The future of general practitioners in the management of divisions of general practice

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BACKGROUND The role of divisions of general practice has changed significantly since its inception. Divisions have evolved from simply assisting general practitioners in their practices and providing complementary support to existing health services through project work, to becoming major instruments of organisational change.
OBJECTIVE This article looks at the short history of divisions of general practice and explores options for the future that may help build a better interface between practical medicine and the growing bureaucratic, organisational and managerial demands being placed upon divisions.
DISCUSSION In the process of the change in the role of divisions we have experienced a paradigm clash between the essential work of GPs as effective medical practitioners, and their role in divisions as managers and leaders of the wider health care system change.

In the 1992 report of the General Practice Consultative Committee, concerns were raised regarding general practice.[1] These concerns related to quality, workforce, integration and financing.[2] In the 1992-1993 Federal Budget, funding made available to implement change resulted in the establishment of divisions of general practice. These were organisations of and for general practitioners to have responsibility for integrating health care initiatives, communicating with consumers and others in the health arena, and to provide an infrastructure for GPs to communicate with each other. They were also expected to participate in coordinated care trials, accreditation of practices and to work with state and regional health authorities.

One of the founders of divisions, the late Des Scholz, succinctly defined why divisions were needed when he wrote:

'In work with area health authorities and local planning, it has always been a paradox that area health activity could be undertaken without including the single largest group of primary health care providers in the process, that is the GPs. Yet that is what occurred before 1992'.[2]

A statement in 1995 defined divisions as: 'Geographically based networks of general practices which provide: 'The organisational structure for GPs to work together to improve quality and continuity of care, meet local goals and targets, promote preventive care and respond more rapidly to changing community health needs. Divisions also provide GPs with a corporate identity, a method of influencing the organisation of health care delivery, a chance to utilise a broader range of skills, knowledge and expertise and an opportunity to work with other stakeholders on issues of common interest'.[3]

Initially the work of divisions involved setting up an office with a few staff and running projects to suit the needs of local communities and the interests of GPs. Divisions were able to make much needed contributions to the provision of health care where services were scarce.

Additional responsibilities

By 1997-1998 divisions were funded through block grants and were 'poised to make a significant contribution to primary health care in Australia'.[4] They also gained additional responsibilities,

much greater in scope and detail than the original aims, for example, to target outcomes consistent with local and national needs and to have a principal role in data collection and validation. Divisions were also expected to initiate and coordinate professional development for GPs and their staff.

In 1999-2000 the divisions' environment changed further with the introduction of nationally coordinated immunisation programs, the Enhanced Primary Care Package, and increasing concerns regarding after hours primary care and increasing corporatisation of general practices. Divisions also became involved in fee negotiations.[5]

Consolidation

Consolidation is necessary as divisions' functions have increased in scope, number and complexity. Sorting out matters of corporate governance, director's responsibilities, and management and leadership is a great challenge and something that doctors have found difficult. This is not new. It was predicted in 1995 that many GPs would not have the interest, time, training or experience to understand and undertake the myriad functions necessary to run a division and to be involved in local and national initiatives.[6] In 1996 Deakin Australia produced a report for the then Department of Health and Family Services describing the need for management and leadership development in divisions.

The Deakin report[7] listed a number of human resource management problems including GPs' lack of knowledge of their own roles within divisions, those of administrative staff and other players in the health system, and (most importantly) vice versa, time constraints and the difficulties of working within systems rather than as individuals. The lack of clarity related to directors' and administrators' roles and responsibilities remains unchanged. The Deakin report was quite forthright in recommending support for training and inferred that if divisions did not develop good, strong and politically astute management structures they would lose the opportunity to improve health outcomes for patients.

Quality in the health system is a major concern in Australia and throughout the world, and will quite clearly determine the environment in which we all work in the future. Clinicians will be required to play a major part in maintaining quality in all aspects of health care delivery.[8] This will be no different for divisions. The Australian Divisions of General Practice has foreshadowed a system of accreditation of the divisional network.[9]

A cursory examination of the literature confirms how important doctors are as leaders in medicine and how doctors in different health care systems are coming under greater pressure to be involved in management. However, to 'create managers out of doctors' requires training and development.[10]

However, there are impediments to this because of attitudes and abilities of doctors and of health system managers, who have applied little from the literature on organisational behaviour and management.[11]

The current situation in divisions of general practice in Australia can be summarised as follows:

- unlike so many parts of the health system, doctors are major players in the management of divisions
- primary health care and quality are highlights of the current health agenda
- divisions of general practice loom large in the integration and some financial aspects of primary health care
- currently doctors' roles as division managers are changing because of increased bureaucracy
- there is an inherent tension in the management of divisions. Doctors have skills, abilities and respect in the community that can strengthen and legitimise the functions of divisions and ultimately benefit patients. However, lack of knowledge and opportunity, frustration with processes, the low status of administration and time constraints can hinder or prevent involvement in management.

There are number of qualitive and quantitive factors involved - a familiar medical situation.

Qualitive

General practitioners generally have had little training in, or knowledge of, the role of directors, corporate governance and project management and yet may be responsible for millions of dollars. In order for directors to manage effectively they should not be involved in day-to-day operations. The dilemma is that this is what doctors are good at and what we all did in the early days of divisions. It can be hard to let go and work through others. How do doctors learn to look at the future needs of their communities and design strategies to meet those needs? How do they then articulate those ideas to their division's staff, local population, health funders and most importantly, their colleagues?

Not only do individual doctors often lack the skills and knowledge to meet the management challenges ahead, the profession has problems with leadership. Richard Smith cites Warren Bennis as saying: 'leading doctors is like herding cats'. He goes on to write that doctors tend to pull down those who try to lead, are uncomfortable working with others, are wary of power, are used to telling people what to do instead of motivating and empowering them, and are analytical rather than creative. He also describes how doctors find it hard to abandon control to others and to express emotion in themselves, let alone encourage it in others, both of which are extremely important qualities in leaders.[12]

Quantitive

The nature of divisions has changed. There are vastly more bureaucratic requirements. Divisions are now regarded as central in primary health care delivery and this means negotiating with common-

wealth, state and regional health authorities, consumer groups, universities, colleges and other professional bodies and groups, which most GPs are unable or unwilling to make time available to undertake these activities.

There is a solution readily apparent and that is that GPs only take on the formal role of directors and leave non-medical administrators to do the rest. This is a realistic solution and the way things are currently done in many divisions. But do doctors want this to happen or do they want to lead divisions not only as formal directors, but also as hands-on leaders?

Questions that need to be answered

- Is it all that important? Do GPs really want to take a greater part in the changes that are occurring in the Australian health system and if so do they want to do it through divisions?
- Do GPs need training to be better board members, leaders and managers?
- Are GPs losing contact with the day-to-day running of divisions and if so, does this matter?
- Are the structures correct? How are the roles of medical and nonmedical staff defined?
- How do we make administration more attractive? Doctors are important; we still retain enormous public respect and support. Despite some of the difficulties mentioned above doctors are forthright and clear thinking and get things done.
- How do we get more input from GPs about what they want divisions to do and how can they be involved?
- How do we enable doctors to be involved in terms of time spent versus patient demand?

Suggestions for improvement

Divisions can implement training for directors on their roles in corporate governance in association with other divisions or with state based organisations. There are numerous training providers and training should be mandatory.

Divisions can pursue further options of management training/education for directors and salaried medical staff as outlined in the Deakin report. Units can be done at universities or TAFE by direct or distant learning. The new rural clinical schools are obvious places to facilitate this in rural areas and the practice/self management courses sponsored by some of the major drug companies may have a place. Doctors do not place a high value on 'management' but many may be surprised by what can be learned about people's behaviour in organisations, motivation, law, accountancy and politics by this type of study.

If GPs wish to lead divisions forward and add value to divisions, ways that will enable GPs to find the time and financial support to undertake and enjoy training and education in management must be created. A part solution and starting point at least could be the development of flexible learning options and recognition for CME points for such activities.

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