CASE STUDIES

Divisions of general practice: a status review

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Abstract

This paper looks at the emergence of divisions of general practice in Australia. Divisions are local groups of general practitioners working to integrate general practice into the wider health system and to explore opportunities for improving service delivery, teaching and research. There are now 116 divisions of general practice, covering over 95 per cent of the Australian population. Projects and infrastructure funding was approximately $35 million in 1994–95.

Divisions have enabled general practitioners to retain their autonomy while responding to a government health reform process which depends on their participation. They are a uniquely Australian solution to the problems confronting general practice in the 1990s, bridging the gap that previously existed between individual general practitioners and the health system as a whole.

The Divisions and Projects program is being evaluated using a variety of methods which allow feedback into the program in a timely way. The program thus remains sensitive to new strategies and directions, either from the general practitioners themselves or from other stakeholders.

Introduction

Australian general practice is currently undergoing a number of significant changes. Perhaps the most remarkable of these changes is the emergence of divisions of general practice. Three years ago there were rudimentary

concepts of divisions emerging, with a number of organisations exploring area-based general practitioner associations, some linked to existing organisational structures such as the Royal Australian College of General Practitioners, the Australian Medical Association or academic departments of general practice. This concept was further developed in the National Centre for Epidemiology and Population Health (NCEPH) paper (Douglas & Saltman 1991), the National Health Strategy Issues Paper, 'The Future of General Practice' (Macklin 1992), and in the early divisions in New South Wales and Tasmania. The Federal Government saw general practitioners' individualistic approach to care, combined with the perceived inefficiencies of solo and small practices and the highly competitive nature of practice, particularly in urban areas, as obstructing the reform agenda that it wished to pursue. It was clear that it required changes and the challenge to the profession was to develop acceptable options. Initially there was pressure from government, notably Brian Howe, for small and solo practices to amalgamate. The profession opposed this. As a result, representatives from the Royal Australian College of General Practitioners and the Australian Medical Association developed the concept of divisions. They convinced an initially reluctant Federal Government to fund the idea on a pilot basis by including it in a more sweeping set of reform proposals. Thus 10 demonstration divisions were established, along with the funding of a large number of small practice-based grants. Today there are 116 divisions, with membership levels at least equal to any other organisation representing the interests of general practitioners. These divisions are being established in every State and Territory and cover over 95 per cent of the Australian population. However, numbers alone do not convey the significance of what is occurring.

In the early 1990s commentators were increasingly predicting the demise of general practice. Some of the problems identified for general practice were the lack of a voice in health planning; the lack of any means to sensibly involve general practitioners at a local level; the increasing fragmentation of care; the inadequacy of the links between general practitioners and other health care providers; the diminishing role of general practitioners in hospitals and many other areas of care; and the profession's own inability to reach any kind of consensus about what should be done to correct these problems. The individualistic general practice cottage industry view of the world was increasingly at odds with the multidisciplinary shared care/shared responsibility models developing

in the rest of the health industry (and, indeed, in other parts of the world). Added to this was the paradox of a profession clinging to 'private' ideology while becoming increasingly dependent on the public purse through almost total reliance on a fee-for-service income which limited rewards to throughput-driven medicine. While these problems may be seen as the problems of Australian general practice, the reality is that they have an enormous impact on the way in which primary health care is delivered in Australia.

Divisions, however, are changing the landscape of general practice. They are introducing a level of structure and organisation never before seen in private medical practice. Indeed, there are few parallels in any form of practice (medical or allied health), either within this country or any other, although there is some consistency with intrahospital organisational reforms. The solution is uniquely Australian.

Through this structure, divisions of general practice are addressing each of the problems identified above. The purpose of this paper is to provide some insight into how this is being achieved and what progress has been made thus far.

Definition and history

The concept of divisions of general practice was outlined in a discussion paper published by the National Centre for Epidemiology and Population Health (NCEPH) between late 1991 and early 1992 (Douglas & Saltman), although others in the profession, notably the Royal Australian College of General Practitioners, were beginning to crystallise the idea. The most recent NCEPH discussion paper (McNally et al. 1995, p 1) contained the following functional definition of divisions.

> Divisions of General Practice provide the organisational structure for general practitioners to work together to improve quality and continuity of care, meet local health goals and targets, promote preventive care, and respond more rapidly to community health needs. Divisions also provide general practitioners 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.

The concept of divisions was taken up by the organised medical profession in the first half of 1992. It was included in a strategy document jointly developed between the Australian Medical Association, the Royal Australian College of General Practitioners and the Federal Department of Health, Housing and Community Services (General Practice Consultative Committee 1992), which was released in July 1992 after several months of debate and discussion. It is important to understand that this was a response by the profession to the Federal Government's wish to see general practitioners cooperate at the local level in order to address local health issues while maintaining the autonomy and individuality of practice which gives it strength and consumers choice. As the major providers of primary care, general practitioners were seen as being in the ideal position to highlight local health needs and implement innovative ways of addressing them. This strategy was supported by the Federal Government, with funding being provided in the 1992 Budget to establish 10 demonstration divisions. In 1993, $17 million was provided to develop divisions of general practice more widely. This was followed up in 1994–95 with annual funding levels of around $71 million for both infrastructure development and project funding.

How divisions operate

Divisions of general practice have been set up by interested general practitioners as either incorporated associations or companies limited by guarantee. Each division has its own elected board of management and typically employs a general practitioner as director (either part-time or full-time), an administrative officer (ranging from a part-time position to several positions) and perhaps a project officer (a part-time position to several positions). Staff funded may range from 2 to over 20, with a mix of part-time and full-time, from a wide variety of health and managerial backgrounds. Most divisions would have less than five core staff. There is usually a part-time general practitioner manager and a non-medically qualified project officer for each separately funded project being undertaken by a division. Membership of divisions is voluntary, with a nominal membership fee commonly being required. This leads to some variation in how membership is measured, particularly in divisions without a fee requirement.

Divisions receive Commonwealth funding of two kinds: infrastructure grants which cover the cost of their core functions; and project grants which include a wide range of activities such as health promotion, shared care programs, hospital liaison projects, projects targeting chronic conditions (for example, diabetes and asthma), outreach services for the disadvantaged (for example, homeless and Aboriginal peoples) and general practitioner upskilling. Project grants may also be seeding grants to finance the development of complex projects, or special purpose grants aimed at particular disadvantaged groups and national health priorities.

Although the financing of divisions has to date largely been through the Federal Government's Divisions and Project Grants Program, there has been increasing interest shown by State governments and the private sector. Also, some divisions have undertaken other income-producing activities, albeit of limited degree.

Table 1 shows statistics concerning the location, membership and funding of divisions under the Divisions and Project Grants Program.

Integration and coordination of care

The integration and coordination of health care has, in recent times, developed into a central theme in health care planning at the macro or government level (for example, Council of Australian Governments 1995). It reflects the emerging world trend to shift the provision and responsibility away from hospital-based care to community-based care where possible. Divisions are part of this process.

With that background the general practice divisions process has to be judged as an extraordinary achievement and on all levels a major success. Its very success has raised a number of major structural and organisational questions which could not have been anticipated two years ago.

Table 1: Divisions statistics (as at November 1994 funding round)

State	Number of divisions	Number with rural loading	Infrastructure grant range (and average)	Number of projects/ Div (and average)	Project costs ($) range (and average)	Average cost per project	Membership range (and percentage)
NSW	36	15	62 005 to 337 635 (155 450)	0–10 (2.8)	5000 to 239 790 (151 159)	53 350	25–100 (69)
Vic	32	18	36 000 to 260 035 (151 466)	1–8 (3.8)	3628 to 220 810 (143 368)	33 916	34–100 (70)
Qld	18	10	93 681 to 265 000 (148 097)	0–8 (3.2)	7465 to 177 810 (115 044)	33 947	30–78 (52)
WA	12	5	72 080 to 288 087 (159 921)	0–7 (2.9)	9975 to 104 933 (129 723)	44 476	30–81 (50)
SA	12	8	54 932 to 288 997 (137 022)	1–9 (3.75)	6495 to 485 362 (247 222)	65 926	35–100 (60)
Tas	3	3	114 171 to 175 779 (146 398)	2–6 (3.67)	5081 to 61 600 (151 192)	41 234	54–85 (74)
ACT	1	0	325 723	16	19 168 to 96 747	49 345	In NSW figures
NT	2	2	122 283 to 179 532 (150 908)	0–2 (1)	0 to 122 802 (61 401)	61 401	na
Total	**116**	**61**	**152 922**	**3.35**	**154 657**	**44 616**	**66**

Major issues and achievements

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 care practitioners in the process, that is, general practitioners. Yet this is what occurred before 1992. It may also explain why some of the barriers faced by area health services in implementing their planning often seemed intractable.

Achievement

Since the advent of divisions there has been an explosion of general practitioner participation in local area health care planning and activity at all levels.

> Hunter Urban Division of General Practice has general practitioners involved in the Hunter Area Health Service planning and activity. Examples are the Hunter Area Health Service General Practice Strategy Task Force, Strategic Planning Committee, Health Care Review Committee, Emergency Services Review Committee, Community Health Services Review, Aged Care Review, Hospital Beds to the Year 2000 Committee, Mental Health Committee, Health Outcomes Committee Preoperative Assessment Working Group, Have you got a GP Campaign, Kids Care Hotline, and dissemination of Hunter Area Health Service information through the monthly newsletter.

General practitioners who participate in these types of activities have the support of their division (including, where appropriate, remuneration for their involvement) and report back directly to the board of the division. This approach has completely changed the face of local area service planning from having general practitioner input as an afterthought, if at all, to such involvement being routine at all stages. The example above is typical of what is happening around Australia, with local variations. Some divisions, for example, Central Sydney, have direct area health funding and therefore direct access to the area health authority. Others have a direct division to government approach, for example, the Australian Capital Territory. Others are negotiating formal contracts defining the relationship between the division and the regional health authority, for example, Fremantle. The

capacity of divisions to make a contribution to local area planning has been enhanced by the fact that most either already have or currently are undertaking extensive health needs assessments in their local area.

The shift of general practitioners from minimalist or negative activity to high-level and increasing participation in local health services in the space of two to three years is a considerable achievement.

Work with hospitals

It is important to differentiate between rural and urban settings in the achievements in this area. Many rural general practitioners and health authorities have a well-developed working relationship, with general practitioners providing the work force.

By contrast, general practitioners in urban areas had been effectively excluded from the hospital system before 1992. Information exchange between hospital and general practitioner was for the most part inadequate and little or no activity was being undertaken in integrating roles (with the exception of a small number of shared care activities such as antenatal care).

Achievement

There have been many project and structural activities in the hospital/general practice interface area. The key areas are the development of shared care programs which give greater flexibility to health care provision; admission/discharge processes improving the two critical phases of hospital care, that is, entry and exit from the system; general practitioner participation in patient care with its consequent improvement in care, particularly for the aged; and emergency and after hours care. Specific areas have been targeted, for example, shared antenatal care and mental health services.

The Hospital in the Home Project, jointly run by the Central Sydney Area Health Service and Division of General Practice, reflects a major achievement of the divisional process. The division has been central to the planning and implementation of this program, which has resulted in the effective inclusion of general practitioners into patient care that would otherwise have been solely hospital-based.

Working with other primary health care providers

The relationship between general practitioners and other health providers is the most potentially challenging area in primary care. In the past it has been bedevilled by the dual funding system, with the majority of non-medical health workers being funded through State health budgets. The issues of role delineation have also caused a degree of mutual distrust and occasionally confrontation.

Achievement

The explosion of projects initiated by general practitioners which have non-medical workers ranging across the full spectrum is a stunning cultural change, which could not have been anticipated before 1992. The divisions program has unleashed a commonality of interest between general practitioners and other primary health workers which makes possible many of the goals put forward by Macklin (1992). In fact, such has been the extent of this area of activity that the department has had to foreshadow limits to the funding of allied health projects to avoid consuming all of the program's resources in one area.

The Top End Division has a project involving a cooperative approach from general practitioners and Aboriginal health workers to provide a culturally appropriate approach to women's health aimed at reducing the large inequalities in health status and outcomes in a specific community.

Working with academic departments

General practice academic departments are characterised by a lack of staffing and resources and a wide brief for activity. Most departments already had a working relationship with their general practitioner base. The divisions program has opened up major opportunities for collaborative activities in training and research.

Achievement

Involvement of academic departments in field support units and evaluation activities has enhanced the capacity of divisions to undertake effective projects and has established strong links between academic research and

everyday general practice. This has laid the foundation for research and teaching in general practice to be owned and driven by 'bag carrying' general practitioners. In return, divisions have provided academics with a more structured access to general practitioners and their practices.

The Melbourne University Department of Community Medicine approach of providing field support to all of the Victorian divisions is an example of a systematic approach to the relationship, thereby pooling learning and achieving consistency of advice.

Work with consumers and community groups

This has been a most interesting area of the program and another area where to some degree rural and urban approaches need to be seen somewhat differently. General practitioners have a relationship with individuals in the community which is unique in its access (80 per cent of the population visit a general practitioner in any one year) and continuity. This has clouded general practitioners' views to wider systemic issues affecting the community (with the exception being rural areas perhaps). Yet it is in the area of patient and community advocacy in its broadest sense—medical and non-medical—that general practitioners may yet play their most important role. Divisions have acted as a collective focus for these issues to be debated and acted upon.

Achievement

In the past year there has been an upsurge in the direct contact between divisions and consumer groups, allowing specific broader patient and community agendas to be dealt with at the primary care level. In the majority of cases this has been a profitable experience for both groups and has meant that consumers are achieving a 'recognition' of the problems they face. The development of formal partnerships, particularly in the project area, has opened up new possibilities for consumers.

Adelaide Southern Division has a project specifically funded to enable general practitioners and consumers to meet and discuss approaches to local health problems on an equal basis. Consumers and general practitioners are paid for their input.

Development of divisional networks

One of the reasons for the lack of integration of primary health care at the State health level has been the absence of a State-based general practice structure. This has led to decision-making by government and non-government bodies which has not reflected the realities of practice, to the detriment of both general practitioners and patients.

Achievement

There has been a rapid development of particularly State-based divisional structures with a lesser and more vexed development of a national structure. The formation and funding of Rural Divisions Coordinating Units allowed a coordinated response to occur to State-based rural issues and, through this, to national rural work force issues. This was closely followed by urban divisions groups in each State. These forums have brought divisions together to discuss issues of mutual concern and have created opportunities to link with community groups and government at the State level. Divisions have linked at this level through interdivisional work group grants.

Queensland divisions have collectively commenced discussions with the Queensland Government. The New South Wales Urban Division has appointed a liaison general practitioner. The Victorian Government has established a general practice interface unit. Other States are talking to divisions but no formal arrangements have been established as yet.

Quality of Care

Divisions are involved in developing long-term strategies designed to produce a culture that accepts continuous quality improvement as a central driver. This has three levels which are manifest to varying degrees in different divisions. Firstly, some divisions are taking a leading role in the education of undergraduates and general practitioners in training. This is particularly strong where the division has close links with an academic department or the Royal Australian College of General Practitioners. For example, the Northern Sydney Division is running a project in which general practitioners provide tutorials to Resident Medical Officer trainees.

Secondly, most divisions are conducting continuing medical education programs as reflected in the expressed needs of their members. This encourages existing general practitioners to maintain quality through sessions that cover clinical and non-clinical aspects of general practice. These sessions are funded from infrastructure or, in many cases, combined with pharmaceutical company sponsorship.

Where there is an expressed need that entails prolonged and/or detailed training in areas not normally considered core general practice, this has generated a number of upskilling projects. This mechanism has enabled many general practitioners to regain lost skills and learn new ones that are relevant to their particular practising environment. Typical areas of interest are palliative care, diabetes management, counselling and psychiatric case management.

Some of these projects have required collaboration with other sectors of the health industry, with the added vicarious benefit of fostering a better mutual understanding.

Thirdly, some divisions have been involved in evaluating current care methods and suggesting ways in which these can be improved. The development of shared care models alluded to above is one example of this. There are also projects looking at prescribing patterns and many looking at the needs of minority groups such as Aboriginals and Torres Strait Islanders and ethnic people.

Divisions have taken on the task of improving the rational prescribing of drugs with projects as diverse as management of drugs in the ethnic elderly in Illawarra Division to the large academic detailing DATIS project over three divisions in Adelaide.

Links with other reforms

There are several other general practice reform strategies under development and/or implementation. While some of these are associated with other professional organisations (such as the Royal Australian College of General Practitioners with standards development; the Australian Medical Association and the Royal Australian College of General Practitioners with general practitioner representation nationally; and the Consumers Health Forum with program evaluation and consumer participation), they are now linked to divisions as key organisations in thinking through issues and exploring possible implementation options.

Achievement

Divisions were able to sample views on the Better Practice Program, quickly allowing representative opinions to be available to industry negotiators and government for further development of the concept.

Achievement

Divisions bridge the gap between macro policy decisions and micro-level implications and implementation in a way that was not possible previously. When this is a two-way process, strategies developed are more likely to be practical and acceptable to the grass roots providers.

It is a major achievement that divisions have provided a prominent focus for dealing with the inherent difficulties of a dual funding system at the primary care level. The coordinated care trials to be undertaken in 1996 by the Federal Government have attracted some divisions' potential solutions to improving patient care by attacking these barriers.

In New South Wales the State health system is exploring the possibilities of health outcomes approaches to chronic disease management. The participation of general practitioners in this strategy is a key feature, without which it would not progress. Each local division works in conjunction with the local health authority in assessing need and ensuring that the resources are appropriately placed to maximise access and use. Diabetes has been chosen as the pilot model, with divisions providing the structure to implement the proposal. It also presents an opportunity for State and Federal cooperation in resource provision.

Accreditation

One of the major reforms to the organisation of general practice concerns accreditation. However, the gap between a centrally conceived and locally implemented strategy would be too large to bridge without an area focus such as is offered by divisions. Equally, divisions allowed general practitioners to participate in the development and trials of the standards to improve the acceptability of the final product.

Thirty divisions were involved in using the 'Entry standards for general practice' developed by the Royal Australian College of General

Practitioners as part of a trial of the accreditation process. This complemented the field tests of the standards conducted by the college. There is now a large base of trained surveyors available to implement the next phase of the accreditation initiative. In addition, this project has produced one of the largest databases on general practice in the world. This is currently the subject of much analysis. Divisions could be the point of organisation of future implementation of accreditation, with several divisions already indicating a willingness to perform this work. They may be the appropriate instrument to link accreditation with the Better Practice Program, removing some of the current professional criticisms of the relevance of the program criteria.

Achievement

The work offered to general practitioners through infrastructure and project activities is allowing them to experience the variety of non-fee-for-service remuneration.

There are a number of health system reforms which are not specifically targeted at general practitioners yet could not succeed without their involvement. The division is the logical structure to access general practitioners for these reforms, provided they are involved at the planning stage and not just used as an instrument to impose a strategy developed by others. Some of these reforms are early discharge planning associated with casemix reforms, managed care proposals, changes to undergraduate and postgraduate training and shifting ambulatory care to the community.

Information management and the technology associated with it are a central focus of health system reform. This is a new area for many general practitioners who are more used to a cottage industry. Several projects are looking at cost-effective ways in which advances in information technology can be introduced to general practice. General practitioners can be remunerated through divisions for participating in important initiatives outside the surgery setting or those which take time from consulting with patients. This would not be possible under an exclusive fee-for-service system.

Local service provider role

Many general practitioners have seen traditional professional organisations as unresponsive to local issues. Local branches of the Australian Medical Association are often dominated by specialists—or at least perceived to be.

Divisions allow a very general practice-focused approach to local issues, beginning with a needs assessment of general practitioner members as the driving force behind strategic planning and implementation. Not all divisions have completed needs assessments, but it is clear that those that have are operationalising their planning in a way that increases member participation rates. Some divisions (for example, Northern Division, Victoria; Fremantle, Western Australia; and Gold Coast, Queensland) have taken the next step in conducting an open-ended needs assessment of the local area with a view to overlapping local health needs and general practitioner needs. Where such needs can be established, projects can be designed to pilot ways of dealing with such matters; for example, asthma in schools projects and diabetes shared care models.

Some divisions have approached projects from the other direction by taking National Health Goals and Targets and seeking ways to address them at the local level. This opens the way for national coordinated strategies for divisions. Mental health is being used as a prototype model, as this area has attracted a large number of diverse projects to date. Recent State meetings with divisions representatives endorsed in principle the need for a strategic divisional approach.

Evaluation

An expert group from a broad range of interests is evaluating the activities of divisions. (This group includes representatives/individuals from the Consumer Health Forum, the National Centre for Epidemiology and Public Health, the Australian Community Health Association, the University of New South Wales, St Vincent's Hospital Melbourne, the Royal Australian College of General Practitioners, the Australian Medical Association, divisions of general practice and the Department of Human Services and Health.) The evaluation strategy follows a temporal hierarchy of process, evaluability, impact and outcome. Aspects of the evaluation are grouped into key areas to form an evaluation hierarchy. Specific measures being included in the collection of data include the use of pro formas and reports, questionnaires, case studies, interviews, group discussions, indirect and special data collections. The outcome of the evaluation process will be a series of publicly available reports. The first series of evaluation reports concerning the demonstration grants has recently been released (Milne 1995).

The next phase of the program will see the establishment of Support and Evaluation Resource Units which will seek to benchmark projects undertaken by divisions and to develop health outcome measures that are consistent and validated.

Conclusions and beyond

The underlying assumption before the divisions program commenced was that there would be a slow and somewhat low level of integrative activity on the part of general practitioners at the local area and that this integration would be with existing systems, particularly with area or regional health.

What was not anticipated was the speed, depth and enthusiasm for the process exhibited by many general practitioners, other non-medical health workers and consumer and community groups. The practical outcome is that the divisions program is rapidly developing into a parallel primary care system which reflects and responds to community need. However, not all general practitioners have embraced the process and not all activities have been an unqualified success. Indeed, there are significant numbers of general practitioners who are sceptical about a reform program which is primarily government-funded. It is imperative that the divisions program is not viewed as a panacea for all the problems alluded to in the introduction to this paper.

Nevertheless, it is exciting to ponder what could develop from here. Should divisions work towards becoming an independent parallel primary care system incorporating medical and non-medical professionals and managing all of the resources that this involves? Or should they work towards formal close links with regional health structures and risk losing their community-based character and responsiveness? Divisions and their activities have made inroads in the area of integration at the local level which would not have been possible two years ago. It can be argued that this is a uniquely Australian solution to the global problem of health reorganisation and resource allocation. There needs to be considerable thought given to the future of divisions within the health system structure and particularly their role in service delivery on a wider scale. In addition, divisions have become a strong voice for general practitioners on reform initiatives which inevitably have medico-political overtones. The exact role that divisions will play remains a subject of debate. Divisions have also

developed at disparate rates creating a range of support needs in terms of management skills, project development and implementation and evaluation activities. It is a challenge to the program to provide for this diversity which is currently being addressed through an ongoing process involving divisions, the department and, where appropriate, external consultancy expertise.

Note: The examples used in this paper are illustrative only. There are many examples occurring across Australia that could equally have been used from the several hundred projects funded to date. It is not inferred that the examples used are benchmarks.

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