), ‘knows how’ (able to apply knowledge) and ‘shows how’ (demonstrates skills) and is a variation on the Miller Triangle. These three levels are moderated by the patient interaction, the practice systems in place and the clinical tasks required.

The model (Figure 7) has six core competences: primary care management, person centred care, specific problem solving skills, comprehensive approach, community orientation and holistic modelling. The model has three implementation areas (clinical tasks, communication with patients and practice management) and three background features (context, attitude and scientific aspects).⁵⁷

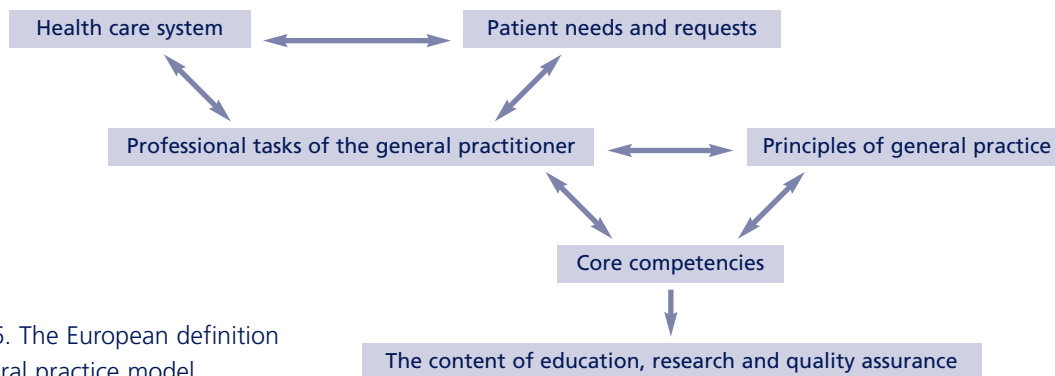


Figure 6. The European definition of general practice model

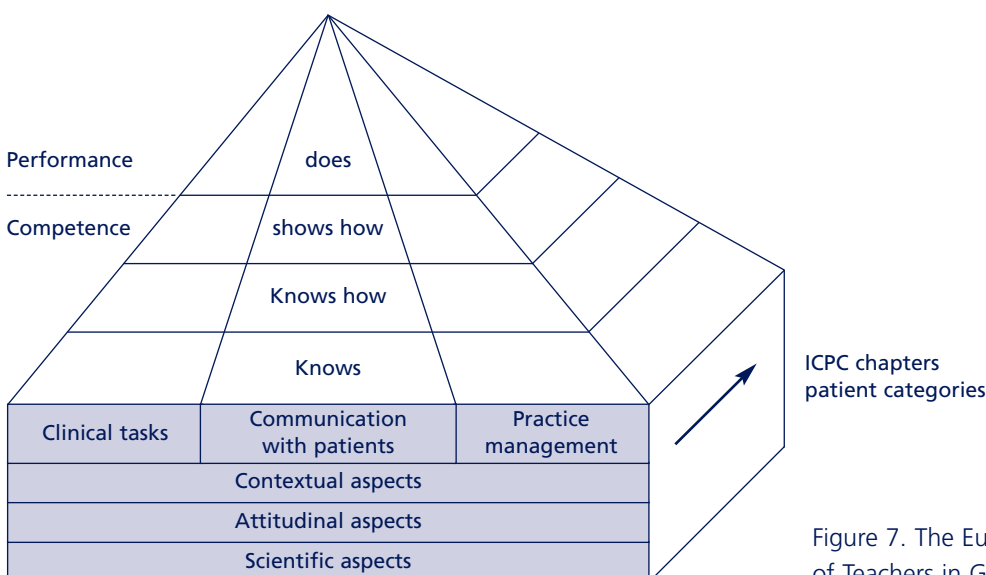


Figure 7. The European Academy of Teachers in General Practice model

3.2 Quality frameworks in Australia

There are many examples of quality frameworks that have been developed to support quality health service delivery within the Australian health care system.⁵⁸⁻⁶⁰

3.2.1 Australian Council for Safety and Quality in Health Care

In July 1999, the National Expert Advisory Group on Safety and Quality in Australian Health Care advised the Australian health ministers of the need for national action to enhance:

- strengthening the consumer voice
- fostering best clinical practice
- learning from incidents, adverse events and complaints
- developing frameworks for quality improvement and management
- developing information systems to support quality
- education and training for safety and quality improvement.⁶¹

The Australian Council for Safety and Quality in Health Care (ACSQHS), established in 2000, leads 'national efforts to improve the safety and quality of health care, with a particular focus on minimising the likelihood and effects of error.'⁶² The council has a conceptual and structural framework of the health care system (*Figure 8*).

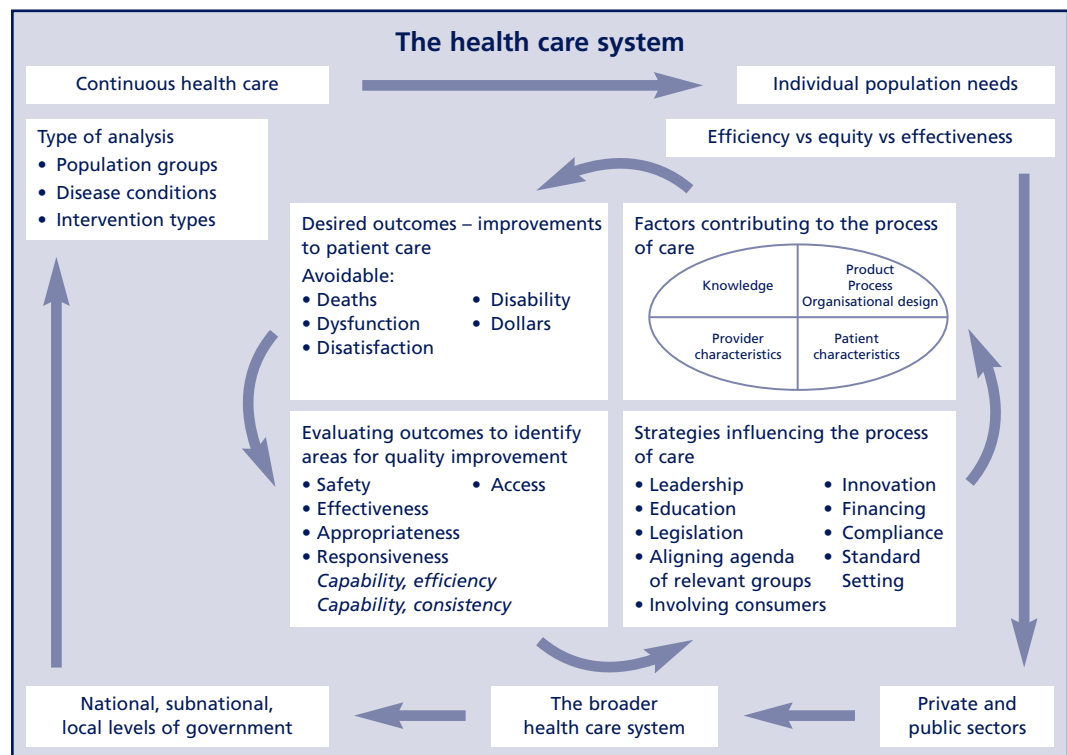


Figure 8. The Australian Council for Safety and Quality in Health Care conceptual framework of the health system

Each program area progresses through a concept framework from initially understanding the issue and promoting effective approaches, followed by redesign and strengthening of systems. In the third phase the focus is on 'safety in action'. The current focus is on maximising effectiveness. Current program areas are investment and governance, redesign and information technology, workforce, consumers, practice improvements, building awareness, measures of improvement and strategic directions.⁶³ These build on preceding work.

For example, in the specific area of integrated risk management, strategies include:

- open disclosure processes
- improved medication safety
- national audits, registers and benchmarks

- reduced patient falls
- review and actions on patient deaths, health care acquired infection, international lessons learned
- qualified privilege reform
- common glossary of terms
- national standards for credentialing
- understanding consumer needs
- specialist vocational registers
- alerts from trends in coronial data
- national standards for incident monitoring, education systems safety human factors, communication, state and territory involvement.

This framework locates health care within a broader community and philosophic context. Within the model strategies that influence care provision are separated from the factors that contribute to that care provision. These in turn impact on outcomes.

3.2.2 NSW Health

NSW Health has developed a framework for managing the quality of health services in New South Wales. Conceptually, the framework places the consumer in the centre surrounded by his or her interest and support groups. The providers of health care services are responsible to the patient for treatment, education, health promotion and other health related activities. The patient interest groups and providers make up the health system and are part of a broader community. Six key dimensions of quality are safety, effectiveness, appropriate patient centred care, efficiency of service provision, and equitable access to health care and consumer participation. These are moderated by five cross-dimensional issues (*Table 6*) to provide consumers, providers and funding bodies with a clear picture of what is considered important in providing quality health care. In this model, each dimension is not considered as a completely separate entity, and the framework acknowledges the overlap between them. The framework envisages that if a system improves its performance on the six dimensions of quality, the quality of health care will be enhanced.

Table 6. Five cross-dimensional issues used in the NSW Health Services Framework

1. Competence of providers of health care
2. Continuity of care
3. Information management to support effective decision making
4. Education and training for quality
5. Accreditation of health services

In addition, the framework for managing the quality of health services in NSW contains a number of sub structures (*Figure 9*), which include a committee structure, a performance frame and a reporting frame. Each of these structures are underpinned by a set of principles for achieving quality in health care at a system wide and area service level.

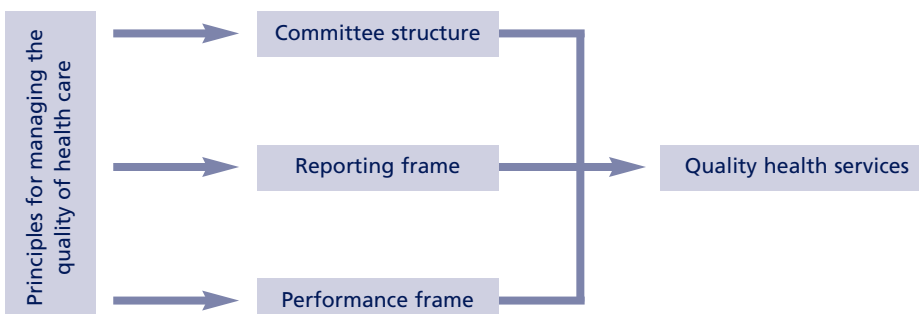


Figure 9. The framework for managing the quality of health services in NSW

3.2.3 Victorian Quality Council

The Victorian Quality Council has recently developed a quality framework as part of a strategic approach to improve the safety and quality of patient care. The Safety and Quality Improvement Framework (*Figure 10*) is based on similar quality improvement principles used in the NSW health framework.

This framework describes the intersection between four critical organisational processes (governance and leadership, consumer involvement, competence and education and information management) that are essential for quality improvement. It also describes the six dimensions of quality outlined in *Figure 10*. In addition, it explores the related roles and responsibilities of each of these factors throughout the health system. The framework is built upon a foundation of clinical governance, which clearly delineates the broad responsibility for ensuring that service and quality care is addressed with the same rigour as financial governance, and ensures that corresponding accountabilities are delegated throughout the organisation.

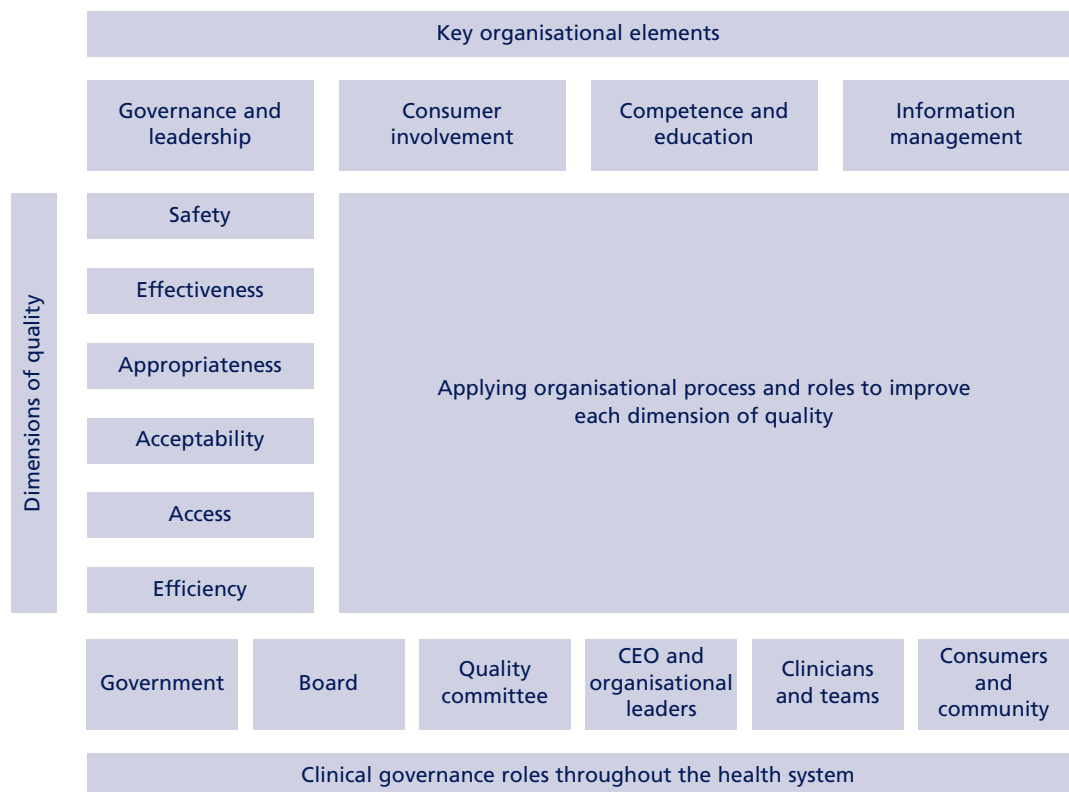


Figure 10. The Victorian health services safety and quality improvement framework

3.2.4 West Australian Council for Safety and Quality in Health Care

The Western Australian Council for Safety and Quality in Health Care developed a strategic quality plan for 2003–2008 to provide a strategic framework for promoting and delivering consumer focused, safe, quality health care in Western Australia.⁶⁰

The Conceptual Framework for Quality and Safety in Western Australia (*Figure 11*) is built on four important, interlinked strategic areas: consumer focused health care, clinical practice improvement, risk management and system improvement and accountability. Consumer focused health care engages consumers as partners at all levels of health care. Clinical practice improvement (CPI) ensures effective tools and methodologies are available to support clinicians in their work. This includes ensuring that evidence based best practice information is developed, accessible and used to reduce variation on clinical practice. Risk management ensures effective tools and methodologies are available to identify, manage and reduce risks at all levels of the health care system. System improvement and accountability facilitates system improvement through redesign, improved accountability and greater use of information. Accountability in health services is a vital component of a quality and safe health care system, and encompasses

not only individuals, but systems as a whole. As previously seen with the NSW and Victorian Quality Frameworks, the four major areas of the WA framework are supported by six principles. These are access, efficiency and effectiveness, ability to reproduce, safety, appropriateness, and participation of consumers, providers and employees.



Figure 11. Conceptual framework for safety and quality in Western Australia

3.2.5 National health performance framework

The National Health Performance Committee reported to the Australian Health Ministers' Conference on a national health performance framework in 2001.⁶⁴ Unlike the ACSQHC model, the national health performance framework is not a model of health service, rather an approach to appraising how well the health system is performing. Consequently the model will lead to consistent benchmarking. The framework has three tiers; health status and outcomes, determinants of health, and health system performance. These are not hierarchical but reflect the multiplicity of factors that impact on health care performance. Each tier is subdivided as indicated in the *Table 7*.

Table 7. National health performance framework⁶⁴

Health status and outcomes			
How healthy are Australians? Is it the same for everyone?			
Where is the most opportunity for improvement?			
Health conditions	Human function	Life expectancy and wellbeing	Deaths
Prevalence of disease, disorder, injury or trauma or other health related states.	Alterations to body, structure or function (impairment), activities (activity limitation) and participation (restriction in participation).	Broad measures of physical, mental, and social wellbeing of individuals and other derived indicators, eg. Disability Adjusted Life Expectancy (DALE)	Age and/or condition specific mortality rates

Determinants of health

Are the factors determining good health changing for the better?

Is it the same for everyone?

Where and for whom are these factors changing?

Environmental factors	Socioeconomic factors	Community capacity	Health behaviours	Person related factors
Physical, chemical and biological factors, eg. air, water, food and soil quality resulting from chemical pollution and waste disposal	Socioeconomic factors, eg. education, employment, per capita expenditure on health and average weekly earnings	Characteristics of communities and families, eg. population density, age distribution, health literacy, housing community support services and transport	Attitudes, beliefs, knowledge and behaviours, eg. patterns of eating, physical activity, excess alcohol consumption and smoking	Genetic related susceptibility to disease and other factors, eg. blood pressure, cholesterol levels and body weight

Health system performance

How well is the health system performing in delivering quality health actions to improve the health of all Australians? Is it the same for everyone?

<p>Effective</p> <p>Care, intervention or action achieves desired outcome</p>	<p>Appropriate</p> <p>Care/intervention/action provided is relevant to the client's needs and based on established standards</p>	<p>Efficient</p> <p>Achieving desired results with most cost effective use of resources</p>
<p>Responsive</p> <p>Service provides respect for persons and is client oriented. It includes respect for dignity, confidentiality, participation in choices, promptness, quality of amenities, access to social support networks and choice of provider</p>	<p>Accessible</p> <p>Ability of people to obtain health care at the right place and right time irrespective of income, physical location and cultural background</p>	<p>Safe</p> <p>The avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered</p>
<p>Continuous</p> <p>Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time</p>	<p>Capable</p> <p>All individual's or service's capacity to provide a health service based on skills and knowledge</p>	<p>Sustainable</p> <p>System or organisation's capacity to provide infrastructure such as workforce, facilities and equipment, and be innovative and respond to emerging needs (research, monitoring)</p>

Source: derived from Canadian Institute for Health Information (CIHI) and Statistics Canada, Canadian Health Information Roadmap Initiative Indicators Framework 2000. Available at: www.cihi.ca

3.3 Quality frameworks in general practice

The General Practice Strategy Group (GPSG) considered a quality framework for Australian general practice in 1998. That framework focused on the levels beyond the general practice, exploring ‘those aspects that are outside the direct responsibility of individual GPs and their practices.’¹⁶

The GPSG recognised multiple participants in general practice: patients, GPs, the practice team, divisions of general practice, funding bodies. The framework identified four specific areas:

- General practitioners – while vocational registration and training, and provider legislation support a quality practitioner model, additional supports were identified:
 1. expanding the GP workforce
 2. encouraging all doctors to operate within the existing and developing framework
 3. improving the effectiveness of continuing professional development
 4. emphasis on peer review
 5. better detecting poor practices, using positive approaches rather than sanctions.
- General practices – standards and accreditation are central to a quality improvement approach
- Services – clinical practice guidelines are pivotal for effective care benchmarking
- Information management and technology – information and communication technology are central to improving care provided by general practitioners.

The review noted that:

“GPs strive to provide high quality care but face substantial barriers and disincentives. Some incentives actually encourage poor quality care. The framework in which GPs are working must be strengthened to support GPs providing high quality care and to encourage a culture of continuous improvement ... (the) three essential elements of such a framework:

- benchmarks to enable general practice to demonstrate its achievements
- tools that enable GPs to use their skills to best effect
- evaluation and monitoring to assess how the quality of care changes over time.

Components of the quality framework are ways of ensuring continuing skills maintenance and development, practice accreditation, greater use of clinical practice guidelines, information management and information technology, remuneration and financing and patient linkages.”¹⁶

This focus on systematic engagement is echoed in the US report, *Crossing the quality chasm*, which noted, ‘trying harder will not work. Changing systems of care will.’⁶⁵

The GPSG enunciated a framework that extended beyond the assurance of the individual GP that centres on training, assessment, certification and continuing education. Other components are vocational training, Fellowship of the RACGP (FRACGP), accreditation and divisions of general practice. This fledgling framework provides the basis for ongoing developments of a quality system in general practice.

As with health care generally, the general practice environment is composed of series of interrelated subsystems that support high quality care and patient outcomes. Four of those subsystem quality frameworks are those of the RACGP, General Practice Education and Training (GPET), the Australian College of Rural and Remote Medicine (ACRRM) and Australian Divisions of General Practice (ADGP).

3.3.1 The Royal Australian College of General Practitioners

The RACGP is the body that has defined the nature of general practice. The RACGP has set and maintains the standards for high quality Australian general practice; leads the education, training and assessment processes; advocates on behalf of the discipline; and supports this country's GPs in meeting the primary medical care needs of the Australian public. Since its foundation in 1958, the RACGP has demonstrated national leadership in setting and maintaining the standards for quality clinical practice, education and research in Australian general practice. The RACGP Council determines the RACGP's formal position with respect to any changes or additions to the existing standards. General practitioners have seen, and continue to see the RACGP as the arbiter of standards on behalf of the craft.

In order to meet its commitments, the RACGP has focused on the quality of individual GPs, eg. their knowledge and skills. Development of assessment and certification of competence through the RACGP Fellowship began in 1967. This was followed by the RACGP Vocational Training Program in 1974 and the RACGP Quality Assurance and Continuing Professional Development in 1987. The RACGP's general practice curriculum is centred on the five domains of general practice:

- communication skills and the patient-doctor relationship
- applied professional knowledge and skills
- population health in the context of general practice
- professional and ethical role
- organisational and legal dimensions.

Each domain is defined and includes essential knowledge and skills in the form of competencies. The focus is on the GP developing competencies in establishing effective therapeutic relationships with all members of the community and managing undifferentiated presentations. Therefore the education standards do not differentiate between generic and discipline specific training components.

The Quality Assurance and Continuing Professional Development (QA&CPD) Program is designed to reflect the key concepts of lifelong learning, adult education and self directed learning. The RACGP has been undertaking a number of improvement activities, including the development of standards for vocational training. The RACGP has recently undertaken accreditation by the Australian Medical Council (AMC). That review supports the RACGP's key roles in education standards setting, quality assurance and assessment. The RACGP has recently developed standards for regional training providers and training posts and standardised accreditation for training providers.

In addition to its work in the education area, the RACGP developed standards for general practices (the standards for the structure and organisation of practices). This work extends over 10 years. The RACGP *Standards for general practices* were developed in 1996 and practice accreditation was established through Australian General Practice Accreditation Limited (AGPAL) from 1997.

Since *Standards* was published in 2000, there has been a rapid growth in the literature surrounding quality improvement. A significant development since publication of the 2nd edition of *Standards for general practices* has been the maturing of the accreditation process. There are now two organisations providing services to general practices that seek accreditation against the RACGP *Standards*.

3.3.2 General Practice Education and Training

General Practice Education and Training (GPET) is responsible for ensuring 'quality outcomes from vocational training for GPs in Australia.'⁶⁶ The GPET Quality Framework guides the implementation and evaluation of the program. General Practice Education and Training conceptualises GP vocational training within the wider context of general practice and health care systems. The conceptual model is represented in *Figure 12*.

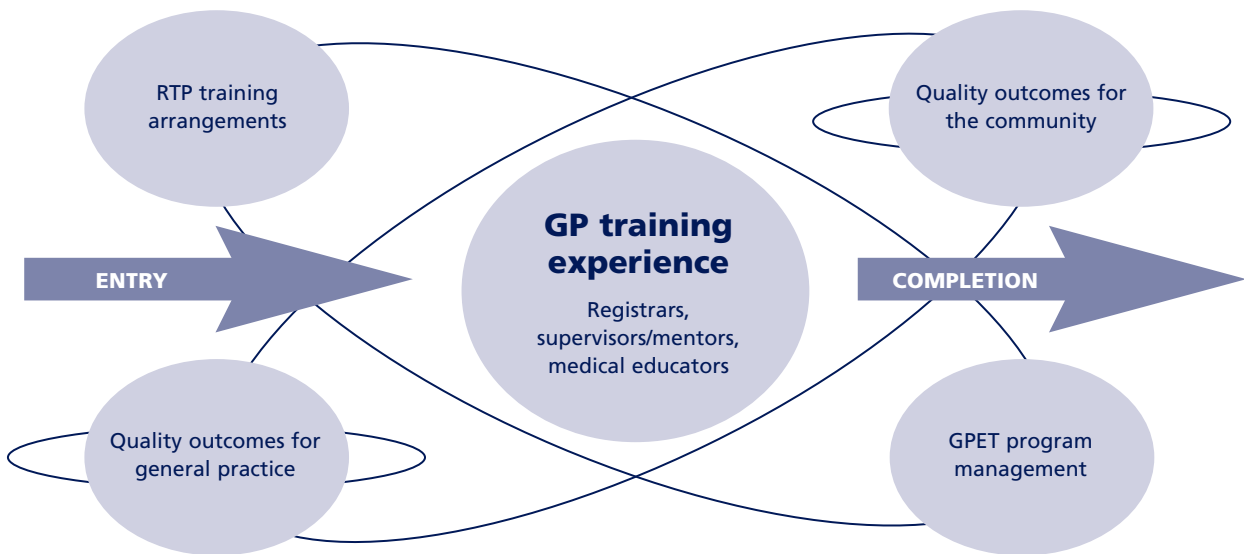


Figure 12. The General Practice and Education Training Quality Framework

This model identifies four domains of quality as: the training experience, policy outcomes, strategic leadership and program management. This model explicitly acknowledges the need to integrate with the wider community.

Quality is defined broadly as comprising compliance, assurance, organisational performance, capability of business processes, performance of management systems, continuous improvement and innovation, and client and stakeholder focus.

3.3.3 Australian College of Rural and Remote Medicine

The ACRRM Quality Framework is predicated on ‘the emergence of rural and remote medicine as a distinct discipline, the need for well designed vocational preparation and continuing medical education for rural doctors (and) the need to address the shortage of rural and remote doctors in Australia by providing them with a separate and distinctive professional body.’⁶⁷ The framework has five levels: medical student, two postgraduate years, Fellow of ACRRM (Assoc), full FACRRM, and continuing professional development.

Each level is represented by a defined set of learning outcomes. Achievement of the outcomes provides the means for certification at each level (Figure 13).

						Continuing professional PDP
						FACRRM (Full)
						FACRRM (Assoc) – VR
						PGY ₁ and Y ₂
						Medical student
Domain 1 CCS	Domain 2 AH	Domain 3 PH	Domain 4 EC	Domain 5 ECP	Domain 6 PEP	

Figure 13. The Australian College of Rural and Remote Medicine Quality Framework

3.3.4 Australian Divisions of General Practice

The Australian Divisions of General Practice (ADGP), one of the initial pillars of a quality framework for general practice, is currently developing a quality framework.

In summary the ADGP Quality Framework will:

- be a tool for systematic analysis of current quality in the health service environment and support visibility, transparency, understanding and confidence in service structures
- have an interface with the broader community
- incorporate the Institute of Management's six dimensions of quality (*Table 8*)
- contain principles, strategies and concepts. Principles include patient centredness, equity, multi level activity, and the adoption of best practice clinical evidence. Concepts include dynamic interactivity, leadership, communication and culture. Strategies include guidelines, accreditation, ongoing professional development, measurement, standards, and management of risk, competencies and skill review.

Table 8. The six dimensions of quality⁶⁵

Safe – avoiding injuries to patients from the care that is intended to help them

Effective – providing services based on scientific knowledge to all who could benefit and retaining from providing services to those not likely to benefit (avoiding under use and overuse, respectively)

Patient-centred – providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions

Timely – reducing waits and sometimes harmful delays for both those who receive and those who give care

Efficient – avoiding waste, including waste of equipment, supplies, ideas and energy

Equitable – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socioeconomic status

Barriers that affect quality in general practice

This section outlines the challenges faced by Australian general practice. These challenges will need to be considered in the development of a general practice quality framework.

There is a range of factors that impact on general practice capacity to provide consistent high quality care in Australian general practice. These include:

- an explosion of medical knowledge, without a consequently maturing of systems to translate that knowledge into a form that can be readily accessed by GPs has resulted in a gap between current practice and best practice care
- the limited alignment between the financing of general practice and the provision of quality care. The volume finance model rewarding throughput. Quality initiatives tend to be nonvolume payments that require specific administrative and management strategies
- the aging Australian population requires differing health care. For general practice this changed demand manifests in increased need for continuing and integrated care to service chronic conditions. This is exacerbated by policy that seeks to treat people in the community rather than in institutions and that encourages community based care
- a culture of general practice that contains remnants of blame and competitiveness
- changing aspirations of the GP workforce without changing business and delivery systems
- limited investment in infrastructure and business capacity
- a health care delivery system unable to capitalise on information management across sectors and has created fragmentation, duplication of services, and limited agreement on recording and measurement of data
- workforce shortages in some areas of Australia. There are limited GPs, nursing and allied health staff in some areas. Training is limited, which has contributed to pressure on individual practitioners and growing waiting lists for services. Morale is low.
- fear of litigation.^{16,65,68,69}

Quality general practitioners

In Australia, GPs largely undertake independent, unsupervised, general practice with continuity of care being an essential element of practice. The provision of quality GPs is dependent upon education and training with these in turn being built upon professional standards and assessment, and the provision of a workforce to meet the needs of the community. This section examines the systems, processes and key stakeholders that are involved in the provision of quality education and training in Australian general practice. It also examines workforce issues that influence quality care at the individual practitioner level.

5.1 Routes to Fellowship of the RACGP

There are several routes through education and training for doctors entering unsupervised general practice. Ensuring quality GPs requires attention to both training methods and final assessment that meet the needs of the profession, community and the individual doctor.

This process must strive to:

- ensure the standards of general practice are met by all doctors entering general practice, regardless of origin of primary medical degree or route of entry
- ensure all doctors are encouraged and supported to become vocationally registered
- provide rigorous methods of assessment which are in line with current recommended methods of assessment for clinicians and are responsive to the realities of busy experienced GPs.⁷⁰

Members and associates of the RACGP who have demonstrated satisfactory training, met general practice experience and undertaken assessment requirements are awarded Fellowship of the college. Fellowship is accepted as the standard of competence for unsupervised general practice in Australia. It also leads to GP recognition status with the Health Insurance Commission (HIC). Conferring Fellowship, and ensuring the quality of the various pathways that lead to Fellowship, is core business for the college. Currently, there are a number of routes leading to Fellowship of the Royal Australian College of General Practitioners (FRACGP). These are represented in *Figure 14*. In brief, these are:

- the Vocational Training Program route, via structured specialist education and training of general practice registrars. This is the largest route, undertaken by 450 registrars each year
- the Practice Eligible Route, comprising general practice experience and college summative assessment. There is no special educational component with this route, which is currently chosen by approximately 250 GPs a year
- the alternative pathway, comprising a college approved education program, general practice experience and college summative assessment. This new route is currently chosen by only a handful of GPs but once fully operational could attract approximately 100 GPs a year
- Fellowship *ad eundem gradum*, and Fellowship via reciprocity. These routes are taken by approximately 100 GPs each year
- Fellowship via a conjoint examination. Fellowship of the RACGP is a benefit of conjoint examinations with Malaysia and Hong Kong and is awarded to approximately 30 GPs a year.

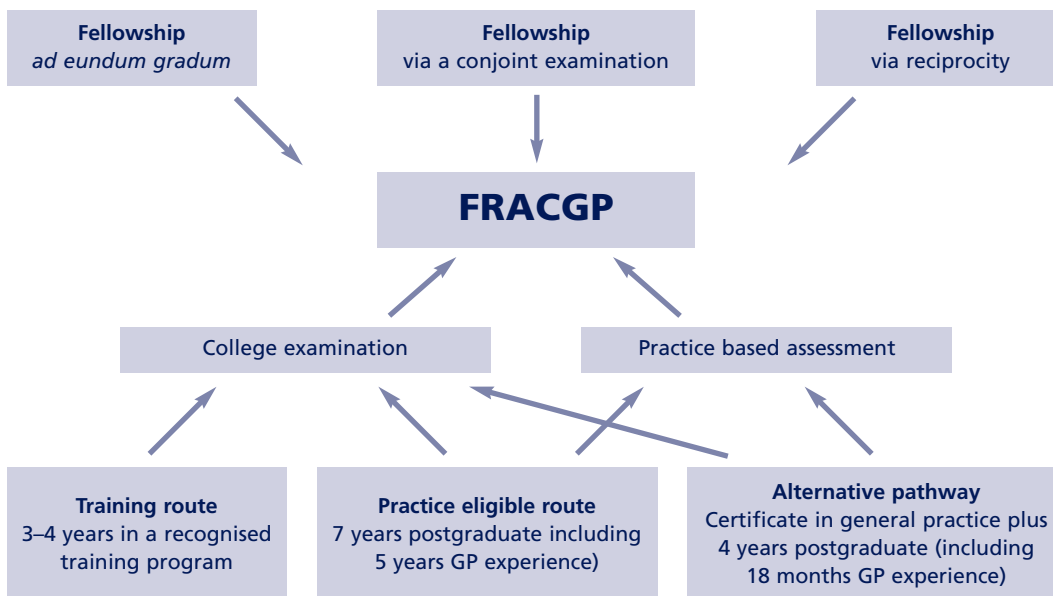


Figure 14. Routes to Fellowship of the RACGP

5.2 Routes to Fellowship of the ACRRM

The ACRRM Fellowship is conferred to rural medical practitioners who meet the ACRRM's standards for rural practice. Medical practitioners are required to maintain the qualification by participating in professional development programs that are relevant and accredited for rural practice. At the time of writing, the only mechanism for attaining an unrestricted provider number under the Medicare system in Australia is the RACGP certification process. Participants in the ACCRM Vocational Preparation Program must therefore also satisfactorily complete the requirements of the Australian general practice training pathway including the attainment of Fellowship of the RACGP. In a similar model to the RACGP, ACRRM candidates have three routes to Fellowship. They are:

- the vocational training pathway, a model that operates within the regional training provider environment auspiced by GPET. It provides ACRRM accredited regional training providers with the opportunity to incorporate the ACRRM's requirements within their training arrangements
- the independent pathway, registrars who are training within a rural region or regional training program which has not formally sought accreditation by ACRRM and/or ACRRM registrars who do not seek the current general practice vocational registration certificate may undertake their training towards Fellowship by applying directly to ACRRM for admission to their independent pathway
- the remote vocational training pathway is run cooperatively with the RACGP. It provides vocational training for isolated rural medical practitioners who under ordinary circumstances could not complete this except by leaving their communities. It is almost entirely delivered by distance education and supervision. Successful completion qualifies participants for award of the Fellowship of ACRRM and eligibility to sit the RACGP Fellowship exam.

5.3 Vocational training

The pathway to general practice begins with the successful completion of a 4–6 year medical degree and assessment of an individual's aptitude for the vocation. The selection of Australian medical students based on academic merit ensures a high standard entry of scholars into medicine and differs from other countries where full fee paying students can access tertiary placements. In Australia, only a limited number of places are available for full fee paying overseas students. These students may enrol in an Australian medical school on the understanding that they may not practise here after graduation and/or an intern year in a teaching hospital.⁷¹

It has long been recognised; however, that undergraduate medical education does not prepare graduates for unsupervised general practice.⁷² This is because of differences in clinical context, process of care and context of care. The specific content and the process of general practice care are taught during the postgraduate years. Vocational training for general practice in Australia involves a period of hospital training in a range of medical disciplines, combined with supervised experience in general practice. The duration of the program varies but is usually 2–3 years (Figure 15).

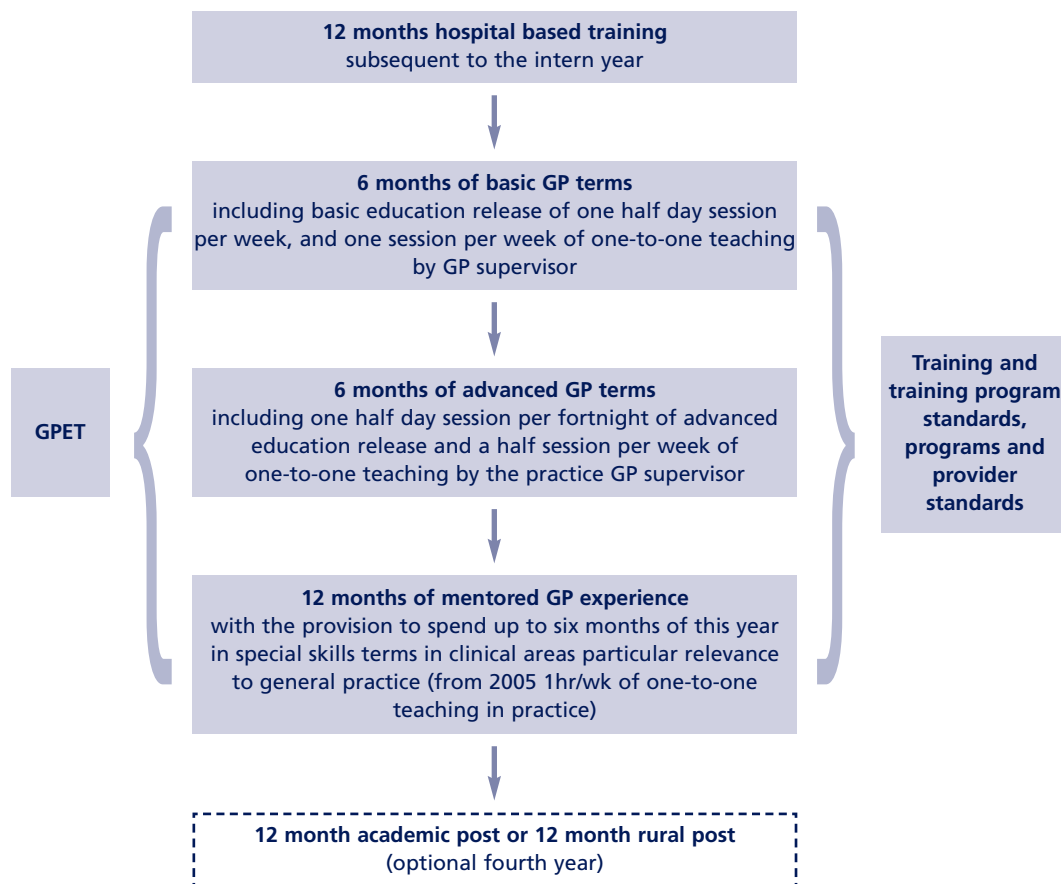


Figure 15. Vocational training in Australian general practice

Vocational training in general practice began in Australia in 1973, under the auspices of the RACGP. The program was based on adult education principles, and over time developed a defined curriculum and endpoint examination that certified competence. The curriculum framework is based on patient presentations, national health priorities, curriculum statements relating to particular population groups, aspects of general practice or new issues of national significance, and the five domains of general practice, which are:

- communication skills and the patient-doctor relationship
- applied professional knowledge and skills
- population health and the context of general practice
- professional and ethical role, and
- organisational and legal dimension.

Until 1993, the program was known as the Family Medicine Program and was initially a voluntary scheme. In 2001, General Practice Education and Training (GPET) was incorporated by the Commonwealth Government to manage the new system of general practice education and training across Australia. The Commonwealth introduced the new arrangements to better coordinate GP education and training, promote localised delivery of education and training, re-order funding priorities towards community based education in rural and remote Australia, and promote innovation. From January 2002 GPET has assumed the administrative, funding distribution and policy responsibility for GP training.

Regional training providers undertake the actual delivery of vocational training to registrars. The regional training providers are commonly a consortium of GP groups, universities and sometimes members of the community. Funding for GP training is allocated on behalf of the Commonwealth by GPET to providers under contract. Regional training providers (often referred to as a consortia) are selected by GPET following a tender process. In 2002, GPET approved and funded 15 regional training providers. In 2003, this number increased to 22. As the system matures, competition will be encouraged between providers for registrars. Regional training providers are required to participate in monitoring, accreditation, review, evaluation and reporting processes implemented and overseen by GPET, and to deliver general practice training and education in accordance with standards set by the RACGP.⁷³

General Practice Education and Training's interest in quality extends to the performance of regional training providers, the integration of professional and other standards, policy outcomes for the wider community and GPET's own internal program management.⁶⁶ The organisation interprets the term 'quality' to embrace a variety of concepts including:

- compliance (eg. with standards, contracts)
- assurance (eg. to external stakeholders)
- organisational performance (eg. against specific quality objectives)
- capability of business process (eg. cycle times, error rates, amount of rework)
- performance of management systems (eg. clarity of directions, achievement of objectives)
- continuous improvement and innovation (eg. integrated improvement cycles, realisation of planned improvements), and
- client and stakeholder focus (eg. needs understood, satisfaction, and policy outcomes).⁶⁶

5.3.1 The Rural Training Scheme

The Australian Government has prescribed two pathways in the general practice training program, with financial incentives to registrars who join the rural pathway. The Rural Training Scheme commenced in 1993 and is a distinct track with additional requirements to the usual training program which include:

- selection into the Rural Training Stream by interview with a panel comprising training program, rural health training unit and rural faculty representatives
- hospital terms to be ideally undertaken in regional hospitals
- general practice terms in rural practices (at least 50% is mandatory)
- a total of at least 12 months of general practice training in rural practices
- training advisers who are rural doctors
- rural components coordinated by rural health training units in regional areas, and
- an additional year of advanced rural skills posts (ARSPs).

In return, rural general practice registrars are eligible to receive the RACGP Graduate Diploma Rural General Practice and become Fellows of the college.

5.3.2 Research in training

It is well recognised that research plays a major role in the provision of quality care in general practice and a number of initiatives are in place to provide education and training for GPs interested in research. In the current setting, general practice registrars have the option of undertaking academic training as part of a 6 month special skills post located at a university department of general practice across Australia. General practice registrars also have the option of undertaking a fourth year of training (post Fellowship) as an academic registrar post. The Registrar Scholarship and Research Fund provides registrars with an opportunity to conduct a 12 month supervised research project. There are a number of research grants, scholarships and fellowship available from the RACGP and various state and territory based primary health care research evaluation and development programs that also encourage the capacity of GPs to conduct research.

5.3.3 ACRRM general practice education and training

The Australian College of Rural and Remote Medicine (ACRRM) asserts that it is the professional organisation for rural medical education and training in Australia. The ACRRM's core function is to determine and uphold the standards that define and govern competent, unsupervised rural and remote medical practice.

The ACRRM also has a set of standards that define learning outcomes. It also has operating principles, policies, procedures and administrative mechanisms to ensure that ACRRM accredited training posts and providers are supported to provide quality training against ACRRM standards. These standards are documented in:

- *Primary curriculum for rural and remote medicine*, 2nd edition and *Vocational training handbook*
- The ACRRM *Standards for accreditation of training (hospital and community posts) and supervisors*
- The ACRRM *Standards for accreditation of regional training providers*, and programs

5.4 Ensuring the quality of vocational training

The RACGP, like other colleges, has traditionally set policy and standards for the entire education process in addition to delivering GP training directly; assessing registrars at the end of their training and conferring Fellowship to those who qualify. Within the context of the delivery of vocational training by GPET, the role of the RACGP in assuring the quality of the next generation of GPs must remain central. The RACGP believes that there are three critical points that need to be assured in the vocational training cycle to maintain quality and safety outcomes. They are (Figure 16):

- vocational training standards that guide selection of registrars and represent an agreed end point for GP education. They are coupled with a curriculum framework which guides training delivery by regional training providers
- a robust accreditation process that requires providers, practices, supervisors and posts to meet quality standards, and
- contemporary evidence based assessment and/or examination processes that test against the vocational standards and result in competent GPs able to practice unsupervised anywhere in Australia.

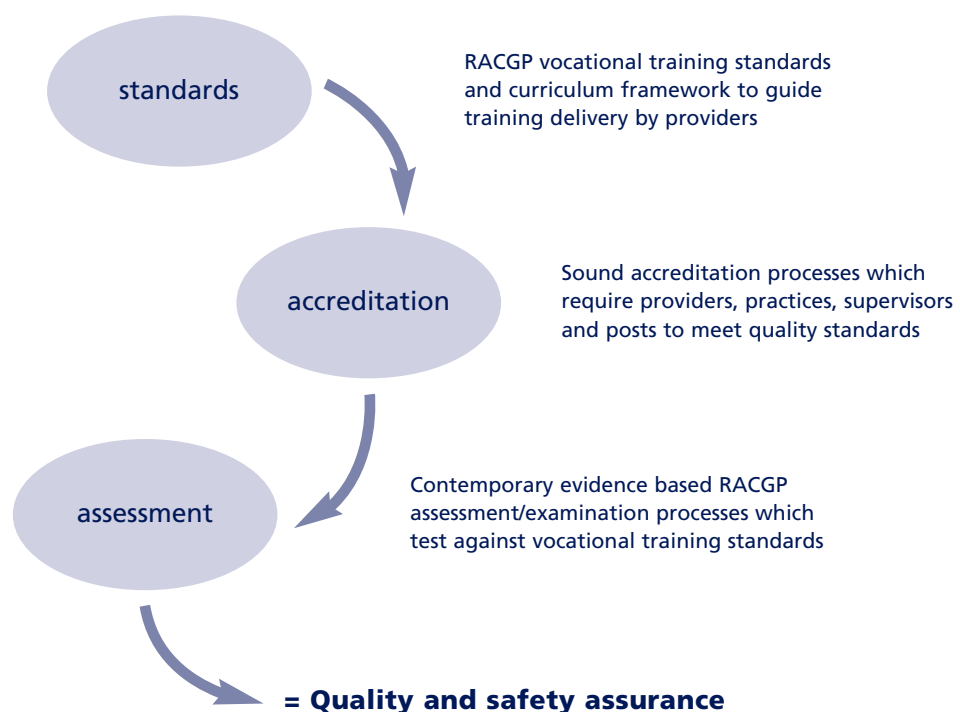


Figure 16. Critical points for assurance for vocational training route to RACGP Fellowship

The RACGP has been developing standards designed more specifically for the 'new' general practice training environment. These will come into effect in 2005. Two sets of standards have been approved – *Standards for general practice education and training: programs and providers 2005* and *Standards for general practice education and training: trainers and training posts 2005*.

The Standards for general practice education and training: programs and providers 2005 outlines the standards required of general practice education and training programs and their providers in order to be accredited by the RACGP. The college ensures that the standards are met through a regular accreditation visit and monitoring of the program delivery. The aim is to have a uniform standard of general practice training across the country that can ensure that general practice registrars are equipped and motivated for a career as a GP. The Standards address requirements under five headings:

- education and training programs
- education and training providers
- selection and enrolment
- support for registrars, and
- support for trainers.

The Standards for general practice education and training: trainers and training posts 2005 outlines the standards required of trainers and training posts providing general practice education and training, in order to be accredited by the RACGP. The standard of general practice trainers is exceptionally important in ensuring high quality training for unsupervised general practice. The college ensures that the standards are met through a regular accreditation visit and monitoring of delivery of training in the training posts. The aim is to have a uniform standard of general practice training across the country that is adequate to ensure that general practice registrars are equipped and motivated for a career as a GP. The Standards address requirements under five headings:

- general practice trainers
- general practice or primary care facility
- monitoring and feedback
- hospital training posts, and
- extended and advanced skills training posts.

5.5 Vocational registration

In 1989 the Australian Government introduced vocational registration of GPs to raise the standards and quality of care in general practice. Vocationally registered GPs are eligible for a higher rate of Medicare benefits than those of nonregistered GPs. In addition, restrictions were introduced that required new registrations of GPs to have formal qualifications. All vocationally registered GPs are required to participate in ongoing quality assurance and continuing professional development to maintain their registration. This process established general practice as a speciality in its own right, and removed the capacity of doctors to become GPs without specific training.

For those who do not already have 5 years general practice experience, the requirements for vocational registration are:

- the completion of a formal general practice training program
- attainment of Fellowship of the RACGP by examination, and
- demonstration of ongoing involvement in continuing education and quality assurance activities.⁷¹

In addition, provision was made through the introduction of a 'grandfather clause' that allowed vocational registration for GPs who were 'first recognised as medical practitioners before 1 November 1996' and who have practised predominantly in general practice for a total of 5 years or more.

According to the Medicare Benefits Schedule, for a GP to become vocationally registered they must obtain certification from either:

- the RACGP
- a General Practice Recognition Eligibility Committee, or
- the General Practice Recognition Appeal Committee.

The certification must state that the practitioner's medical practice is, or will be within 28 days, predominantly general practice and that the RACGP or the Eligibility Committee has certified that the practitioner is a Fellow of the RACGP. The RACGP must certify that the practitioner meets the minimum requirements for taking part in continuing medical education and quality assurance programs.⁷⁴

An individual GP's vocational registration can be revoked by the HIC if the RACGP, in accordance with section 3G of the *Health Insurance Act 1973* and regulation 6, notify the HIC of GPs who have not completed the minimum triennium requirements of the QA&CPD Program.

5.6 Continuing professional development

There are currently two general practice organisations that deliver continuing professional development programs for Australian GPs – the RACGP and ACRRM. This section will focus specifically on the RACGP program.

Since its inception, the RACGP has placed great importance on providing support to GPs to allow them to develop and maintain their clinical knowledge and skills. In 1987, the college introduced the RACGP Quality Assurance program for its fellows and members. The program was expanded significantly in 1989 when amendments to Commonwealth legislation required all 'vocationally registered' GPs to participate in the RACGP Quality Assurance and Continuing Medical Education (QA&CME) Program. Today, the RACGP Quality Assurance and Continuing Professional Development (QA&CPD) has around 22 000 participants of which 17 000 are recognised GPs, for whom participation in the program is required to maintain recognition by the HIC.

The RACGP QA&CPD operates on a points system. In this system, GPs are required to accrue points for participating in specific educational activities over a 3 year period. The Australian Medical Council (AMC) accredits the program. It is accepted as a quality program by other medical colleges in both Australia and New Zealand. The program provides reciprocal arrangements with the Hong Kong College of Family Physicians and has an agreement with the Royal New Zealand College of General Practitioners, and operates within a quality system.

The RACGP has established a number of measures to ensure and maintain the quality of the QA&CPD Program. These include:

- oversight and governance by the RACGP National Standing Committee for Education
- defined program aims and objectives
- provision of a structured program of clearly developed modules and defined education activities grounded in evidence
- standards for adjudication based on evidence of good practice
- policies, procedures and resources (including state based staff) to support the program
- auditing of adjudication decision and activities
- review of providers of education activities
- review of CPD activities, and
- continuous evaluation of the program.

5.7 International medical graduates

International medical graduates (IMGs) have been recruited to Australia to work in rural and regional areas of Australia that are facing workforce shortages. These IMGs may be permanent residents who are overseas trained doctors and who have undertaken AMC accreditation and/or assessment, or they may be temporary resident overseas trained doctors who have undertaken no formal assessment process before entering Australian general practice. A summary of the quality measures and gaps for overseas trained doctors working in unsupervised Australian general practice is illustrated below.

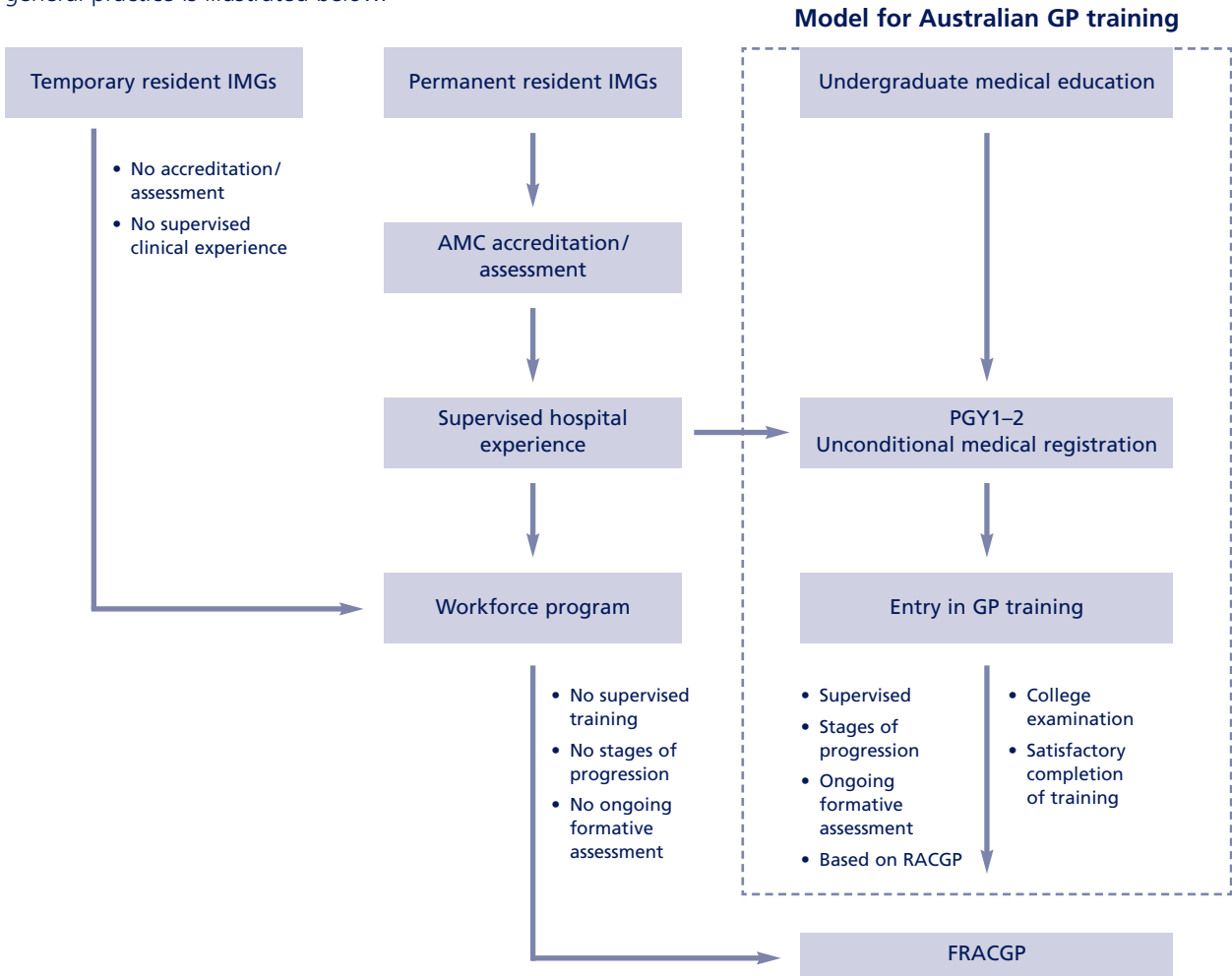


Figure 17. A summary of the quality measures and gaps for overseas trained doctors working in unsupervised Australian general practice⁷⁵

In the current environment, IMGs that travel to Australia to work in unsupervised general practice do not undertake any formal type of assessment to determine their ability to practice in Australia before they arrive. Upon arrival, some overseas trained doctors move through the two stages of assessment conducted by the AMC. It should be noted that this assessment does not cover the competency of these IMGs to work in unsupervised general practice. Those that do not move through the AMC assessment process, or are currently undergoing the process are often appointed to GP positions in rural and regional areas of Australia, despite not being obliged to participate in continuing professional development or a Fellowship preparation activity. Despite the introduction of bridging programs to support IMGs, these are only available on a user pays basis.⁷⁶

State medical boards use various assessment tools and grant conditional registration to doctors. In some cases the assessment tools are loose. Yet registration remains the critical entry point to medical practice in Australia and the criteria for registration varies considerably from state to state. For doctors on a temporary resident visas working in Australian general practice there are often no entry standards at a level acceptable to the RACGP, including no formal requirement to pass the AMC examination.⁷⁶

5.8 Workforce factors

A consultation with a small group of GPs interested in improving quality in general practice was held in August 2004. The following were some of the factors identified as impacting on the quality of care GPs are able to provide to their patients:

- fee-for-service payments seen as a disincentive for having longer consultations with patients
- no formal structure for building in leave (GPs can be left feeling 'tired and stressed').

From these, it would appear that the funding of general practice and the availability of additional doctors to share the load (ie. workforce issues) are important factors that affect the quality of care patients receive.

According to *General practice in Australia: 2000*,⁷¹ the major workforce factors that impact on the structural organisation of GPs are a slowing growth in GP numbers, the distribution of practitioners between urban and rural areas and the feminisation of the workforce.

In 1999, the Australian Institute of Health and Welfare analysed the Australian medical workforce and found that growth in the general practice workforce had slowed. This was mainly as a result of general practice training intake being held constant at 400 per year (from 1994) and restrictions (since 1996) on new graduates and temporary resident overseas trained doctors gaining access to Medicare provider numbers. Between 1994 and 1997, the general practice workforce was estimated to have increased by 6.2% while the population of Australia increased by 3.7%.⁷⁷

One of the major problems facing Australian general practice is the distribution of doctors. With a changing culture in rural general practice, Strasser et al 1999 showed that women and younger rural doctors rate practice style and lifestyle issues (eg. hours of work, being able to take on public health promotion) as being significantly more important than their older and male colleagues.⁷⁸ This demonstrates that conventional rural general practice, which involves long hours on call and an emphasis on hospital based procedures, will not necessarily be attractive to recent graduates and female doctors.

Finally, the increasing number of women entering the general practice workforce is expected to have an effect on the future structure of general practice in Australia. Women tend to have fewer patient encounters each week, accept longer consultations and deal with more clinical problems in a single encounter than male GPs.⁷⁹ In addition, female GPs appear to find participation in after hours and on call arrangements less acceptable. This could be due to concerns about personal safety and/or child care responsibilities.

The compounding effect of these factors has resulted in a changing general practitioner workforce, which is being faced with an ever increasing demand on time and service delivery. The Australian Government funded 13 rural health initiatives under the Rural Health Strategy: More Doctors, Better Services Program. The aim of the program is to redress the imbalance between rural and city health by working to enhance rural health education and training, increase workforce support for health professionals, and provide better services for rural Australia.

However, with the number of Australian funded medical school student places decreasing from 1310 in 1995 to 1240 in 1999, the concern regarding the strains on the general practice workforce continue to grow.⁷¹ In 1999, an initiative to address this workforce problem saw the introduction of 100 additional places in Australian medical schools for overseas trained doctors. This initiative provided an alternative option to the AMC licensing examination for overseas medical graduates who agreed to provide 5 years of rural service in Australia. These graduates still needed to complete an internship to obtain general registration but could then apply for a general practice training program.

Quality general practices

The RACGP defines a general practice as:

“A service that provides initial, continuing, comprehensive and coordinated medical care for individuals, families, communities and which integrates biomedical, psychological, social and environmental understanding of health.”⁸⁰

This section describes the key quality initiatives that exist in Australia to support and ensure general practices are able to support the provision of quality health care. These initiatives include:

- standards and practice accreditation for general practices
- standards for medical deputising services
- the role of general practice nurses
- the role of practice managers, and
- information management and information technology.

6.1 Standards and accreditation for general practices

In 1991, the RACGP, with support from the AMA and the Australian Government, commenced work on the development of a set of national entry standards for general practices. The aim was to engage the profession in a comprehensive process of continuous quality improvement. The *Standards for general practices* and practice accreditation were developed to provide:

“An independent and voluntary system of practice accreditation to be developed to enhance the delivery of services and facilities by general practices through a process of continuous quality improvement.”

After 3 years of drafts and extensive consultations, the Standards Reference Group conducted a national field test in 1994, involving 199 randomly selected practices and over 700 GPs. The aim of the field test was to test the applicability and validity of the standards. The field tests achieved their aims and demonstrated that the standards were valid, reliable, acceptable and achievable. These results were further confirmed through a program of demonstration trials, conducted by the Commonwealth through divisions of general practice.

The RACGP *Standards for general practices* were published in 1996 and sent to all general practices in Australia. The conclusions about the implementation of these *Standards* and the process for assessment were used to design the basis of a system of practice accreditation, which was established through Australian General Practice Accreditation Limited (AGPAL) from 1997. Using further research and feedback on accreditation from AGPAL, the *Standards* were revised in 1999, and the 2nd edition released in August 2000.

Since the last edition of *Standards* was published in 2000, there has been a rapid growth in the literature surrounding quality improvement. A significant development since publication of *Standards for general practices* 2nd edition has been the maturing of the accreditation process – with two organisations now providing services to general practices that seek accreditation against the RACGP’s *Standards*.

The college’s *Standards for general practices* 3rd edition was launched in July 2005. The third edition incorporates a focus on standards for after hours primary medical care, and standards for information technology in general practice. A diverse group of stakeholders informed the revised edition of *Standards*. The college has sought to understand the barriers some practices (eg. some Aboriginal Community Controlled Health Services) have in meeting the college’s *Standards* (and therefore to being accredited). The college has also tried to ensure that the *Standards* have been revised in a way that allows all general practices to have sufficient quality to become accredited.

6.2 Practice accreditation

Currently there are two organisations within Australia that are responsible for the accreditation of general practices, Australian General Practice Accreditation Limited (AGPAL) and Quality Practice Accreditation (QPA).

Practice accreditation against the RACGP *Standards* is conducted by peers during a practice visit and should:

- aim to attain the highest quality of general practice in an achievable and gradual manner
- provide a publicly recognised measure of quality in general practice
- be voluntary, but should have tangible benefits
- be for a defined period
- be an educational and developmental process and not a punitive one
- be in the hands of the profession.⁸¹

Practice accreditation is voluntary, however it provides a number of benefits to the practice including:

- a practice system driven by efficiencies, minimal risk and geared towards best practice
- access to the Commonwealth's Practice Incentives Program (PIP)
- recognition by the RACGP QA&CPD Program.

6.2.1 Australian General Practice Accreditation Limited

In 1996, the Presidential Task Force on Standards and Accreditation signed an agreement that led to the established of AGPAL. Australian General Practice Accreditation Limited is a GP managed and operated national accreditation body offering peer review to assess general practices against the RACGP Standards for General Practices. Over 80% of Australia's general practices are accredited with AGPAL.⁸² At July 2005, AGPAL had 4750 practices registered or accredited.

Representatives from the Australian Association of General Practitioners (AAGP), Australian Association of Practice Managers (AAPM), ACRRM, ADGP, the AMA, the National Association of Medical Deputising Australian Limited (NAMDS), the RACGP and the Rural Doctors Association of Australia (RDAA), govern AGPAL. The Consumers' Health Forum also has nominees to the Board of Directors. Practice accreditation with AGPAL involves a 3 year cycle whereby practices:

- receive registration for 12 months to perform a self assessment against the RACGP *Standards for general practices*
- undergo a survey visit facilitated by two GP surveyors who report on the visit
- receive documentary validation and recognition as an accredited general practice on achievement of AGPAL accreditation
- commence a continuous quality improvement cycle towards best practice.

AGPAL has independent accreditation from the International Society for Quality in Healthcare (ISQUA), an international accrediting body which assesses national accreditation bodies against international best practice standards.

6.2.2 Quality Practice Accreditation

Quality Practice Accreditation (QPA) was established in 1999 as an independent company to provide certification, practice development and education and training services to Australian general practices. Practice accreditation with QPA involves participation in the GPA ACCREDITATION *plus* program. This program has been accredited by the Joint Accreditation System of Australia and New Zealand (JAS-ANZ), an independent accreditation body for accreditation/certification organisations. GPA ACCREDITATION *plus* offers general practices:

- a modular program
- a dedicated client manager to support the practice
- feedback and evaluation prior to the survey visit
- independent accreditation by JAS-ANZ to guidelines specifically developed for general practice accreditation organisations.

At the end of the first accreditation cycle in 2002, QPA had 500 practices registered or accredited.⁸³

6.3 Standards for medical deputising services

The Australian Government established the Approved Medical Deputising Service (AMDS) program under section 3GA of the *Health Insurance Act 1973*. The purpose of the program is to expand the pool of available medical practitioners who may provide after hours home visit or 'after hours only' clinic based services. The services must be provided in an accredited 'after hours only' clinic, by allowing otherwise ineligible medical practitioners to provide a restricted range of professional services for which Medicare benefits will be payable if those practitioners work for an approved deputising service.⁸⁴

This program enables medical practitioners who are permanent residents or Australian citizens and do not have recognised postgraduate qualifications to obtain a provider number, and to provide after hours services. Placements for medical practitioners recruited by a deputising service are for a maximum of 12 months. Practitioners must hold medical registration in the state or territory of practise, have a minimum of 2 years postgraduate medical experience and hold an appropriate membership of a medical defence organisation approved by the service provider.

In order to be classified as an 'after hours only' clinic, the clinic must be accredited against the RACGP's standards for medical deputising services. Service providers need to demonstrate that minimum standards for clinical supervision and support are provided for doctors participating in the program. The RACGP developed the standards for the provision of after hours primary medical care in general practice (*Table 9*) according to three basic principles:

- all Australians should have access to appropriate medical care at all times
- the provision of primary medical care after hours should complement routine general practice and reflect the principles of a primary health care approach
- arrangements for after hour's primary medical care should reflect appropriate occupational health and safety practices, including safe working hours and physical security of medical practitioners, patients and staff.

Table 9. The RACGP standards for the provision of after hours primary medical care in general practice

Position of the RACGP

The RACGP considers that:

While no individual GP can be available to patients at all times, all general practices are responsible for ensuring that reasonable arrangements are made for access to appropriate care for their patients at all times. A range of acceptable after hours primary medical care arrangements can be provided by general practices. Explicit advice should be provided to patients concerning the practice arrangements in place for provision of after hours primary medical care.

All medical practitioners providing after hours primary medical care should be recognised GPs. In some areas it may be impossible to recruit recognised GPs. In such circumstances, after hours care doctors who are not recognised GPs should have a minimum of 2 years postgraduate experience, which should include 3 months in accident and emergency, as per the RACGP *Standards for medical deputising services*.

Those providing after hours primary medical care should ensure that a record of such contact is sent to the relevant general practice the next working day.

The RACGP supports the provision of telephone based triage services to direct patients to the service most appropriate to their medical need. The RACGP *Operating guidelines for community access triage service* provides guidance on the operation of such services.

The environment in which after hours primary medical care is provided should ensure the safety and physical security of the general practitioner, the patient and staff.

After hours primary medical care in general practice should be provided in a financially sustainable manner.

Recommendations to general practitioners

Individual GPs should:

Ensure that they are aware of the arrangements made by their practice for after hours care and participate, to the maximum extent possible, in ensuring that such arrangements meet the standards set by the RACGP *Standards for general practices*, including communication of the arrangements to patients.

6.4 The role of general practice nurses

General practice nurses can contribute to the quality and delivery of health care in general practice by undertaking a number of functions including:

- clinical nursing services
- coordination of patient services
- management of the clinical environment by assisting the practice to meet relevant standards and legislative requirements
- health promotion and educational activities
- management of human and material resources
- management of health through immunisation, recall systems and acute and chronic disease management.

In 2003, the Commonwealth Department of Health and Ageing funded the RACGP/RCNA Nursing in General Practice Project, conducted by the RACGP and Royal College of Nursing, Australia (RCNA).⁸⁵ The purpose of the project was to explore the current and future roles of nurses in general practice, the educational needs of nurses and GPs and the current educational programs available to support the role of nurses in general practice in Australia. The project found that the typical general practice nurse in Australia:

- is a registered nurse
- works on a part time basis
- works in a medium to large practice with two or more GPs
- works with at least one other enrolled or registered nurse
- has worked in general practice nursing for less than 5 full time years

- has little postbasic formal education and this education is unlikely to be general practice specific
- has received professional development training on issues that are directly related to general practice nursing.

Australian general practice nurses currently have four major responsibilities within the practice. These are:

- clinical care – reflects the nurse’s responsibility to undertake clinical based procedures and activities
- clinical organisation – reflects the responsibility to undertake activities that require management, coordination and higher level administration of clinical activities, particularly a systems approach
- practice administration – reflects the responsibility to undertake activities that provide administrative support to the general practice as a business enterprise
- integration – reflects the responsibility to develop effective communication channels within the practice and between the practice and outside organisations and individuals.

General practice nursing has the potential to contribute to the enhancement of primary health care in Australian general practice. The study made a number of short and long term recommendations, which ultimately focused on the continued sustainability of the general practice nurse as a career choice and as a valuable continuing and future resource for general practice in Australia.

6.4.1 The Australian Practice Nurse Association

The Australian Practice Nurses Association (APNA) is the professional association run by practice nurses for practice nurses. It provides representation, support and networking for practice nurses at national, state and local levels.

6.5 The role of practice managers

Practice managers play a major role in influencing the delivery of quality health services in today’s general practice and are represented on a number of committees that influence quality care in general practice including the RACGP’s Standards Committee and Quality in General Practice Committee. Throughout the years, general practice has witnessed a number of changes in technology, industrial relations, economic circumstances, delivery alternatives and government legislation. The role of the practice manager is to manage the ‘business’ of general practice enabling the GP to focus on the provision of quality care to patients.

6.5.1 The Australian Association of Practice Managers

The Australian Association of Practice Managers (AAPM) was founded in 1979 and is recognised as the professional body dedicated to supporting effective practice management in the health care profession. The AAPM:

- represents and unites practice managers and the profession of practice management throughout the health care industry
- promotes professional development and the code of ethics through leadership and education
- provides specialised services and networks to support quality practice management.

The AAPM contributes to quality in general practices through the provision of a Practice Manager Development Program that provides nationally accredited vocational qualifications in health care practice management. The AAPM Professional Development Program consists of a suite of qualifications that include:

- Certificate III in Business (Office Administration) – Medical Receptionist Course
- Certificate IV in Practice Management
- Diploma of Practice Management.

In addition, the AAPM provides a formal pathway to Fellowship that begins as an Associate Fellow and works through a vocationally based program that includes:

- qualifications
- continuing professional development points requirement
- professional paper or case studies
- oral and multiple-choice examination.

6.6 Information management and information technology

As stated in the report of the General Practice Strategy Review Group, good information management and communication are believed to be central to enhancing the quality of the care delivered by GPs. While sophisticated information technology is seen as having enormous potential to assist GPs in this regard, the report noted that in 1998 less than 10% of Australian GPs were using computers for clinical applications. Finding ways to promote the rapid adoption of information technology to improve information management is seen by many as the single most important step that could be taken to enhance the quality of general practice. The report identifies potential areas of benefit to patients and providers. For example, management of screening and other preventive health activities; reminder systems; patient education; record management; data collection and analysis; and practice business management.⁷¹

As clinical computer use in general practice becomes more widespread, evidence of the quality benefits is being accumulated. Computerised prescription software packages are now being used widely in Australian general practice and have the potential to improve the quality use of medicines through providing the GP with information about medications, access to clinical guidelines and warnings about potential contraindications, adverse reactions and allergies. Prescriptions are legible and accurate and allow audits of prescribing for individual patients and the practitioner's patient population. Individualised consumer medicine information can be produced at the time a prescription is generated.⁷¹

In 1996, the Australian Health Ministers Advisory Council (AHMAC) Taskforce on Quality in Australian Health Care examined the role of information technology in quality health care. This report included the recommendation that information is central to improving health care safety and quality. The report advocated routine feedback systems to inform health care workers of the outcomes of their care and to provide information to health care policy makers and consumers to drive necessary changes in the health system.

6.6.1 The General Practice Computing Group

The General Practice Computing Group (GPCG) was established in 1997 as the peak body for general practice computing – providing a strategic and cooperative approach to Australian GP informatics. The GPCG is funded by the Australian Government Department of Health and Ageing, and auspiced by the RACGP. The group focuses on the effective use of information management and technology for clinical and administrative purposes. It has a two phase work plan. Phase one includes funding to progress standards development and the practical use of information management. Phase two will build on the results and outputs of phase one and will help GPs harness new technology and perform many of their important clinical and administrative tasks better. These activities will enable the effective implementation of a range of health initiatives to enhance GPs clinical work and streamline GPs business processes to support more efficient work practices. Targeting 'at risk' patients and providing GPs access to the latest evidence based clinical guidelines to support patient care will achieve improved GP management of chronic illness. There is also a strong consumer focus around ensuring patients are better educating and have an increasing participation in the management of their personal health information.⁸⁶ The five key projects undertaken by the GPCG include:

- practical support for GPs via divisions of general practice
- the GPCG IT Clearinghouse Initiative
- Standards Development Program
- Development and Evaluation Program
- Information Management Program.

Quality initiatives in Australian general practice

The infrastructure for general practice and primary care services in Australia is complex. This reflects the complexity of the Australian health care system which is influenced at all levels by government, peak bodies, professional organisations, colleges, the private sector, practitioners, nurses, allied health professionals and consumers all having an important role to play within the system.

This section will map the quality systems and tools that currently affect the general practice environment in Australia, based on the model used by the World Organisation of Family Doctors.¹⁵ Quality initiatives in Australian general practice will be grouped according to the level at which they have their primary effect:

- the consumer
- the individual GP
- the practice
- the local or regional level
- the national or policy level.

7.1 Quality care for consumers

Ensuring that consumers receive quality general practice requires an effective system that meets the needs of the profession, community and the individual doctor. This system must strive to:

- ensure that the standards of quality general practice are achieved and maintained in order to optimise quality of health care provision for the community
- ensure that patients are given access to affordable, quality medical care irrespective of location
- ensure that patients are given access to doctors who participate in ongoing continuing professional development and lifelong commitment to continuing education.⁸⁷

Consumers have defined quality in a variety of ways. A numbers of studies have found common themes.^{88,89} These include:

- open communication between consumer and GP
- appropriate and quality provision of information
- affordability
- equity of access (geography, culture, race and gender)
- links with other services and supports (from hospitals through to self help groups)
- technical competence and commitment to learning
- continuity of care
- accessibility (location, hours of opening)
- doctor-patient relationship (respect, partnership, choices).

In 2000, Wensing et al published an internationally standardised instrument that could be used to compare patient evaluations of general practice care. The EUROPEP is a 23 item questionnaire, which has been validated in 16 countries and by more than 24 016 patients.⁹⁰

Strengthening the involvement of consumers in addressing quality care issues is a growing field. The Consumers' Health Forum (CHF) is the primary organisation responsible for ensuring that consumers have a voice in the health care system. The CHF can trace its beginnings back to 'A petition of reform addressed to the Minister', in May 1985, which called for 'a formal system of public participation to be built into the national health administration'. Following a subsequent review of community participation undertaken by the Department of Health, a health forum consisting of a coalition of community and consumer groups was established

to provide a strong community voice on health issues. The CHF was formally established in 1987, as a national, nongovernment organisation to represent consumers on health care issues and to provide a balance to the views of government, industry, service providers and other health professionals. Membership is made up of consumer and community groups with an active interest in health issues.

The health policy and health service delivery debate has shifted considerably since the forum's establishment in 1987. Consumer participation is well recognised by many politicians, policy makers and service planners. Consumers are being encouraged and given opportunities to become involved in decision making about their own health care, health service planning, policy development, setting priorities and addressing quality issues in the delivery of health services. However, despite the considerable gains being made in many areas for the benefit of health consumers, the CHF states that the need for effective consumer participation is not universally accepted. Strategies to strengthen the involvement of consumers in acute health service delivery are being developed in conjunction with the Consumer Focus Collaboration. The collaboration was established in 1997 to progress work at all levels of the Australian health care system on consumer issues in acute health.

The challenge for CHF in the coming years is to maintain and enhance the recent gains made for consumers. The CHF will need to articulate and contribute to effective consumer and community participation in health care policy and planning, service planning and delivery, and research and evaluation. The CHF's work includes a number of activities and strategies related to general practice. For example, in 1996, the CHF, with funding from the then Commonwealth Department of Human Services and Health, commissioned a project to examine consumer perceptions of quality in general practice (a final report *Integrating consumer views about quality in general practice* was released in November 1996). In addition, the CHF currently has consumer representatives on a number of committees addressing quality initiatives within general practice including the Board of the ADGP and AGPAL, and on the RACGP's Expert Committee on Practice Standards.

7.2 General practitioner and patient partnership

The General Practice Strategy Review endorsed the view that partnership approaches to primary health care work. The future of general practice includes the development of partnerships and relationship building between GPs and patients, carers and other health professions, as well as the implementation of coordinated and integrated health care models.¹⁶ This entails encouraging self care and self responsibility among patients.

The Primary Care Partnerships Strategy developed by the Victorian Department of Human Services identified the following benefits of a partnership approach:

- active participation in community life is good for individuals' health and wellbeing, and communities that encourage participation report overall health and wellbeing outcomes
- consumers who take an active role in their own health decision making have been shown to enhance their sense of control over their health care, and lead to more appropriate use of, and better access to relevant health services.⁹¹

There are a number of state/territory based initiatives, programs and organisations focused on improving the quality of health care provided in general practice in Australia. These include:

- state health departments
- divisions of general practice
- faculties of the RACGP.

7.3 State government health departments

Each state government's health department has a unit or region that tackles general practice policy issues for the state. These departments work closely with the Australian Department of Health and Ageing to provide state/territory based services and programs in a number of areas that effect quality in general practice. In summary, state health governments generally fund and support programs that fit into the following categories:

- integrated care (GP/hospital interface) to enhance patient outcomes through improved GP/hospital linkages, eg. 'Improved information flow between hospitals and general practice' project conducted by ACT Health
- integrated care (primary and community health care), to enhance primary care services and improve health outcomes, eg. 'Building healthier communities' conducted by NT Health, and General Practitioners in Community Health Services Strategy conducted by Victorian Department of Human Services
- Recruitment and retention of rural GPs, eg. Victorian Rural Clinical Schools, Rural and Remote Area Placement Program, Continuing Professional Development for GPs Subsidy Program and Rural Medical Family Network conducted by Victorian Department of Human Services
- information management/information technology
- population health, eg. General Practice Dementia Projects and NSW Chronic Disease Prevention Strategy conducted by NSW Health
- communication, eg. 'Collaborating for improved health outcomes', a Memorandum of Understanding between Tasmanian General Practice Divisions (TGPLD), regional divisions of general practice and Tasmanian Department of Health and Human Services (DHHS).

These programs are generally run in close collaboration with divisions of general practice and other key state/territory based health organisations. For further information on general practice projects funded by each state health department, refer to *Table 10* for links to each website.

Table 10. State health government websites

State	Website
Victorian Department of Health Services	www.dhs.vic.gov.au
NSW Health	www.health.nsw.gov.au
ACT Health	www.health.act.gov.au
QLD Health	www.health.qld.gov.au
NT Department of Health and Community Services	www.nt.gov.au/health
WA Department of Health	www.health.wa.gov.au
SA Department of Health	www.health.sa.gov.au
Department of Health and Human Services Tasmania	www.dhhs.tas.gov.au

7.4 Divisions of general practice

The first local divisions of general practice were established in 1992 by the Australian Government to forge better links between GPs and other health agencies, both community and institutional, and to facilitate alternative practice models and payment mechanisms.⁷¹ Today, about 94% of GPs are members of a local division of general practice.⁹² Divisions of general practice have become a key influence on quality and outcomes in Australian health care. As outlined in the report of the General Practice Strategy Review Group, among the roles of divisions in quality initiatives are the following:

- At a national level, contributing to the development of:
 - the national set of quality indicators
 - priorities for best practice research
 - a national set of clinical practice guidelines.

- At the local level:
 - supplementing national quality indicators with regionally relevant ones
 - adapting clinical practice guidelines for local relevance, and supporting GPs and practices in continuing medical education and quality assurance; peer review accreditation, uptake of improved information technology management systems and information technology, consumer liaison and education about quality in general practice.

The divisions network seeks to advance the health of the Australian community through the delivery of high quality general practice services that are well linked with the broader health system. The work of divisions at a local level is supported by state/territory based organisations (SBO) at the state and territory level, and by Australian Divisions of General Practice (ADGP) at the national level.⁹³ *Table 11* identifies some of the key quality improvement programs and initiatives ADGP are involved in, including continuing professional development programs, state/territory based programs and national initiatives.

Table 11. Key quality improvement programs of the Australian Divisions of General Practice

State	Programs	Website
General Practice Divisions Victoria and Rural Workforce Agency of Victoria	After hours care Aged care homes Broadband for health Chronic disease management Enhanced primary care GPs in community health centres GP hospital communication GP education Immunisation IM/IT Mental health Nurses in general practice Primary care partnerships Quality use of medicines	www.gpdv.com.au and www.rwav.com.au/
Alliance of NSW Divisions and NSW Rural Doctors Network	After hours care Aged care Alcohol and other drugs Broadband for health program Finance and administration support Mental health Population health SARS WorkCover	www.answd.com.au/ and www.nswrdn.com.au/
Health Workforce Queensland and Queensland Divisions of General Practice	Australian Integrated Mental Health Initiative Chronic disease Domiciliary Medication Management Review Every family General practice and psychiatry partnerships Immunisation Information technology Medical Specialist Outreach Assistance Program Mental health development and liaison officer Practice nurses and Aboriginal health workers	www.healthworkforce.com.au/ and www.qdgp.org.au/

ACT Divisions of General Practice	Aged care Chronic disease management GP business + Health partner Home medicines review Information technology Mental health Quality use of medicines The Opiate Program	www.actdgp.asn.au/
General Practice and Primary Health Care NT	Workforce programs, eg. Overseas Trained Doctors Scheme, Rural High School Visits program, Locum programs, grants Mental health Aboriginal mental health Tropical health CPD program Immunisation	www.gpphcnt.org.au/
Western Australia Centre for Rural and Remote Medicine	Care and Co program The Medical Specialists Outreach Assistance program Specialist support programs Retention programs Medical indemnity support Northern Wheatbelt Enhanced Patient Record Keeping System (EPRKS) project	www.wacrrm.uwa.edu.au/
Rural Doctors Workforce Agency and SA Divisions of General Practice	Aboriginal and indigenous health initiatives Aged care Asthma Chronic disease management Clinical nursing in general practice Consumer initiatives Diabetes GP access to psychiatrists GP obstetric shared care GP peer support (mental health) Immunisation Information management Medical workforce National Suicide Prevention program Scholarships Population health Primary mental health care Quality use of medicines Rural issues SA GP Registry	www.sadi.org.au/
Tasmania General Practice Divisions and Workforce Support	Chronic disease Continued professional development. Field support General Practice Advisory Council of Tasmania Immunisation Information management/information technology Locum relief Mental health Workforce planning Recruitment and retention Rural Family Medical Network	www.tgpd.com.au/

7.4.1 Review of the Australian Divisions of General Practice

On 8 October 2002, the Minister for Health and Ageing announced that a panel would undertake a review of the role of Australian Divisions of General Practice.⁹⁴ The review collected and considered a range of background information about the divisions network, including:

- descriptions of the current features of the network
- material outlining the changing role of ADGP since their inception
- details of the current method of Commonwealth funding to the network
- comparative information about the arrangements for the organisation of groups of general practitioners in other western countries
- views about the changing nature of general practice in Australia.

Overall, the review found that the divisions network is making an important contribution to improving the coordination of the delivery of health services to the community and the health outcomes of the communities that they serve. Despite this, the review noted that divisions have grown and matured over the past 12 years and this has resulted in significant differences in their focus and performance across the nation. There is a need to implement changes to ensure all divisions:

- address broader primary health care issues
- maintain focus on supporting general practitioners and their practices
- become more accountable to the community for their performance.

The review identified four requirements concerning 'the future role of divisions of general practice'. These include:

- the need to continue the support for general practices and GPs
- the need for divisions to play a stronger role in primary health care
- the need for divisions to undertake activities in relation to their core roles
- the need for a process to drive continuing improvement in the divisions network.

The review also identified the following 'implications of this future role for the organisation and structure of divisions of general practice':

- the need to unite the divisions network into a more streamlined structure
- the need to consider progressively the size and boundary alignment of some divisions
- the need to ensure that the governance arrangements for divisions will be able to meet their changing roles and modern governance requirements
- concern about the adequacy and methods of funding, and priorities for Commonwealth funding.

The ADGP compiled a response to this review following discussions at the National Divisions' Strategic Summit in Adelaide in August 2003.⁹³ In brief, the divisions felt that although the review was highly consultative, the report focused mainly on 'recommendations for incremental change and operational issues'. ADGP noted that many divisions are 'already considering broader roles and functions around focusing on the role of general practices in delivering community based care in collaboration with other primary care providers, through mechanisms such as pooled regional primary care funding'. They also commented that 'it would be a pity if implementation of the findings of the review were to put the brakes on this process, merely to achieve greater consistency among divisions'. It is vital that the roles and structure of the divisions network are discussed and agreed among divisions, SBO and ADGP. This is in order to ensure that 'lead' divisions can continue to move forward, while providing the opportunity for other divisions to consider undertaking similar roles.

Although many divisions have undertaken activities aimed at improving the health of Aboriginal and Torres Strait Islander peoples, the review concluded the relationship between divisions and Aboriginal Community Controlled Health Services (ACCHSs) varied from poor to very good.

If indigenous Australians are to have better access to quality general practice services, divisions must support the provision by 'mainstream' general practices for quality, multi disciplinary care that is sensitive to the needs of, and culturally safe for, indigenous Australians.

7.4.2 General Practice: Building on Quality

The General Practice: Building on Quality project was designed, developed and undertaken by a consortium of six divisions of general practice in 2001. Its focus was on improving health outcomes for individuals, enhancing rewards for, and recognition of the role and quality of general practice in primary care, and enhancing the role of divisions of general practice in the health system.

The project resulted in the development of a series of models for achieving a range of quality outcomes for individuals, GPs and the health care system via a systems approach. The model builds on the existing quality in general practice, and is operationally feasible within the Australian context and has broad support from other sections of the primary health care sector and the general practice community. They also articulate the role for divisions in supporting systems approaches to quality improvement.¹⁷

7.5 Faculties of the Royal Australian College of General Practitioners

At a state and territory level the RACGP has been organised into faculties to support quality standards and practices in Australian general practice. Each faculty has its own infrastructure, with a faculty board consisting of elected members. There are eight faculty offices covering the following areas:

- NSW/ACT
- North Queensland
- Queensland
- South Australia and Northern Territory
- Victoria
- Western Australia
- Tasmania
- National Rural Faculty

The RACGP recognises the important role that faculties play. Faculties provide local advocacy and support for their members, run local collegiate events, work with state and territory governments, liaise and collaborate with other GP and medical (and health services) associations, and provide a vehicle for member input to college policy development and decision making at the national level. The current roles and functions of faculties are broadly summarised as follows.⁹⁵

7.5.1 Role of the RACGP faculties

The role of the RACGP faculties is to provide a link from the college to both members and the broader community. Faculties aim to shape and implement the college's plans, programs, policies and processes, and to promote its ethos and standards. As such, faculties are the fundamental building block in the college's organisation and corporate governance structure.⁹⁵

Responsibilities of the RACGP faculties:

- leadership and advocacy for general practice
- collegiality and member support
- quality and standards in general practice
- the scholastic aspects of the discipline.⁹⁵

Functions and activities of the RACGP faculties:

- National programs and activities
 - college governance
 - training and assessment services
 - QA&CPD
 - participation in general and specific policy, planning and administrative review activities.
- Faculty activities
 - faculty administration
 - membership services and activities
 - social and collegial events
 - local and regional education courses and events
 - organisation and delivery of college assessment
 - liaison with relevant health and related organisations at the state/territory, regional and local levels
 - special projects, research and other interests.⁹⁵

7.6 Quality initiatives at the national level

There are a number of national initiatives, programs and organisations that focus on improving the quality of health care provided in general practice in Australia. The Primary Care Division (PCD) of the Australian Government Department of Health and Ageing has an integral place in providing leadership for better access, integration, management, quality and effectiveness of primary care service provision in Australia. The PCD supports a number of programs that affect the quality of health service provision in Australian general practice. These programs include:

- After Hours Primary Medical Care (AHPMC)
- Australian Primary Care Collaboratives Program (APCCP)
- General Practice Immunisation Incentives (GPII) scheme
- General Practice – Hospital Integration
- Health Call Centres (HCC)
- Quality Indicators
- Quality Use of Medicines (QUM)
- Rural and Remote General Practice

7.6.1 After Hours Primary Medical Care

The After Hours Primary Medical Care (AHPMC) program was introduced to improve access to quality after hours primary medical care and progress systemic reform by trialling key interventions. General practitioners, like other professionals, are committed to maintaining a balance between their work and family responsibilities, as well as safeguarding their personal health and well being. Consumer expectations of access to general practice care outside the traditional Monday to Friday, 9.00 am to 5.00 pm, hours already mean that 'normal' surgery hours commonly include earlier opening hours, later access in the evenings and Saturday morning surgeries have become more common. General practices are finding it increasingly difficult to make arrangements from within the practice for care outside those already extended hours of access.⁹⁶

All sectors of the primary health care system are currently exploring options and models for meeting community expectations of and needs for after hours primary medical care. These include:

- different types of telephone triage systems
- hospital or community based facilities for after hours care
- general practice cooperatives with GPs being rostered on call

- use of medical deputising services
- practice GPs rotating on call responsibilities.

In rural areas where there is a shortage of GPs, there is greater use of hospital accident and emergency services for after hours primary medical care. Such services may involve GPs in a variety of ways, eg. as staff or on call. More remote areas may require different models with GPs participating from a distance. It has become more common to use medical deputising services (MDS) to provide after hours primary medical care. However, they also experience difficulties in recruiting recognised general practitioners or medical practitioners with appropriate general practice experience or training to carry out after hours primary medical care.

The Australian Government announced in the 2001–2002 Budget significant measures to improve the provision of after hours primary medical care in Australia. This included a commitment to implement a funding program for MDS supporting quality innovation.

The Quality Innovation Funding (QIF) Program for MDS was designed to enable MDS to develop and implement specific quality improvement activities. The QIF was intended to assist MDS to meet specific aims in real work settings leading to the ongoing delivery of quality care. A number of initiatives to improve the situation for both consumers and GPs were funded by QIF. These include:

- research to better understand the issues for consumers and GPs
- trials to test better models of care
- development grants to improve and increase the number of services available
- deputising activities to improve the quality of existing services
- call centre initiatives to improve consumers access to care
- consumer education programs.

7.6.2 Australian Primary Care Collaboratives Program

In late 2003, the Australian Government called for applications for the Australian Primary Care Collaboratives Program (APCCP). The aim of the APCCP is to adapt methodology used successfully in the UK, USA and Europe. The methodology aims to generate improvements in service delivery in the Australian primary health care setting and to drive local level changes aimed at meeting national objectives and goals. It is envisaged that the APCCP will build on work (already being supported by DoHA) with general practices and consumers relating to the management of chronic and complex conditions.

The APCCP will improve clinical outcomes, reduce lifestyle risk factors and help maintain good health for people with chronic conditions. It will do this by promoting a quality improvement culture in general practice and primary health care in Australia and will focus on prevention, chronic disease management; and clinical and business systems. Outcomes sought as a result of the APCCP overall include:

- improved patient health outcomes as a result of better integrated, evidence based primary health care
- evidence about the effectiveness of Collaboratives methodology as a technique for effecting and spreading local and regional level improvements aligned to national health outcomes in Australia
- collaborative guides and learning materials applicable to Australia in the areas of clinical and business systems, chronic disease management and prevention
- a cohort of comprehensively trained Collaborative coordinators and participants skilled in continuous quality improvement methods
- a critical mass of primary health care provider teams willing and able to spread knowledge gained from their quality improvement activities
- primary health care providers with the knowledge and ability to continue to apply continuous quality improvement techniques to create local level improvement.⁹⁷

7.6.3 General Practice Immunisation Incentives scheme

In February 1997, the Australian Government announced several initiatives as part of the Immunise Australia: The Seven Point Plan with the aim of improving Australia's childhood immunisation level. One of the initiatives announced was a scheme to support GPs to play a central role in preventive health care and their ability to increase the childhood immunisation level. This scheme commenced on 1 July 1998 and is known as the General Practice Immunisation Incentives (GPII) scheme. The GPII scheme provides financial incentives to GPs who monitor, promote and provide immunisation services to children under the age of 7 years. The GPII scheme is made up of three components:

- a service incentive payment (SIP) – an \$18.50 payment to GPs and other medical practitioners (OMPs), who notify the Australian Childhood Immunisation Register (ACIR) of a vaccination that completes an immunisation schedule according to the National Immunisation Program.
- an outcomes payment (OP) – a payment to practices that achieve 90% or greater immunisation coverage of children less than 7 years of age attending their practices.
- immunisation infrastructure funding – this provides funds to divisions of general practice, state and territory based organisations and a national GP immunisation coordinator to improve the proportion of children who are immunised at local, state and territory, and national levels.

7.6.4 General Practice – Hospital Integration Program

The General Practice – Hospital Integration Program builds on past initiatives to address an identified priority area for collaborative action between the Commonwealth and states/territories in the AHMAC Primary Health and Community Care Agenda. The program involves integration demonstration sites jointly funded by DoHA and, state and territory governments in Launceston, Darwin, North Wyong, South Brisbane and Perth.

The sites have various aims, target groups and models of best practice. They aim to forge integration through shared protocols and improved IM/IT linkages for patient management and service delivery across pre existing service providers.

7.6.5 Health Call Centres Program

In Australia there are growing consumer expectations that health services will be accessible 24 hours a day, 7 days a week. There is also increasing interest both in Australia and overseas in health call centres (HCC) as one way of meeting these expectations. Statewide health call centres currently operate in Western Australia (HealthDirect) and the Australian Capital Territory (Health First). Other states and territories are assessing their value or working toward introducing them in their jurisdictions. Internationally the United Kingdom has provided health call centre services through NHS Direct since 1998.

Health call centres are similar to other types of call centres. They use information and communications technology, such as the telephone and/or the Internet, to provide consumers with access to health information and advice. Typically they employ specially trained nurses who answer calls and then, using specially designed computer based decision support tools and service directories, offer advice about the next steps in obtaining appropriate health care. This process is known as telephone triage.

The Australian Government has been working with all states and territories to develop national policy on health call centres. Adopting a strategic national approach will ensure consistent standards and protocols for service delivery and optimise the sustainability, economies of scale and linkages with other e-health programs.⁹⁸

7.6.6 Quality indicators

Quality indicators are measurable aspects of care. They can reflect process and outcome aspects of clinical care and can include service quality and patient assessments. They can be used in a formative way to provide feedback to individual practitioners. They can also be associated with incentives and sanctions to increase behavioural pressure and can be publicised in league tables to direct consumer choice of services. Indicators, guidelines, standards and review criterion, while often used synonymously are very different concepts. Indicators have a variable role on quality improvement initiatives. Marshall et al⁹⁹ claim that:

“The development and use of objective measures of the processes and outcomes of health care is a fundamentally important part of improving our health systems. Some medical specialities have recognised this for years, eg. the analysis of morbidity data by epidemiologists, the use of physiological data by anaesthetists and the auditing of mortality rates by cardiac surgeons. For almost 30 years, British general practice has been a leading light in the quality field, mostly through the activities of the Royal College of General Practitioners. However, much of this work has focused on formative educational programmes and GPs have been relatively slow to engage with the measurement agenda.”

Australia shares the same slowness in routinely measuring the quality of general practice as one approach to supporting and promoting quality improvement. In June 2000 the Newcastle Institute of Public Health produced a report for the Commonwealth on quality indicators for Australian general practice. This report suggested a set of basic indicators from a widespread consultation process among GPs, consumers and other key stakeholders. It also recommended that Australian general practice needs ‘a national quality framework...to better integrate existing quality initiatives’.¹⁰⁰

To date, none of the recommended indicators are in routine use. This may reflect, in part, legitimate concerns about the value and outcomes from use of quality indicators. Problems identified include variable clinical recording, access to records, the time and resources needed for data collection, the validity of the data to reflect quality care, the use of the data, and likelihood of subsequent improvement. There is also concern that the regulatory aspects of indicator measurement and use can undermine other factors (eg. professionalism) and approaches to enhancing quality of health care.¹⁰¹

7.6.7 Quality Use of Medicines and the National Medicines Policy

Stimulated by the World Health Organisation (WHO), countries around the world are implementing national medicinal drug policies to ensure the availability of essential, affordable drugs of acceptable quality, safety and efficacy. Australia began to develop aspects of the National Medicines Policy as early as the 1950s. By the 1990s a comprehensive policy was in place, and in December 1999, a formal policy document entitled, Australia’s National Medicines Policy was launched. Quality Use of Medicines (QUM) is an integral part of this policy and aims to promote the judicious, appropriate, safe and effective use of medicines in Australia.

Figure 18 illustrates the interdependence of the four components of Australia’s National Medicines Policy. At the centre is the policy goal: to optimise health outcomes. It is encapsulated by the QUM component of the policy, which supports the goal. Like a jigsaw puzzle, the QUM component locks into the other three components of the policy that are essential in enabling and supporting QUM: quality, safety and efficacy; equity of access; and a viable pharmaceutical industry. The figure also depicts the National Medicines Policy in the wider context of national policies to demonstrate that public policy on medicines must be integrated with broader health and trade policies.

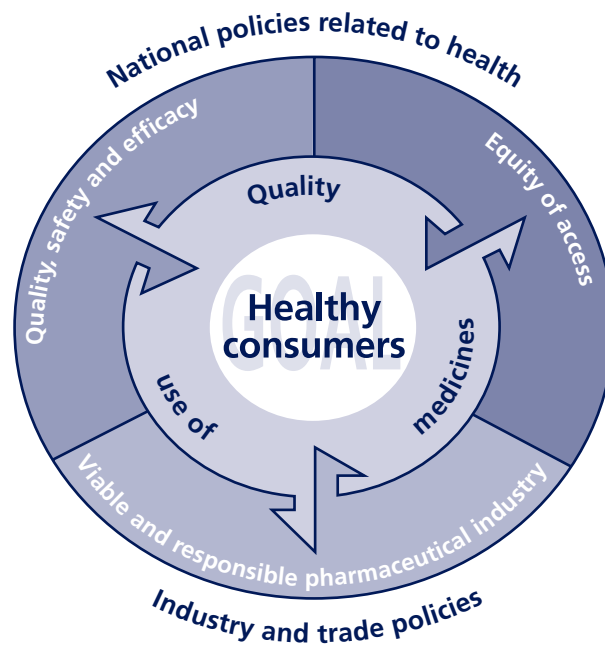


Figure 18. Australia's National Medicines Policy

Five principles underlie the national strategy for QUM:

- primacy of consumers
- partnership
- consultative, collaborative, multi disciplinary activity
- support for existing activity
- systems based approaches.

The six building blocks that support QUM are based on evidence and expert opinion about interventions, regulatory efforts and programs to improve medication use. They are:

- policy development and implementation
- facilitation and coordination of QUM initiatives
- provision of objective information and assurance of ethical promotion of medicines
- education and training
- provision of services and appropriate interventions
- strategic research, evaluation and routine data collection.

The national strategy uses a conceptual framework based on principles derived from the education, behaviour change, community development, health promotion, public health and social advocacy literature. The framework recognises the need to take various perspectives – individual, community development and public health – in planning, implementing and evaluating initiatives to improve use of medicines. This has also been described as a multi strategic, multi level systems approach that:

- involves all groups whose activities influence QUM
- includes all stages of learning that support and maintain QUM, including the development of awareness, knowledge, skills, behaviour and motivation
- addresses all settings within which problems arise and decisions affecting QUM are made.

7.6.8 Rural and Remote General Practice Program

The Rural and Remote General Practice Program (RRGPP), which replaced the General Practice Rural Incentives Program, was introduced in 1998 in response to recommendations of the General Practice Strategy Review Group. The program's aim is to provide a flexible, coordinated, cost effective and consumer focused framework for the delivery of incentives and support for the recruitment and retention of general practitioners in rural and remote communities.

Under the RRGPP, the rural workforce agencies have the responsibility to identify areas where there is an undersupply of GPs and develop strategies to improve access to general practice services taking into consideration specific community needs. As central coordinators, these agencies develop support initiatives for rural GPs and their families, and act as the central contact for GPs and other health professionals interested in practising in rural and remote areas. Several programs operate under the RRGPP, including:

- The Rural Retention Program that aims to recognise and retain long serving general practitioners in rural and remote communities that may experience significant difficulties in retaining general practitioners.
- The Rural Medical Family Support Scheme, which supports families of GPs, registrars, other medical practitioners and locums in rural and remote areas.
- The Rural Women's GP Service is administered by the Australian Council of the Royal Flying Doctor Service (RFDS), and aims to improve access to primary and secondary health care services for women in rural Australia who currently have little or no access to a female GP. It gives women in rural and large remote communities the opportunity to seek health care of their choice, and provides personalised care and advice for those women who prefer to discuss their needs with a female doctor. The services offered include cervical cancer screening, breast and skin examinations and other preventive health care. It also delivers education and self help information, which is very important to women in rural areas, as they often need to play a greater role in their own health care.
- The John Flynn Scholarship Scheme provides medical students with an opportunity to spend part of their annual vacation working in the bush. The scheme was established in 1997 and is an integral part of the Commonwealth Government's long term strategy to attract more GPs to, and improve the quality of health care in, rural areas. Under the John Flynn Scholarship Scheme, medical students commit to a 2-week placement in a rural or remote community each year, over four consecutive years of their medical course. Placements are at general practices; hospitals, Aboriginal medical services or other health care facilities and all are supervised by a medical professional. Up to 150 new scholarships are offered each year, with a total of 600 scholarships active in any one year.
- The Rural Australia Medical Undergraduate Scholarship Scheme is a new initiative in the Commonwealth Government's long term strategy to increase the number of GPs working in rural and remote Australia. The scheme provides scholarships worth \$10 000 to rural students enrolled full time at an Australian medical school. Under this scheme scholarship holders are required to maintain regular contact with their mentor and undertake rural activities to strengthen their links with rural Australia.

7.7 Key stakeholders

This section outlines the key stakeholders that provide a direct link between the general practice profession and the Australian Government. The development of a quality framework for general practice would need to consider and engage each of these stakeholders to ensure it had the support of the Australian Government.

7.7.1 Australian Government Department of Health and Ageing

The Department of Health and Ageing (DoHA) states that it is responsible for creating, supporting and maintaining the policies in the Australian health system to support quality general practice. The Department operates on a portfolio basis with other agencies that include the:

- Health Insurance Commission
- Private Health Insurance Administration Council
- Private Health Insurance Ombudsman
- Professional Services Review Scheme
- Food Standards Australia New Zealand
- Australian Institute of Health and Welfare
- Australian Radiation Protection, Nuclear Safety Authority
- Aged Care Standards and Accreditation Agency.

As national leaders in health and aging, the portfolio:

- provides expert policy advice, analysis and other services to the Commonwealth Government
- works with consumers, communities, providers, peak bodies, industry groups, professional organisations, state and territory governments, and portfolio agencies through consultation and collaboration
- promotes healthy living and communicating information about health and aging services
- manages the Commonwealth's health and ageing programs to ensure the provision of quality, cost effective care
- safeguards health, safety and equity, in a way that imposes the minimum necessary regulatory burden.

The portfolio's vision is reflected in part by the achievement of the following broad health and aging services targets, which are measured biannually by the Australian Institute of Health and Welfare. They are:

- continued improvements in life expectancy for both men and women over time
- further reductions in infant mortality rates over time
- additional improvements in health expectancy rates over time
- improved life expectancy, health expectancy and infant mortality rates for Aboriginal and Torres Strait Islanders so that they are comparable with the general population
- improved life expectancy, health expectancy and infant mortality rates for low income Australians so that they are comparable with the general population.¹⁰²

7.7.2 General Practice Representative Group

The Australian Government established the General Practice Representative Group (GPRG) in 2003 to discuss general practice issues that are currently at the centre of community and political debate, and present the views of general practice to the Australian health minister.

The GPRG comprises senior elected and secretariat officers from ADGP, the AMA, the RACGP and the RDAA. The group's charter is to consider current and new policies and provide a direct communication conduit to government on behalf of all Australian GPs.

7.7.3 Quality in General Practice Committee

The Quality in General Practice Committee (QGPC) has been established by the Commonwealth Government and the RACGP to address the broad range of issues relating to quality in general practice, and to bring together the key stakeholders of the various components into one forum. The purpose of the QGPC is to act as an expert strategy group, advising on:

- the development of a quality framework for general practice
- refinement/improvement of the quality framework over time
- priorities and targets to fill gaps identified through the framework, bearing in mind the local, regional and national constraints and opportunities
- oversight of the accreditation system for general practices, including deciding on credentialing requirements for accreditation agencies.

Due to the broad nature of the committee's interests, national representatives from a wide variety of areas including – general practice, nursing, rural medicine, indigenous health, education, consumers, and government have been invited to join the committee.

7.8 General practice representative groups

This section outlines the key organisations that represent the general practice profession in Australia. There is a brief description of some of the quality programs the organisations have been involved. To ensure the profession has a sense of ownership of the final product and that input from each organisation and its members is considered and represented, it is important that key organisations are involved in the development of the quality framework for general practice.

7.8.1 Australian Association of Academic General Practitioners

The Australian Association of Academic General Practitioners (AAAGP) states that it aims to develop the discipline of general practice by encouraging teaching and research; providing a forum for the exchange of information and ideas; and fostering and supporting career development of academics in general practice. Any full or part time academic staff of recognised institutions involved in general practice, and all other teachers and researchers in the field of general practice, are eligible for membership. The members of the association produce much of the general practice research, and are representative of a large proportion of the teaching expertise in Australia.

7.8.2 Australian Divisions of General Practice

The Australian Divisions of General Practice (ADGP) was established in 1998 after the Government General Practice Strategy Review recommendation that ADGP be funded as the national organisation representing the Divisions of General Practice across Australia. Australian Divisions of General Practice (ADGP) states that it was established to promote the health and well being of Australians through divisions of general practice, by:

- strengthening the effectiveness and vitality of the general practice sector by supporting advocacy and representation of member divisions and member state and territory based organisations to the Commonwealth Government, other national organisations and to the Australian public
- contributing to the development of national health policy in collaboration with member divisions and member SBO
- promoting cooperation and communication with other national organisations in Australia with objects similar to these objects of the company
- providing national leadership in health system development.

Australian Divisions of General Practice work at a national, state/territory, and local level to improve the health and wellbeing of Australians through divisions of general practice. At a national level, ADGP manages a number of national programs for the divisions network to support general practice locally. These primary care programs include:

- the AHPMCP which is aimed at improving access to quality after hours primary medical care for consumers
- the Medicare Plus Aged Care GP Panels Initiative, which aims to ensure better access to primary medical care for residents of aged care homes and to enable GPs to work with homes on quality improvement strategies for the care of all residents
- the Enhanced Divisional Quality Use of Medicines Program which has been developed in the context of the National Medicines Policy to improve QUM in the community
- the Chronic Disease Management in General Practice Program, which involves appropriate prevention, early identification and best practice management strategies for chronic disease
- the Medication Management Review (Home Medicine Review) Program, which is the key national infrastructure to support the implementation of the Home Medicines Review, a consumer focused, structured and collaborative health care service provided in the community to optimise quality use of medicines and consumer understanding
- the National General Practice Immunisation Program which aims to improve the quality of vaccination services provided by general practice, with the overall goal of improving immunisation rates Australia wide
- the National Divisions Youth Alliance which is a national program that aims to work in partnership with GPs, the divisions network, young people and other stakeholders to support general practice in improving health outcomes for young people
- the National Primary Mental Health Care Initiative that supports GPs in the provision of quality mental health care
- Nursing in General Practice, which provides assistance to ADGP to support nursing in general practice, to provide input into future policy directions for practice nursing.

At a state and territory level ADGP works closely with the SBO and divisions to implement national programs and to ensure they meet the local needs of their communities. At a local level, ADGP helps and supports divisions to deliver programs such as the IM/IT support service within individual divisions, continuing medical education, and other national programs.

7.8.3 The Australian Indigenous Doctors' Association

The Australian Indigenous Doctors' Association (AIDA) was incorporated in late 1998 as an Australian charitable body, with seeding funding from the Office for Aboriginal and Torres Strait Islander Health, Commonwealth Department of Health and Aged Care. The AIDA states that it aims to:

- provide professional and personal support to indigenous medical undergraduates
- develop and promote initiatives to enhance the recruitment retention of Aboriginal and Torres Strait Islander people to medicine and allied health
- involve AIDA members in mentoring and role model initiatives
- develop core Aboriginal and Torres Strait Islander health curricula in medical schools.

The AIDA has over 70 potential members, either as undergraduates throughout the medical schools, or graduates practising in a variety of careers. The association also has consultants and trainees in public health, policy and research, psychiatry, surgery and general practice, and teaching and development roles within universities and nongovernment organisations.

7.8.4 Australian Medical Association

The Australian Medical Association (AMA) is an independent organisation which represents more than 27 000 doctors, whether salaried or in private practice, whether GPs, specialists, teachers and researchers, or doctors in training. The AMA states that as the peak health advocacy organisation, it exists to advance the professional interests of doctors and the health of the community. The AMA exists to:

- promote and advance ethical behaviour by the medical profession and protect the integrity and independence of the doctor/patient relationship
- promote and advance public health
- protect the academic, professional and economic independence and the wellbeing of medical practitioners
- preserve and protect the political, legal and industrial interests of medical practitioners.

The AMA will achieve these aims by:

- fostering and sustaining consultation, cooperation and communication within the medical profession
- acting as the principal coordinating and lobbying body for the medical profession
- fostering unity amongst medical practitioners by providing a forum for their opinions
- promoting the achievement and maintenance of high clinical and ethical standards in medical practice
- fostering communication between the medical profession and the community.¹⁰³

7.8.5 General Practice Registrars Australia Limited

General Practice Registrars Australia Limited (GPRA) is an independent, national organisation advocating and supporting general practice registrars in all states and territories in Australia. The vision of the GPRA is to promote general practice as the medical specialty of choice and improve the health care of all Australians through excellence in education and training. Managed by an elected Board, GPRA represents over 90% of general practice registrars across Australia.

7.8.6 The Royal Australian College of General Practitioners

The Royal Australian College of General Practitioners (RACGP) sets and maintains the standards for high quality Australian General Practice, leads the education, training and assessment processes, advocates on behalf of the discipline, and supports GPs in meeting the primary medical health care needs of all people in Australia.

The RACGP has over 11 600 financial members including over 3200 rural GPs, and over 95% of all general practice registrars. Approximately 22 000 medical practitioners participate in the college's Quality Assurance and Continuing Professional Development (QA&CPD) Program. The college's publication, *Australian Family Physician*, is distributed to over 33 000 medical practitioners.

Since its foundation in 1958, the RACGP has demonstrated its commitment to improving standards in general practice through the development of the Fellowship exam, the RACGP Training Program, and the QA&CPD Program. These programs have been concerned with the quality of individual GPs. Efforts to assess and enhance the quality of the structure and organisation of general practice have been addressed through the development of standards for general practices. The RACGP *Standards for general practices* were developed in 1996 and practice accreditation was established in 1997. Since the last edition of the Standards was published in 2000, there has been a rapid growth in the literature surrounding quality improvement. The third edition of the Standards was launched in mid 2005.

7.8.7 Rural Doctors Association of Australia

The Rural Doctors Association of Australia (RDAA) was formed in 1991 to give rural doctors a national voice. The RDAA comprises the Rural Doctors Association of each state and the Northern Territory – representing rural doctors from all over Australia. Members are typically drawn from small rural towns and remote areas in categories four to seven of the Rural, Remote and Metropolitan Areas (RRMA) classification system.

The RDAA's vision is for excellent medical care in Australia's rural and remote communities. The RDAA states that it advocates for highly skilled and motivated medical practitioners, who are adequately trained, remunerated and supported, both professionally and socially. By working closely with members and key stakeholders such as the Australian Government, RDAA provides support, policy development, research, submissions and strategic advice on relevant issues. In 1996, in response to demand from rural doctors and trainees, RDAA created the Australian College of Rural and Remote Medicine (ACRRM), a separate organisation to look after standards, training and continuing medical education for rural doctors.

The RDAA recently completed the Viable Models of Rural and Remote Practice Project, which was funded by the Australian Government in response to the ongoing challenge of recruiting and retaining doctors in rural and remote Australia. The research project involved two stages. The first involved undertaking a detailed analysis of the content, cost, complexity and context of general practice in different rural and remote environments. This was followed by onsite visits to enhance the understanding of how practice's rural locations impact on the range and complexity of activities, and their economic base.

The results from this study show that an integrated approach, addressing fundamental structures, is required if the problem of medical workforce shortages in rural and remote Australia is to be solved. There are three key inter-related factors affecting practice viability. These factors – practice economics, professional issues, and practice organisation and infrastructure – form the basis of a viability framework. The viability framework and the benchmarks identified during this project can be used to inform policy development and monitor practice viability at the local community level.¹⁰⁴

7.9 Organisations impacting on quality of care in general practice

Finally, the development of a quality framework for general practice should consider the role of organisations that are not directly focused on general practice, but are involved in implementing or ensuring quality and quality systems both exist and are implemented, within the Australian health system. This section describes the key stakeholders that have an interest in ensuring quality in general practice.

7.9.1 The Australian Council for Safety and Quality in Health Care

The Australian Council for Safety and Quality in Health Care (ACSQHC) was established in January 2000 by Australian health ministers to lead national efforts to improve the safety and quality of health care provision in Australia.

The role of the council is to:

- lead the way by developing a national strategy for improving safety and quality, defining national standards and influencing others to act to improve safety and quality in health care
- define a framework for action by identifying national priorities and recommending specific actions that address the priorities
- form partnerships by working with health care professionals, the commonwealth, states and territories, professional associations, private, nongovernment, and consumer organisations
- coordinate existing activities to better achieve action in priority areas
- put consumers first by making sure that safety and quality measures are practical and will make a real difference
- encourage public understanding and increase the community's confidence in the steps being taken to improve the safety of health care

- promote monitoring and research to address the many things we still don't know about challenges with safety and quality, and how to fix them.¹⁰⁵

In July 2005, all Australian health ministers agreed that the ACSQHC be succeeded by a national body called the Australian Commission on Safety and Quality in Health Care.

7.9.2 Australian Institute of Health and Welfare

The Australian Institute of Health and Welfare (AIHW) was established as a statutory authority of the Commonwealth of Australia in 1987 as the national agency for health and welfare statistics and information. The organisation's mission states: 'To improve the health and wellbeing of Australians, we inform community discussion and decision making through national leadership in developing and providing health and welfare statistics and information.'

The Institute produces authoritative and comprehensive publications about key health and welfare issues in Australia. In addition to Australia's Health and Australia's Welfare (biennial reports to the Commonwealth Parliament on the nation's health and welfare services) they produce over 80 reports and working papers each year. Policy makers, academics, students and the general public use the information.

7.9.3 Australian Medical Council

The Australian health ministers established the Australian Medical Council Incorporated (AMC) in 1984 as a national standards body for primary medical training. The activities of the council are funded through annual grants from the Commonwealth Government, state/territory governments and medical boards – fees are raised from the accreditation of medical schools and from the examination of overseas trained doctors. The duties of the council include advising and making recommendations to state and territory medical boards on:

- accreditation of Australian and New Zealand medical schools and medical courses
- the assessment for admission to practice of overseas trained medical practitioners
- uniform approaches to registration of medical practitioners
- maintaining a national network of medical registers
- providing advice to the Australian Health Ministers Advisory Council on the registration of doctors.

7.9.4 Consumers' Health Forum

The Consumers' Health Forum (CHF) was established in 1987, as a national, nongovernment organisation to represent consumers on health care issues and to provide a balance to the views of government, industry, service providers and other health professionals.

7.9.5 National Aboriginal Community Controlled Health Organisation and other Australian indigenous health agencies

A number of commonwealth and state and territory government agencies are responsible for health services to Aboriginal and Torres Strait Islander communities. Commonwealth agencies include the DoHA, the Aboriginal and Torres Strait Islander Commission (ATSIC), the Australian Bureau of Statistics (ABS), and the AIHW. State and territory agencies include the health and Aboriginal affairs departments in all general practice and divisional programs in indigenous health. They are being developed in partnership with government agencies and with local Aboriginal community controlled health organisations, as well as at the national level through National Aboriginal Community Controlled Health Organisation's (NACCHO) organisational structure.

The NACCHO is the national peak Aboriginal health body representing Aboriginal community controlled health services throughout Australia. An Aboriginal medical service (AMS) is a primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community, that controls it through a locally elected board of management.

In keeping with the philosophy of self determination, Aboriginal communities operate over 128 AMS across Australia. They range from large multi functional services employing several medical practitioners and providing a wide range of services, to small services without medical practitioners, that rely on Aboriginal health workers and/or nurses to provide the bulk of primary care services (often with a preventive, health education focus). The services form a network, but each is autonomous and independent both of one another and of government. The integrated primary health care model adopted by AMS is in keeping with the philosophy of Aboriginal community control and the holistic view of health that this entails. The NACCHO has been actively involved in a number of quality initiatives affecting general practice including:

- successfully advocating for the introduction of a Medicare rebate for the preventive health assessment of younger Aboriginal and Torres Strait Islanders
- developing, Australia's first curriculum in Aboriginal health for general practice registrars (1994), in partnership with the RACGP and in 2000, a supplementary Aboriginal health training module for GPs
- assisting with the production of the 1989 National Aboriginal Health Strategy, a policy document that has recently been complemented by the National Strategic Framework for Aboriginal and Torres Strait Islander Health (2003)
- completion of a large-scale clinical research trial on chronic ear infections that won the AMA Wyeth prize for the best research article published in the Medical Journal of Australia in 2003
- collaborating and contributing to clinical textbooks for medical and health professionals and a range of national clinical guidelines.¹⁰⁶

7.9.6 National Association for Medical Deputising Services

The National Association for Medical Deputising Services (NAMDS) was established in 1992 with the objectives of developing standards, sharing ideas, determining strategies and establishing a negotiating body for deputising services, their principal GPs and deputising doctors. The NAMDS states it is the 'pre-eminent body on matters relating to medical deputising and after hours primary care'.

The NAMDS finalised a set of standards and introduced accreditation of member services according to these standards in 1993 (ie. before general practice). The NAMDS subsequently instigated and succeeded in having these standards incorporated into the RACGP's *Standards for general practice*. The premise for this initiative was, and remains, that accreditation of general practice is deficient without co-accreditation of those after hours arrangements delivering a clinical continuum to patients for up to 118 hours, or 70%, of the week. In addition the NAMDS has been integral in achieving many other important developments in after hours GP service delivery. These include:

- an increased rebate for Schedule A after hours MBS Items of Service in 1998
- the introduction of the national AHPMC trials and the subsequent conduct of a trial by one member service
- the introduction of the AMDSP
- development of a postgraduate training program in after hours primary medical care and medical deputising in conjunction with the RACGP
- the National Medical Deputising Workshop
- negotiation of increases in the rebate for after hours MBS Items of Service in 2000 and additional increases for non-VR doctors in 2001
- recognition as the peak negotiating body for the medical deputising sector among government at Commonwealth, state and territory, and other peak medical representative organisations.

The NAMDS continues to work with the RACGP in reviewing and refining standards for MDS to ensure they are up to date and consistent with the objectives of accreditation in underpinning comprehensive, continuous and quality patient care.

7.9.7 National Health and Medical Research Council

The National Health and Medical Research Council (NHMRC) is an independent statutory body of the Commonwealth Government. The NHMRC was established in 1936 to be responsible for allocating commonwealth funds for health and medical research, providing health advice, considering ethical issues in health and regulating sensitive medical research activities. Its primary focus is to integrate the activities of research, advice, ethics and regulation to produce better health outcomes for Australians.

The need for a national agency to oversee Australian health and medical issues became evident following the tragic influenza epidemic of 1918–1919. It was realised that health and medicine was a concern that spread beyond state borders and therefore required a national response. In 1926 a royal commission on health recommended that the Federal Health Council and Health Research Council be created. The NHMRC was created in 1936.¹⁰⁷ The NHMRC has played a role in the provision of a number of quality initiatives that affect general practice including:

- the provision of ethical guidelines for primary health care and clinical research involving humans through the 'National Statement on Ethical Conduct in research Involving Humans' (1999)
- funding research in general practice through the NHMRC Primary Health Care Research Project Grants Program that commenced in 2001 and aims to provide support for primary health care research within universities, medical schools, hospitals and other research institutions, including general practice and primary health care settings
- funding research in general practice through the NHMRC Primary Health Care Fellowship and Scholarship Program, which aims to support the development and strengthening of the general practice and primary health care research and evaluation workforce
- the provision of evidence based guidelines for clinical practice.

7.9.8 National Institute of Clinical Studies

The National Institute of Clinical Studies (NICS) was established by the Commonwealth Department of Health and Aged Care in December 2000 to provide a national focus to champion continuous improvement in the quality and delivery of clinical practice to the Australian community. The institute's mission is to work in partnership with consumers, health professionals, organisations, researchers and governments. It aims to close the gaps between evidence and clinical practice by providing practitioners and health organisations with systems that will assist them to improve the health outcomes of those within their care.

The NICS has a number of programs and projects that directly benefit quality in general practice. These include, a primary care program, that focuses on the organisations existing knowledge and experience of change and aims to promote improvements in clinical practice in primary care and general practice. In particular, the NICS is interested in examining ways in which it can usefully contribute to support the uptake of evidenced based practice in general practice and actively promote approaches that can be rolled out and sustained across the primary care system.

The Evidence-Practice Gaps Report was developed to draw attention to specific situations where health outcomes could be improved if the application of best evidence was to become more widespread. The report describes 11 examples of health care practices where there are gaps between best available evidence and current clinical practice. Access to the Cochrane Library, where GPs (and others) can access an online database of scientific research drawn from around the world, is renowned for being one of the best sources of reliable evidence about health care interventions.¹⁰⁸

7.9.9 National Prescribing Service

The National Prescribing Service (NPS) is a nonprofit organisation, independent of government and the pharmaceutical industry. The NPS was established in 1998 to provide prescribers with evidence about prescribing that they could use in their daily practice. The vision of the organisation is 'to be the most trusted source of independent information about medicines for Australians' and their goals are to improve the health of all Australians through QUM in partnership with stakeholders by:

- supporting nationally coordinated approaches to quality use of medicines
- providing independent information about medicines to health professionals and consumers
- delivering messages about medicines to health professionals and consumers using multiple strategies and services to support change in behaviour
- encouraging and supporting cross-discipline and cross-sector collaborations that promote QUM
- utilising incentives that support QUM initiatives
- undertaking ongoing evaluation.

The NPS works with health professionals and consumers. They have undertaken a number of projects that affect quality in general practice including:

- developing the National Medicines Policy and other tools to assist doctors, pharmacists and other prescribers to navigate the enormous volume of information available about medicines, and to provide their patients with the best treatment
- establishing the Community QUM Program in partnership with the Consumers' Health Forum of Australia (CHF) and other consumer groups and organisations, that aims to provide consumers with the information and resources they need to be partners with health professionals in making best use of medicines.
- funding divisions of general practice to employ and supervise an NPS facilitator on a full time, part time or shared basis with another division, and working with divisions to meet the challenges of tailoring programs to meet local needs. To date, agreements to conduct NPS programs have been completed with nearly all ADGPs.¹⁰⁹

7.9.10 Royal Flying Doctor Service of Australia

The Royal Flying Doctor Service of Australia (RFDS) was established in 1928 and developed on a national basis in the 1930s. The RFDS is a nonprofit charitable service that provides aerial medical emergency and health care services, communications, and educational assistance to people that live, work and travel in the remote areas of Australia.

Before the RFDS was established, a serious illness or accident in remote Australia often resulted in death. The RFDS was the first comprehensive aerial medical organisation in the world. To this day the RFDS remains unique for the range of primary health care and emergency services it provides and for the huge area of sparse population and climatic extremes over which it operates – 24 hours a day, 365 days a year.¹¹⁰

7.10 Health care funding in Australia

The main categories of payment systems used to remunerate doctors are salary, capitation and fee-for-service. Most countries have mixed systems of physician payment. Under salary systems, doctors are paid an annual salary usually to work a set number of hours per week per year. Capitation systems, on the other hand, pay doctors an amount per patient registered with them or in their care. Under capitation and salary payment, the doctor knows how much money they will receive before any care is provided. This is known as prospective payment and may encourage doctors to contain costs. Under fee-for-service payment, the doctor is reimbursed for each item of service provided (the fee often depends on the type of service) and is paid after care has been provided.¹¹¹

In Australia, the responsibility for funding health services is shared between all levels of government and the nongovernment sector (eg. workers' compensation and insurance companies), and is predominantly based on a fee-for-service model. Therefore, depending on the level of the fee, there is an incentive to deliver more care in order to inflate income. This can lead to supplier induced demand where the patient receives more care than they would have chosen if they had the required knowledge. This system has been criticised as almost encouraging a disincentive for quality care.¹¹¹

Over the past few years, the funding of general practice by the Australian Government has undergone substantial changes arising from the introduction of new initiatives aimed at improving health care quality and balancing the disincentives of the fee-for-service payment system. These initiatives have seen the introduction of blended payments for practitioners – payments made through a program in addition to other income earned by the GP and the practice, eg. patient payments and Medicare rebates. Blended payments provide incentives for general practices that provide comprehensive quality health care. The introduction of these payments represents a change in the philosophy of health funding by the Australian Government and is likely to play a substantial role in shaping the future use of indicators within general practice.

7.10.1 Fee-for-service payments

Medicare

Medicare is Australia's universal health insurance scheme and is legislated under the *Health Insurance Act 1973*. Medicare was first introduced in 1984, its three objectives are:

- to make health care affordable for all Australians
- to give all Australians access to health care services with priority according to clinical need, and
- to provide a high quality of care.

Medicare provides access to:

- free treatment as a public (Medicare) patient in a public hospital, and
- free or subsidised treatment by practitioners such as doctors – including specialists, participating optometrists or dentists (specified services only).

Australia's public hospital system is funded jointly by the Commonwealth, state and territory governments and is administered by state and territory health departments. The HIC administers the Medicare program, which includes enrolments and benefit payments. Contribution to the health care system is made through taxes and a Medicare levy, which is based on taxable income.

For GPs to be eligible to claim Medicare rebates, they must have a Medicare Provider Number. The Australian Government has adopted Fellowship of the RACGP, as the standard for practising as an unsupervised GP in Australia. Medical practitioners may be recognised as GPs for the purposes of claiming Medicare fee-for-service rebates by:

- holding the Fellowship of the RACGP
- being admitted to the vocational register before 1995, and
- being in a recognised training placement.

Medicare Plus

The 2004 Medicare Plus Scheme outlines major change to the Australian health system to address problems associated with access and affordability. The Medicare Plus safety net is an important structural improvement to the Medicare system to help people cope with the costs of out-of-hospital procedures (eg. MRI, CT scans, ultrasound, and specialist visits), which have never been widely bulk billed. In summary, the scheme:

- provides additional funding to improve access to high quality health care for Medicare cardholders and children

- is moving towards electronic claiming to benefits patients (however, this does raise concerns about increased red tape for general practices)
- provides strengthened safety nets for needy patients who strike barriers to access
- acknowledges workforce issues and includes initiatives designed to address the GP shortage
- acknowledges the need for increased financial support for training practices and GP supervisors
- provides prevocational terms for junior doctors in general practice, which will allow more medical graduates to experience general practice and will promote general practice as a career
- recognises the Commonwealth Government's commitment to ensuring that overseas trained doctors meet appropriate Australian standards before they are able to practice medicine in Australia
- supports rural and remote GPs, especially procedural GPs through enhancing the recognition and support for locum GPs and the adoption of a simple and affordable national medical registration process
- removes deterrents to doctors rejoining the workforce and helps GPs and specialists re-enter the profession
- recognises the multi disciplinary nature of modern general practice through the introduction of a new MBS item for specified services that can be provided by a general practice nurse (GPN) without a GP being present
- supports improvements in access to health care services in aged care facilities.¹¹²

Professional Services Review Scheme

An independent statutory authority under the Health Insurance Act 1973 runs the Professional Services Review Scheme (PSRS). The PSRS examines the conduct of individual practitioners to ascertain if the practitioner has engaged in appropriate practice for the purposes of Medicare.

Inappropriate practice is defined as that which is generally unacceptable to the body of the members of the speciality in which the practitioner is practising when he or she has rendered or initiated the services. If a practitioner is found to have engaged in inappropriate practice, various types of action can be taken.

7.10.2 Non fee-for-service payments

Practice Incentives Program

The Practice Incentives Program (PIP) is part of the blended payment approach for general practice, which grew out of the Better Practice Program in response to a series of recommendations made by the General Practice Strategy Review Group (GPSRG) in 1998. The PIP aims to recognise general practices that provide quality care and that are either accredited or working towards accreditation against the RACGP's Standards for General Practices, and balance the disincentives of the fee-for-service payment system. The PIP payments focus on aspects of general practice that contribute to quality care. These include:

- information management and/or information technology (including the use of prescribing software and the capacity to send and receive electronic data)
- after hours services (24 hour access to care)
- rurality
- teaching of medical students
- participation in targeted incentive programs such as immunisation and quality use of medicines programs. Better management of diabetes, asthma, mental health and cervical screening and
- practice nurses.¹¹³

General Practice Immunisation Incentives

The General Practice Immunisation Incentives (GPII) scheme was introduced by the Australian Government to provide financial incentives to GPs who monitor, promote and provide age appropriate immunisation services to children under the age of seven years. The GPII is made up of three components:

- a service incentive payment (SIP) – to GPs and other medical practitioners who notify the Australian Childhood Immunisation Register of a vaccination that completes an immunisation schedule
- an outcomes payment – a tiered series of payments to practices that achieve certain percentage proportions of full immunisation
- immunisation infrastructure funding – which provides funds to divisions of general practice, SBOs and funding for a national GP immunisation coordinator to improve the proportion of children who are immunised at local, state/territory and national levels.

The overall aim of the GPII is to encourage at least 90% of practices to achieve 90% proportions of full immunisation.¹¹³

In November 2003, the Australian Government announced a range of new Medicare initiatives to protect and strengthen Medicare into the future.

Enhanced Primary Care items

The Enhanced Primary Care (EPC) package within the Medicare Benefits Scheme (MBS) was introduced in 1999. The aim of the introduction of these items was to improve the capacity of GPs to integrate with other health care services and take a stronger preventive approach to the care of their patients. The EPC items provide payments to GPs for taking part in a range of programs designed to assist people with chronic illness and complex care needs (many of whom are elder Australians) as well as their carers and the health professionals who look after them.

The EPC Medicare items provide a framework for a multi disciplinary approach to health care through a more flexible, efficient and responsive match between the care the recipients need and the services provided. There are 28 EPC items on the MBS that cover:

- annual health assessments for Australians aged 75 years and older, and Aboriginal and Torres Strait Islanders aged 55 years and older
- care planning for those with complex care needs
- case conferencing between GPs and other health and support workers about care and progress of patients requiring care from these multiple providers.

Examples of some of the EPC programs include:

- the Domiciliary Medication Management Review
- Coordinated Care Trails
- the Sharing Health Care Initiative (formerly the Chronic Disease Self Management Initiative)
- Better Medication Management System
- Cervical Screening Incentives
- Asthma 3+ Visit plan
- Medicare Allied Health and Dental Care Initiative.

7.11 National guidelines and resources

Clinical practice guidelines are one component of good medical decision making that take into account patient's preferences and values, clinician's values and experience, and the available resources. The main purpose of clinical guidelines is to achieve better health outcomes by improving the practice of health professionals and providing consumers with better information about treatment options. Guidelines can inform consumers about risk factors and how to avert them; they can be used to broaden the education of practitioners and the community, thus contributing to quality assurance processes; and they can assist in the resolution of legal disputes and ethical dilemmas.¹¹⁴

The NHMRC is one of a number of organisations that produces clinical practice guidelines for GPs. The NHMRC aims to foster a critical, evidence based approach to develop health advice on priority health issues and recognises the importance of developing clinical guidelines. In 1999, the NHMRC developed *A guide to the development, implementation and evaluation of clinical practice guidelines*. The guide intended to assist organisations developing guidelines and was a result of various concerns. These included unjustifiable variations in clinical practice for the same condition, increasing availability of new treatments and technology, an uncertainty as to the effectiveness of many interventions in improving people's health, and a desire to make the best use of available health resources.¹¹⁴

It is now acknowledged that guideline recommendations should be based on systematic identification and synthesis of the best available scientific evidence. To assist health professionals with determining what constitutes 'the best available scientific evidence', the NHMRC developed a guide which describes five 'levels of evidence', that represent the most thorough systematic reviews of randomised controlled trials to general opinion. *Table 12* represents the levels of evidence and the coding scheme used in the RACGP's *Guidelines for preventive activities in general practice* 5th edition, which is based on the NHMRC's levels of evidence, to guide GP's activities when providing preventive health care to patients.

Despite guidelines being an excellent source or summary of the available evidence to guide the treatment of particular conditions, it is important to consider the limitations of these resources. With regard to general practice, Silagy et al (1997) have identified barriers to GPs adopting and applying evidence based guidelines in their practice. Silagy et al emphasise that the dissemination and implementation strategies should be multifaceted, participatory and integrated into the process of care for evidence based guidelines to improve outcomes. Consequently, the widespread use of poorly developed guidelines can have the effect of divisions competing for scarce health dollars or of displacing resources and time from other more effective activities.¹¹⁵

The effectiveness of guidelines can be limited, in part because they need to be regularly updated. But also because health care professionals' acceptance of clinical practice guidelines has, to some degree, been marred by a lingering concern that they represent 'cookbook' medicine.

Nevertheless, moves to make evidence based guidelines more readily available to GPs and the continual development of evidence based clinical guidelines highlights the importance of these clinical tools for providing quality care.

Table 12. RACGP Coding scheme used for the levels of evidence and strength of recommendation

Levels of evidence	
Level	Explanation
I	Evidence obtained from a systematic review of all relevant randomised controlled trials
II	Evidence obtained from at least one properly designed randomised controlled trial
III	Evidence obtained from any of the following: <ul style="list-style-type: none"> • well designed pseudo randomised controlled trials (alternate allocation or some other method) • comparative studies with concurrent controls and allocation not randomised (cohort studies), case control studies, or interrupted time series with a control group Comparative studies with historical control, two or more single arm studies, or interrupted time series without a parallel control group
IV	Evidence obtained from case series, either post-test or pre-test and post-test
V	Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees
No evidence	After thorough searching no evidence was found regarding recommendations in general practice for the target disease or condition

Strength of recommendation	
Strength	Explanation
A	There is good evidence to support the recommendation
B	There is fair evidence to support the recommendation
C	There is poor evidence regarding the inclusion or exclusion of the recommendation but recommendations may be made on other grounds
D	There is fair evidence against the recommendation
E	There is good evidence against the recommendation

Source: RACGP. *Guidelines for preventive activities in general practice*, 5th edition, 2002
 A number of organisations produce clinical guidelines and resources for general practitioners, including the following.

The National Health and Medical Research Council

The National Health and Medical Research Council (NHMRC) has been involved in the development of clinical guidelines in a number of areas such as early breast cancer, coronary heart disease, unstable angina, stroke prevention and depression in young people for over a decade. Examples of guidelines produced by the NHMRC specifically aimed at GPs include: *Guidelines for the prevention, early detection and management of colorectal cancer: a guide for general practitioners* 2000, *Acute pain management: information for general practitioners* 1999, and *Management of diabetic retinopathy: a guide for general practitioners* 1997.

The Royal Australian College of General Practitioners

Guidelines for preventive activities in general practice 5th Edition 2002 (red book)

Medical care of older persons in residential aged care facilities (silver book)

Putting prevention into practice (green book)

SNAP: a population health guide to behavioural risk factors in general practice

Other sources of guidelines

The Cochrane Library is an online database of scientific research around the world, and is one renowned for being one of the best sources of reliable evidence about health care interventions

Medical software organisations, eg. Medical Director

Nongovernment health organisations, eg. The Cancer Council Australia, National Asthma Council, The Heart Foundation

Therapeutic guidelines, eg. *Therapeutic guidelines: Antibiotic version 12, 2003, and Therapeutic guidelines: Respiratory version 2, 2000*

7.12 Where to from here?

This section has provided a detailed analysis of the quality initiatives and systems that affect the general practice environment in Australia. It highlights the complexity of the Australian health care system and outlines the organisations that influence quality in general practice at the level of the consumer, the GP, the practice, the local or regional level, and the national and policy level.

However, it does not show how each of these quality initiatives map against organisational domains such as leadership, culture, team development, and information technology, or against dimensions such as safety, effectiveness, patient centeredness, timeliness, efficiency and equity. The development of a quality framework will provide the structure to enable existing (and future) quality initiatives to be mapped against a number of domains and key indicators, and use this information to inform a 'gap and resource' analysis for the Australian general practice environment.

Conclusion

A quality framework for general practice is a tool for analysing the general practice environment from a quality perspective. A quality framework will support the revision and improvement of existing services, it will identify existing and anticipated gaps and it will assist planning and development of new services and approaches.

The GPSR first promoted a quality framework, adopting the Institute of Medicine's definition of quality as 'the degree to which health services for individuals and the population increase the likelihood of desired health outcomes and are consistent with current professional knowledge'.¹⁵ While there are other definitions, most have common features eg. increase in desired health outcomes, technical competence, operating within constraints, and acknowledging and meeting patient preferences. Quality encompasses concepts of quality assurance, quality improvement, and risk assessment and management. In considering a quality framework, it is suggested that:

- the framework will recognise the importance of patient-doctor partnership.
- the framework builds on and acknowledges the high quality system that currently exists ie. GPs, practice teams, divisions of general practice, state, territory and national programs
- the framework will recognise that a general practice quality framework will include subsystem frameworks (eg. education frameworks, implementation frameworks) and will be encased in a wider framework of health care quality systems
- the framework will include individual practitioner quality and systems based quality
- the framework is likely to operate at a range of levels; the individual general practitioner, the practice unit or team, regional and state/territory organisation and national level, recognising both providers of services and funders of those services
- the framework is likely to encompass core domains that build and support quality eg. practitioner and systems assurance, information management and information communication technology (IM&ICT), leadership in the clinical and management sectors, a culture that supports improvement, and the management of clinical and other knowledge
- the framework is likely to be structured around the dimensions articulated by the Institute of Medicine and adopted by Australia's Health Performance Framework and a number of state frameworks. The core dimensions are:
 - safe – avoiding injuries to patients from the care that is intended to help them
 - effective – providing services based on scientific knowledge to all who could benefit and retaining from providing services to those not likely to benefit (avoiding under use and overuse, respectively)
 - patient centred – providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions
 - timely – reducing waits and sometimes harmful delays for both those who receive and those who give care
 - efficient – avoiding waste, including waste of equipment, supplies, ideas and energy
 - equitable – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status.¹⁶⁵
- the framework will be supported by a suite of interventions that account for the various barriers to quality and encourage systematic consideration of options for design of new services and review of existing services and programs
- the framework will support evaluation
- the framework will be dynamic, providing a current snapshot of quality in health care, and guidance for future service delivery planning
- the framework will be represented in diagrammatic form and use metaphor to support understanding.

8.1 Next steps

This document will be considered by the Quality in General Practice Committee, and revised based on suggestions for improvement. Thereafter an indicative quality framework (a separate document) will be considered in a series of state based consultations.

The outcomes of the consultations with key stakeholders, literature view and consideration of the 'grey literature' will be synthesised into a final quality framework for general practice. This will be presented to the Quality in General Practice Committee and DoHA by August 2005.

8.2 Comments

To comment on this document or the quality framework process, contact:

Teri Snowdon

National Manager, Quality Care and Research

The Royal Australian College of General Practitioners

1 Palmerston Crescent

South Melbourne, Vic 3205

Tel 03 8699 0562

Email teri.snowdon@racgp.org.au

References

1. Physicians News Digest. Available at: www.physiciansnews.com/discussion/corrato.html. [Accessed September 2004].
2. Omnilingua. Available at: www.omnilingua.com/omnicenter/qualitytheories.aspx. [Accessed September 2004].
3. Deming W. Out of the crisis. MIT Centre for Advanced Engineering Study Cambridge: 1986;23–4.
4. Senge PM. The fifth discipline: the art and practice of the learning organisation. New York: Doubleday Currency, 1990.
5. Reason J. Human error: models and management. *BMJ* 2000;320:768–70.
6. Amoores J, Ingram P. Learning from adverse incidents involving medical devices. *BMJ* 2002;272–5.
7. Bower J, Christensen C. Disruptive technologies: Catching the wave in Harvard Business Review 1995;73:43–53.
8. Bower J. Disruptive change: when trying harder is part of the problem in Harvard Business Review. May 2002.
9. Australian Council for Safety and Quality in Health Care Available at: www.safetyandquality.org/articles/Action/definitions.pdf. [Accessed September 2004].
10. Nisselle P. Managing medical indemnity: must we choose between quality assurance and risk management? *Med J Aust* 2004;181:65.
11. Donabedian A. Institutional and professional responsibility in quality assurance. *Quality Assurance in Health Care* 1989;1:3–11.
12. Donabedian A. The quality of care: how can it be assessed? *J Am Med Association* 1988;260:1743–8.
13. Ferlie EB, Shortell SM. Improving the quality of health care in the United Kingdom and the United States: a framework for change. *Milbank Quarterly* 2001;79:281–315.
14. Gray B. *Milbank Quarterly*, 2001;145–8.
15. Makkela M, Booth B, Roberts R, (eds). Family doctors' journey to quality. The WONCA Working Party on Quality in Family Medicine 2001.
16. General Practice Strategy Review Group. General practice: Changing the future through partnerships. Canberra: DHFS, 1998.
17. Central Bayside Division of General Practice. Building on quality: changing the future through systematic quality improvement. Sandringham: CBDGP, 2001.
18. Grol R, Wensing M. What drives change? Barriers to and incentives for achieving evidence based practice. *Med J Aust* 2004;180(6 Suppl):S57–60.
19. Woods K, Kely D, Lowy A, et al. Beta blockers and antithrombotic treatment for secondary prevention after myocardial infarction. *Eur Heart J* 1998;19:74–9.
20. Grol R, Wensing M, Eccles M, (eds). Improving practice: a systematic approach to implementation of change in patient care. Oxford, UK: Elsevier Science, 2004;2–6.
21. National Institute of Clinical Studies. Evidence-Practice Gaps Report. NICS 2003;14.
22. Vale M, Jelinek M. *Med J Aust* 2002;176:211–15.
23. Dickinson J, Wiggers J, Leeder S, Sanson-Fisher R, et al. General practitioners' detection of patients' smoking status. *Med J Aust* 1989;150:420–26.
24. Mabbut J, Bauman A, Moshin M. Tobacco use of pregnant women and their male partners who attend antenatal classes. *Aust NZ J Public Health* 2002;26:571–2.
25. Kelly A, Kerr D, Patrick I, Walker T. Call-to-needle time for thrombolysis in acute myocardial infarction in Victoria. *Med J Aust* 2003;178:381–5.
26. Mott K, Kidd M, Weller D. Quality and outcomes in general practice in Australia. Canberra: Commonwealth Department of Health and Aged Care, 2000.
27. Fletcher M. The quality of Australian health care: Current issues and future directions, in occasional papers: Health Financing Series. Canberra: Commonwealth Department of Health and Aged Care, 2000.
28. Sheikh A, Hurwitz B. Log of errors needed. *BMJ* 2000;321:505.

29. Makeham M, Dovey S, Country M, Kidd M. An international taxonomy for errors in general practice: a pilot study. *Med J Aust* 2002;177:68–72.
30. Britt H, Miller GC, Steven ID, et al. Collecting data on potentially harmful events: a method for monitoring incidents in general practice. *Fam Practice* 1997;14:101–6.
31. Bhasale A. The wrong diagnosis: identifying causes of potentially adverse events in general practice using incident monitoring. *Fam Practice*. 1998;15:308–18.
32. Smith J. Redesigning health care – radical redesign is a way to radically improve. *BMJ* 2001;322:1257–8.
33. Berwick DM. Idealized design of clinical office practices Institute for Healthcare Improvement. 2001 Available at: www.ihl.org/idealized/idcop/sampleresults.asp.
34. Institute for Healthcare Improvement, Available at: www.ihl.org/IHI/Topics/Improvement/caseforimprovement.htm. [Accessed September 2004].
35. Coffield A, Maciosek M, McGinnis J, et al. Priorities among recommended clinical preventive services. *Am J Prev Med* 2001;21:1–9.
36. Maciosek M, Coffield A, McGinnis J, et al. Coffield et al. Methods for priority setting among clinical preventive services. *Am J Prev Med* 2001;21:10–19.
37. Brown LD. Comparing health systems in four countries: lessons for the United States. *Am J Public Health* 2003;93:52–6.
38. Wilson R, Runciman W, Gibberd R, et al. Quality of Australian health care study. *Med J Aust* 1995;163:458.
39. Grol R. Personal paper: beliefs and evidence in changing clinical practice. *BMJ* 1997;315:418–21.
40. Rhydderch M, Elwyn G, Marshall M, Grol R. Organisational change theory and the use of indicators in general practice. *Qual Saf Health Care*, 2004;13:217.
41. Bradley E, Webster T, Baker D, et al. Translating research into practice: speeding the adoption of innovated health care programs. Canberra: The Commonwealth Fund Issue Brief July 2004.
42. Schattner P, Markey P, Mathews M. Changing GPs clinical behaviour: what can divisions do? *Aust Fam Physician* 2001;30:300–4.
43. Grol R, Grimshaw J. From best evidence to best practice: effective implementation of change in patients' care. *The Lancet* 2003;362(9391):1225–30.
44. Grimshaw J, Thomas R, MacLennan G, et al. Effectiveness and efficiency of guideline dissemination and implementation strategies. *Health Technol Assess* 2004;8:iii–iv, 1–72 (Review).
45. Knight A. The collaborative method: a strategy for improving Australian general practice. *Aust Fam Physician* 2004;33:269–73.
46. The Improvement Network. Available at: www.tin.nhs.uk/index.asp?pgid=1130. [Accessed September 2004].
47. World Health Organisation. Available at: www.who.int/whr/2000/en/. [Accessed September 2004].
48. World Health Organisation Regional Health Office of Europe. Available at: www.euro.who.int/AboutWHO/Policy/20010827_2. [Accessed September 2004].
49. World Health Organisation. www.who.int/hpr/NPH/docs/jakarta_declaration_en.pdf. [Accessed September 2004].
50. Woodward C. Improving provider skills: strategies for assisting health workers to modify and improve skills; developing quality health care – a process of change. Geneva: WHO, 2000:1.
51. World Health Organisation. The principles of quality assurance. Copenhagen: WHO, 1983.
52. Walshe K, Freeman T, Latham L, et al. Clinical governance: from policy to practice. UK: University of Birmingham, 2000, 1–3.
53. Degeling P, Maxwell S, Iedema R, Hunter DJ. Making clinical governance work. *BMJ* 2004;329:679–81.
54. Greenfield S, Kaplan S. Creating a culture of quality: the remarkable transformation of the Department of Veterans Affairs Health Care System. *Annals of Internal Medicine* 2004;17:316–8.
55. US Department of Veterans Affairs. Office of Inspector General. Quality Management in the Department of Veterans Affairs: Veterans Health Administration, 1998. Available at: www.va.gov/oig/54/reports/8HI-A28-072.htm#e21.

56. Jha A, Perlin J, Kizer K, et al. Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care. *NEMJ* 2003;348:2218–27.
57. European Charter of Teachers in General Practice. Available at: www.euract.org/html/pap04105.shtml. [Accessed September 2004].
58. NSW Health. A framework for managing the quality of health services in New South Wales, 1999.
59. Victorian Quality Council. Better quality, better health care: a safety and quality improvement framework for Victorian health services. Melbourne: Victorian Government Department of Human Services, 2003.
60. Western Australian Council for Safety and Quality in Health Care. The Western Australian strategic plan for safety and quality in health care 2003–2008. WA: 2003.
61. National Expert Advisory Group on Safety and Quality in Australian Health Care. Implementing safety and quality enhancement in health care: national actions to support quality and safety improvement in Australian health care. Canberra: Commonwealth of Australia, 1999.
62. Australian Council for Safety and Quality in Health Care. Maximising national effectiveness to reduce harm and improve care: fifth report to the Australian Health Ministers' Conference. Canberra: Australian Government, 2004.
63. Department of Health and Ageing. Available at: www.health.gov.au/pq/sq/index.htm. [Accessed September 2004].
64. National Health Performance Committee (NHPC). National Health Performance Framework Report: a report to the Australian Health Ministers' Conference. Brisbane: Queensland Health, 2001.
65. Institute of Medicine Committee on Quality of Health Care in America. Crossing the quality chasm: a new health system for the 21st century. Washington: National Academy Editor, 2001;4.
66. General Practice Education & Training. Quality Framework 2003–2005 Part 1: Philosophy, Principles and Policy (ver 6.0);3.
67. Australian College for Rural and Remote Medicine. Primary Curriculum for Rural and Remote Medicine. Edn 2. Available at: www.acrrm.org.au/main.asp?NodeID=3665. [Accessed September 2004].
68. Chassin M. Is health care ready for six sigma quality? *Milbank Quarterly* 1998;76:565–91, 510.
69. Institute of Medicine Committee on Quality of Health Care in America. To err is human. Washington DC: IOM, 2000.
70. Royal Australian College of General Practitioners Policy Paper. Ensuring the Quality of Australia's General Practitioners, op. cit.
71. Commonwealth Department of Health and Aged Care. General Practice in Australia 2000. 1st edn. Canberra: Commonwealth of Australia, 2000.
72. Kamien M, Buttfield IH. Some solutions to the shortage of general practitioners in rural Australia. Part 1. Medical school selection. *Med J Aust* 1990;152:105–7.
73. Royal Australian College of General Practitioners. AMC Accreditation Report of RACGP. Melbourne: RACGP, 2003.
74. Australian Government Department of Health and Ageing. Medicare Benefits Schedule Book. Canberra: Commonwealth of Australia, 2003;7–8.
75. Atkinson K. Ensuring the pathway to quality general practice, RACGP policy paper. Melbourne: RACGP, 2004.
76. Rawlin M. Recruitment of IMGs from abroad for Australian general practice: a solution for the Australian Government. Melbourne: RACGP, 2004.
77. Australian Institute of Health and Welfare. Medical Labour Force 1997, in AIHW cat no. HWL 13. Canberra: AIHW, 1999.
79. Strasser R, Worley P, Hays R, Togno J. Developing social capital: community participation in rural health services. Fifth National Rural Health Conference. Traralgon: Monash University Centre for Rural Health, 1999.
78. Britt H, Miles DA, Bridges-Webb C, Neary S, Charles J, Traynor V. Morbidity and treatment in general practice in Australia 1990–1991. *Med J Aust* 1993;S19:S1–56.
80. Royal Australian College of General Practitioners. Definition of general practice and general practitioner. Melbourne: RACGP Online, 1997. Available at: www.racgp.org.au/folder.asp?id=663. [Accessed 1 December 2005].

81. Royal Australian College of General Practitioners. Standards for general practices. 2nd edn. Melbourne: The Royal Australian College of General Practitioners, 2000.
82. Australian General Practice Accreditation Limited. Available at: www.agpal.com.au. [Accessed August 2004].
83. Quality Practice Accreditation. Available at: www.gpa.net.au/index.htm. [Accessed August 2004].
84. Department of Health and Aged Care. Available at: www.health.gov.au/workforce/workforce/dep.htm. [Accessed September 2004].
85. Watts I, Foley E, Hutchinson R, Pascoe T, Whitecross L, Snowdon T. General practice nursing in Australia, May 2004.
86. General Practice Computing Group. Available at: www.gpcg.org/projects/index.html. [Accessed September 2004].
87. Royal Australian College of General Practitioners Policy Paper. Ensuring the Quality of Australia's General Practitioners. Melbourne: RACGP, 1994.
88. Consumers Health Forum of Australia. Building links with consumers: The key to quality general practice. Canberra: Consumers Health Forum, 1993.
89. Draper M. Involving consumers in improving hospital care: lessons from Australian hospitals. Canberra: Commonwealth Department of Health and Family Services, Australian Government Publishing Service, 1997.
90. Wensing M, Grol R. for the EUROPEP group. A standardised instrument for patient evaluations of general practice care in Europe. *Eur J Gen Pract* 2000;6:82–7.
91. Victorian Department of Human Services. Primary care partnerships: going forward. Melbourne: Aged Community and Mental Health Division Victoria, 2000.
92. Australian Divisions of General Practice. Available at: www.adgp.com.au. [Accessed September 2004].
93. Australian Divisions of General Practice. Response to the review of the role of divisions of general practice, November 2003.
94. The future role of the divisions network: report of the review of the role of divisions of general practice. Canberra: Commonwealth of Australia, 2003.
95. Royal Australian College of General Practitioners. Royal Australian College of General Practitioners Annual Report. Melbourne: RACGP, 2004.
96. Royal Australian College of General Practitioners Policy Paper. After hours primary medical care in general practice. Melbourne: RACGP, November 1999.
97. Department of Health and Aged Care. Available at: www.health.gov.au/pcd/programs/apccp/index.htm. [Accessed September 2004].
98. Department of Health and Aged Care. Available at: www.health.gov.au/pcd/programs/hcc/index.htm. [Accessed September 2004].
99. Marshall M, Roland M, Campbell S, et al. Measuring general practice: a demonstration project to develop and test a set of primary care clinical quality indicators. London: Nuffield Trust, 2003.
100. Jeacocke D, Heller R, Gibberd R, Halpin S, Smith J, Anthony D. Evidence based indicators for improving the quality of health care provision in general practice final report. Newcastle: June 2000.
101. Sheldon TA. The healthcare quality measurement industry: time to allow the juggernaut? *Qual Saf Health Care* 2005;14:3–4.
102. Department of Health and Aged Care. Available at: <http://www.health.gov.au/overview.htm>. [Accessed September 2004].
103. Australian Medical Association. Available at: www.ama.com.au. [Accessed September 2004].
104. Rural Doctors Association Australia. Available at: www.rdaa.com.au/uploaded_documents/SUMMARY_VIABLE_MODELS_S1&S2_REPORT__2pagespreads.pdf. [Accessed September 2004].
105. Australian Council for Safety and Quality in Health Care. Available at: www.safetyandquality.org/index.cfm. [Accessed September 2004].
106. NACCHO. Available at: www.naccho.org.au/. [Accessed September 2004].
107. National Health and Medical Research Council. Available at: nhmrc.gov.au/aboutus/facsheet/fctsheetsheet.pdf. [Accessed September 2004].

108. National Institute of Clinical Studies. Available at: www.nicsl.com.au/. [Accessed September 2004].
109. National Prescribing Service. Available at: www.nps.org.au. [Accessed September 2004].
110. Royal Flying Doctors Service. Available at: www.flyingdoctor.net. [Accessed September 2004].
111. Gosden T, Forland F, Kristiansen IS, et al. Capitation, salary, fee-for-service and mixed systems of payment: effects on the behaviour of primary care physicians (Cochrane Review). The Cochrane Library, Chichester: John Wiley & Sons Ltd, 2004.
112. Royal Australian College of General Practitioners. General Practice Representative Group Paper, 2004.
113. Health Insurance Commission. Available at: www.hic.gov.au/providers/incentives_allowances/pip.htm. [Accessed September 2004].
114. National Health and Medical Research Council. A guide to the development, implementation and evaluation of clinical practice guidelines. Canberra: NHMRC, 1999.
115. Silagy C, Weller D, Moulding N, Fahy N, Foong LH, Yeoh H. A systematic review of the current status of evidence based medicine and its practical application to Australian general practice. Adelaide: Department of General Practice Flinders University, 1997.

