



Divisions of general practice, capacity building and health reform

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The development of the divisions of general practice network has been one of the major health innovations of the past decade. Its establishment was an innovative plan to build capacity in general practice to respond to health needs in the community and develop good quality health services. The network has a secure place in the health system and assists general practitioners to become involved at all levels of health policy and decision making. This capacity has facilitated multiple health reforms including immunisation and information technology, leading to improved health outcomes for the Australian community.

Establishment of divisions of general practice

In the early 1990s general practice was in a difficult position. The general practitioner was seen as central to health care in Australia with 82% of the population in 1991 seeing a GP at least once a year.¹ General practitioners' approach to diagnosis and management of patients influenced referrals to hospitals, specialists and allied health professionals. They also had responsibilities to liaise with other health professionals, and to undertake disease prevention, health promotion, research and health service planning.

However, according to Douglas et al,² Australian general practice was in trouble. Large numbers of GPs were unhappy, felt isolated, and believed that the financing system made it difficult to practise good medicine.² Problems identified for general practice included:

- lack of voice in planning
- lack of structure to involve GPs at a local level
- poor links between GPs and other health care providers

- a diminished role in hospitals³
- urban oversupply and rural shortages, and
- inappropriate financing mechanisms, particularly the lack of financial reward for GP involvement in preventive care, health promotion, teaching, and quality assurance activities.⁴

In December 1991, the General Practice Consultative Council (GPCC), a body comprising representatives of The Australian Medical Association, The Royal Australian College of General Practitioners, and the commonwealth government, met to discuss and develop proposals to enhance general practice. One of the key proposals was the establishment of local divisions of general practice (DGP) under control of GPs, which would take into account local and regional differences and concerns. The GPCC convinced an initially reluctant government to fund the idea on a pilot basis; 10 demonstration divisions were then established. Within 4 years there were 116 divisions.

The division network is now 120 regional based divisions around Australia, state based organisations (SBOs), and the Australian

Divisions of General Practice (ADGP). Ninety-five percent of GPs are members of divisions.⁵

Building capacity

What is 'capacity building'?

Capacity building involves developing structures within the organisation and with other organisations to expand the organisation's scope. Capacity building in public health incorporates:

- the development of systems to solve new problems and respond to unfamiliar circumstances
- responding to particular health needs or problems, and
- the delivery of good quality services.⁶

Capacity building and divisions of general practice

There are four areas that are important for capacity building in divisions:

- governance
- the development of a leadership structure
- membership engagement, and
- improved links between GPs, other primary health providers and hospitals.

Governance

As independent associations or companies, divisions are run by a number of paid employees (some who may be GPs) under the control of a board of management. By 1995, it became apparent that DGP were to become increasingly complex organisations with increasing levels of funding.⁷ One of the problems was the inexperience in management functions, particularly among GPs working in divisions. There was a need to strengthen the management and administrative functions of divisions, particularly in areas of corporate governance.

By 2002, all DGP had a board of management of elected GPs and non-GPs. In 2001–2002, all boards received financial reports from their division; 82% of divisions had a manual covering governance.

In Victoria, GPDV sees capacity building as one of its major objectives. There is continuing support and competency based training for directors, CEOs and treasurers of divisions on governance and financial responsibilities. There is now a move for divisions to achieve accreditation. At the end of 2003, three divisions were accredited in Australia and six more Victorian divisions are in the process of being accredited.

Leadership

In 1995, it was recommended that DGP form a national body to 'provide a focal point for GP involvement in national reforms.'⁵ However, in 1998 no national body had been formed. The General Practice Strategy Review commented that despite general practice being the largest single group in the medical profession, the disharmony between the 16 representative groups made its size a serious weakness. It was time for a national body to be formed to lead divisions in national health negotiations, show leadership, advance the role of divisions and empower general practice. It recommended that funding be provided for the ADGP to fulfil these roles.⁸ The ADGP was established in 1998 with a charter stating these aims.

Engaging GP members

Engagement of member GPs is important to capacity building as it provides credibility to the decisions and integration activities of the division. Engagement occurs through educational activities, support services to general practices, encouraging representation on other committees and participation in divisional programs.

In 1999–2000, 65% of all GPs participated in division activities.⁹ By 2002–2003, there were 21 394 GP members in 121 divisions and 80% (17 308) participated in at least one division activity. In that year, divisions paid GPs over \$18 million for activities including involvement in health programs (93%), division governance (90%), and board activities (86%).⁸

Integration with other health care providers

In the early 1990s one of the main causes of dissatisfaction in general practice was the isolation that GPs felt; little contact with other GPs or other health professionals and little involvement in health policy.⁴ Participation in division management or educational activities has increased GP-to-GP contact.

By 2001–2002, DGP were represented on a total of 1771 external committees with a total number of 1241 GP representatives.⁹ As well, 116 divisions (94%) conducted activities to improve GP collaboration with hospitals, 80% participated in shared care programs, and 99% collaborated with other primary care providers.⁹ In 2004, practising GPs sat on 60 national health sector decision making bodies as representatives of ADGP.¹⁰ The division network has made possible huge changes to GP participation in health policy and decision making at local, state and national level.

Contribution of divisions to health reform

Divisions of general practice have had many successes in health reform. They are very diverse with many common aims and outcomes. Programs and activities include:

- divisions provide CPD and services to support GPs on disease management, risk

factor detection, cancer screening, and preventive measures such as immunisation. Locally run educational activities enhance local GPs' networks

- integration between primary care, community care and acute care sectors
- collaboration with allied health services and community agencies
- services to support and advise GPs and their practices in areas including information technology/management (IT/IM), practice nurse and manager training, accreditation, immunisation programs, and systems development
- indigenous activities and involvement
- consumer involvement, and
- research and evaluation.¹⁰

Two areas in which DGP have played a vital role in successful health reform are described below.

Information technology

In 1991, a questionnaire was sent to 16 000 GPs by the National Centre for Epidemiology and Population Health (NCEPH). Less than half of the respondents (43.2%) had a computer in their practices, and those that did were mainly using it for accounts and word processing. Only one-quarter had facsimile machines.⁴ The structure of general practice (in 1991) meant that few practices could afford these facilities.⁴

Since 1999–2000 all DGP have been involved in IT/IM activities.⁹ This includes providing training and support to GPs and their staff in activities targeting electronic data transfer, disease registers or recall systems, computer literacy, prescribing applications, and practice management applications. The focus now is promoting IM/IT to improve capacity for better health outcomes in areas such as preventive medicine, recall, chronic disease management and research.

In the 2002 BEACH report,¹¹ 89.7% of GPs reported computer usage. The ADGP IMIT stocktake conducted in November 2002 established that approximately 53% of practices were using software for recording clinical notes, 79% were generating scripts electronically, and 75% had drug interaction prompts in effect.¹⁰

Immunisation

In 1994–1995, DGP recognised the need to improve immunisation practices by GPs.¹² Many focussed on the need for reliable information so that recall and reminder systems could be set up. In January 1996, the Australian Childhood Immunisation Register (ACIR) was set up to provide national information on the immunisation of children under 7 years of age, however, by 1997 the immunisation coverage for children up to 6 years had fallen to 52%. The development of divisional leadership at a state and national level meant that the capacity existed for the General Practice Immunisation Incentive (GPPI) to be developed as part of the commonwealth government's 'Seven point plan' commencing July 1998.

Divisions of general practice educated and supported GPs in good immunisation practice. In most divisions, 75% of immunisation resources and activities were funded by GPPI.¹³ Also, incentives were paid to GPs under the Better Practice Payments schedule. In September 1998, the national immunisation coverage was 71.4%, by May 2003; 90.7%.¹⁴

Future directions

In the recent government response to the review of DGP, the commonwealth government stated that the divisions network has a key role in achieving important health priorities. It has stated its commitment to funding the division network into the future; strengthening and securing the place of general practice in the national health program.⁶

The successes of the DGP movement have been substantial but there is certainly room for improvement. Governance has improved steadily in the past few years with further training of board members and CEOs; with the commencement of division accreditation this improvement should continue. However, not all divisions are involved in this training and only a small number in accreditation. As well, increasing engagement of GPs is vital for further capacity building and to maintain credibility.

Despite the stated commitment to DGP, the government has commented that perfor-

mance will be evaluated via a system of rolling reviews. High performance will be rewarded and poor performance will result in reduced flexibility in planning and reporting. It will fund the ADGP to provide national leadership, and SBOs to build the capacity of divisions to achieve expected outcomes and to achieve integration at a state level.⁶ There are already new areas where divisions' capacities are being utilised. Strategies to deal with mental health issues, access to allied health professionals, and aged care delivery are currently being formulated.

Conclusion

The development of the DGP network has been one of the major health innovations of the past decade. It is a huge change to the unhappy days of general practice in the early 1990s. The divisions network has a secure place in the health system and GPs are involved at all levels of health reform and decision making. This capacity in the divisions has facilitated multiple health reforms, including immunisation and information technology, leading to improved health outcomes for the Australian community.

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