A GUIDE TO UNDERSTANDING AND WORKING WITH GENERAL PRACTICE IN NSW

A Guide to Understanding and Working with General Practice in NSW

Disclaimer:

This resource is intended as a guide and catalyst to seeking further information about some aspects of general practice and working with general practice. The content does not constitute legal advice. In no event shall GP NSW and NSW Health, their agents, officers and employees be liable for any special indirect or consequential damages or any loss or damages whatsoever resulting from injury, loss of income or profits, whether in an action of contract, negligence or other tortious action, arising in connection with the use or performance of any information contained herein. People should exercise their own independent skill or judgment or seek professional advice before relying on the information contained in this publication.

LEADERSHIP I SUPPORT I ADVOCACY

Contents

Acknowledgements

General Practice NSW gratefully acknowledges members of an Expert Review Group who provided valuable oversight and advice in the development of this Guide.

Expert Review Group Members:

Purpose of this Guide

This resource provides an outline of general practice. It considers its uniformity and diversity; its funding arrangements, service delivery, workforce, training, capacity and supporting structures. It provides recommendations for identifying and acting on opportunities for collaboration. The Guide draws on published literature as well as the experience of an expert group.

It is important that the complex and essential role of general practice is fully understood by those wishing to work within and across the different components of the health care system in NSW. A better understanding of the particular ways of working and ethos of general practice will support sustainable partnerships, improve health care integration and eliminate misperceptions about general practice and general practice service delivery.

The Guide is not intended to be exhaustive. It attempts to consolidate in one document key information about general practice.

Web links to further information and resources are provided throughout this guide to support a more detailed understanding of the range of areas covered.

You can find this guide in electronic format at www.gpnsw.com.au

Executive Summary

Introduction

Primary care is the foundation of the Australian health care system. General medical practice is the predominant provider of primary care in Australia – delivering over 118 million patient consultations each year. General Practitioners (GPs) out number other medical specialists and compared to hospital and specialist care, general practice consultations are the most cost-effective medical consultations. As the gatekeeper to a range of other health services, general practice is a significant driver of health care activity in Australia. Its reach into each defined community and ongoing relationships with patients and families is unparalleled. Failures in ensuring access to primary care have fundamental rebound effects on the entire health care system.

Context

A combination of features set general practice apart from other health care providers including its whole-person focus, its complex funding arrangements and its generalist nature which requires broad education, information and support. Accredited continuing professional development programs offer GPs and practice nurse's access to a range of activities.

Significant variation exists in the size, workforce, context and capacity of individual general practices which often makes the discipline difficult to fully comprehend and/or to apply a one-size-fits-all approach to collaborative projects and other initiatives.

General practice faces a range of daily pressures not the least of which is maintaining a viable small business. Overwhelming practice workloads often force general practice to focus on core business making it difficult to participate in external programs.

The majority (over 90%) of funding for general practice is provided by Medicare Australia under a fee-for-service arrangement. The recent escalation in the prevalence of chronic disease which requires health care to have a greater focus on more comprehensive and often coordinated care involving other health professionals has led to incremental changes in funding approaches. These include incentive payment schemes and blended payment arrangements which are designed to encourage best practice. The changes to general practice funding via the Medicare Australia framework have introduced significant administrative complexity for general practice.

The number of practice nurses working in general practice has increased considerably in recent years. The role of the nurse in each practice is largely shaped by the professional capacities of the nurse, the practice patient population and available practice and local community resources and services. Practice managers play an important role being primarily responsible for the operational management of a practice. Practice nurse and general practice support programs are key areas of work of Divisions of General Practice.

Structures

Divisions of General Practice are the established regional institutions that support general practice across Australia. There is significant diversity in the geographical size, number of GPs and population within Division boundaries as well as differences in resources and infrastructure with many becoming increasingly complex organisations with significant levels of funding, often from sources outside the Australian Government. Around 94% of Australian GPs are members of their local Division. Divisions have been instrumental in providing a broad range of support strategies and development opportunities for general practice over the past 17 years. The overall scope of Division activity is diverse and includes facilitating continuing professional development for GPs and general practice staff, accreditation, practice management, workforce solutions, change management and a range of other foundation roles.

Reform

A combination of burgeoning medical technology, ageing populations, growing levels of chronic illness and increased patient expectations has placed greater demands on general practice in recent years. Australian health care reform is increasingly focusing on improving quality of life and health outcomes alongside needed improvements in access, equity and cost-effectiveness. The provision of optimal chronic care requires that relevant health and social/welfare providers are linked to ensure the needed range of multidisciplinary services is accessible. Health policy and structural changes in primary care, such as the establishment of primary health care organisations (known as Medicare Locals) across Australia, are designed to further the move toward this type of care delivery on a routine basis.

Conclusion

The most promising chronic disease care models are those which emphasise genuine, ongoing collaboration between health care providers. The commitment and will of different groups to better understand and work with general practice, with the support of the NSW Divisions of General Practice Network, is a challenge. But the costs of not meeting this challenge are even greater.

General Practice Overview
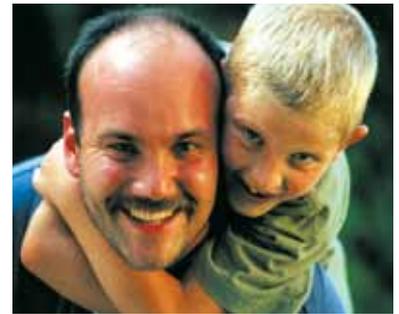
Introduction

General practice is the leading primary care discipline in NSW with distinctive settings, diagnostic, clinical and disease prevention activities and education and support needs. It is a specialty in its own right with a growing focus on the provision of primary health care – a comprehensive approach to care which includes disease prevention, community empowerment and multidisciplinary collaboration.[1]

The Royal Australian College of GPs defines general practice as:

> ...the provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities.[2]

Particular characteristics[3] set general practice apart from other clinical disciplines, including that it:

- Is most often the point of first medical contact within the health care system, providing unrestricted non-referred access to those seeking care.

- Serves patients of all ages and cultures including those presenting with multiple problems in any one visit.

- Is broadly focused to manage established conditions, undifferentiated illnesses and problems requiring urgent intervention.

- Is whole-person centred and deals with health problems in the physical, psychological, social and cultural dimensions.

- Promotes health, disease detection and self-management, and provides longitudinal care tailored to the needs and context of the patient.

- Facilitates comprehensive care including appropriate and necessary referral, testing, monitoring, and follow-up.

- Plays a key role in a patient's ability to understand and navigate the wider complex health care system.

- Has an awareness of the particular health beliefs of local cultural groups.

- Undertakes personal advocacy for patients whose capacity to advocate for themselves is reduced due to illness or marginalisation.

- Promptly applies new scientific medical developments in patient care.

- Has an increasingly important role in electronic clinical information management.

- Provides longitudinal continuity of care which in turn delivers trust and effectiveness for patients.

Australian general practice provides over 116 million patient consultations each year.[4] There have been important changes in its activities over the past decade in terms of numbers of services provided and the focus of these services. These changes have occurred alongside the ageing of the population and the subsequent rise in need for long term management of chronic illnesses.

Over the past decade general practice has increasingly[4]:

- Managed growing numbers of newly diagnosed chronic conditions and patients with multiple chronic conditions.

- Spent a greater proportion of time servicing older patients.

- Managed more problems in each consultation.

- Performed more check-ups and provided more lifestyle advice than ever before.

- Undergone a steady series of changes to Medicare Benefit Schedule item numbers, accreditation standards, continuing professional development requirements, incentive funding arrangements, billing and medical records technologies that has resulted in variable degrees of change fatigue.

A detailed description of general practice service delivery is provided in the most recent report on General Practice Activity in Australia[4] which in summary indicates that:

- On average Australians visit general practice five times per year with over 85% visiting a general practice at least once a year.

- General practice is able to provide all the care needed for around 90% of health problems presented.

1. B Starfield. Basic concepts in population health and health care. Epidemiol Community Health 2001;55:452-454
2. RACGP What is General Practice, 2010
3. Kringos et al. The breadth of primary care: a systematic literature review of its core dimensions. BMC Health Services Research 2010, 10:65
4. Britt H, Miller GC, Charles J, Valenti L, Fahridin S, Pan Y, Harrison C, Bayram C, O'Halloran J & Henderson J 2010. General practice activity in Australia 2009-10. General practice series no. 27. Cat. no. GEP 27. Canberra: AIHW.

- Common reasons for visiting general practice are requests for check-ups, prescriptions, test results, immunisations, coughs and back complaints.

- Chronic illness accounts for around 35% of all problems managed by general practice each year. The most common being hypertension, depression, chronic arthritis, non-gestational diabetes and lipid disorders.

- Prescription medications are the most common treatments provided in general practice. No prescription was given for 57% of all problems managed. More than one prescription was given to around 8% of all problems managed.

- For every 100 problems managed there are around nine referrals to other health care providers, most often to medical specialists (approx. six referrals per 100 problems) with three referrals per 100 problems to allied health professionals. Referrals to allied health services were most often to physiotherapists, psychologists, podiatrists, and dentists.

- The average length of MBS or DVA claimable patient consultations is just over fifteen minutes.

- Australians report substantial trust in doctors, particularly GPs.

Most general practices in NSW are small to medium sized businesses that need to self-fund their staff, premises and equipment to provide quality primary health care. Patients are charged a fee for service for which Medicare will provide the patient a subsidy based on the item provided. To meet increasing costs an increasing number of general practices charge above the Medicare subsidy requiring higher 'out of pocket' expenses for the patient. Under the Medicare fee for service remuneration system the Australian Government, with the advice of an independent review body, decide how much Medicare subsidy a patient will receive and indirectly what a GP can earn.

As with other businesses it is in the best interest of the practice owners to use their staff efficiently and to keep costs down, since the higher their costs the smaller their profits and the less viable they become as businesses.

The responsibility for their own expenses means some GPs work with minimum support in cramped premises. Practical and patient constraints can make it difficult for practices to relocate to larger premises in a different location. Some GPs like the challenge of owning and running their own practice and others prefer to avoid the business side of practice. There are now larger practices owned by corporate businesses where GPs either earn a salary or are contracted. The corporatisation of some practices has led to concerns that patient care may be sacrificed in the name of increased efficiency in these settings, particularly when they are public companies with shareholder interests.[5] Competing arguments suggest that these services save money through greater purchasing power and administrative efficiencies.[6]

GPs are subject to medico-legal responsibilities and must meet the escalating costs of public liability and medical indemnity insurance. The duties, rights and responsibilities of a GP as an employer and the fundamentals of employment law and other legislation must also be followed.[7]

General practice spends considerable time attending to duties considered to be 'non clinical time' meaning no financial recompense is available. This 'non-clinical time' includes official procedures such as the authority script approval process, chasing provider numbers, applying for incentive funding, dealing with Medicare queries and rejected payments, Workcover and insurance reports, being involved in phone consultations and discussing patient matters with the extended health care team, the patients family and other relevant parties.[8]

- Personal motivations for GPs to continue effectively in their role include:

- Professional satisfaction and intellectual challenges

- Long term relationships with patients and families

- The inherent reward of helping others and making a difference in their lives

- Respect in the community

- Financial remuneration

- The wide variety of medicine that they encounter

5.   Rob Anderson, Phil Haywood, Tim Usherwood, Marion Haas and Jane Hall. Alternatives to for-profit corporatisation: The view from general practice. Australian Journal of Primary Health - Vol. 11. No.2. 2c05
6.   Haggerty, J. Burge, F. et al. Operational Definitions of Attributes of Primary Health Care: Consensus among Canadian Experts. Annals of Family Medicine Vol. 5, No. 4: July/August 2007
7.   Marion Easton. Management in General Practice. A business perspective for GPStR3s. 2008
8.   The Royal Australian College of General Practitioners Submission to the Department of Health and Ageing: Development of a Quality Framework for the Medical Benefits Schedule – Discussion Paper. 25 June 2010

In Australia, community members are free to make a choice amongst the general practice services available. Common reasons for changing doctors are: they are not happy with their doctor; their doctor has stopped bulk-billing; they want a second opinion, and/or they wish to attend multiple doctors for different problems.[9]

There is sound evidence that countries with a strong primary health care system have healthier populations. High quality properly resourced primary care services have a sound knowledge of their patients and community and provide collaborative team-based evidence-based care; use and share information through electronic medical records; and have effective patient flow processes.[10] High quality properly resourced primary health care that is provided by a regular practitioner is more likely to lead to patients receiving accurate diagnoses, more preventive care, need fewer tests and prescriptions, and make fewer visits to their doctor, specialists, and hospital emergency departments.[11]

The leadership and support from a range of organisations, understanding that their members and the wider community will benefit from a greater investment in primary care, is a key element in driving needed enhancements in Australian general practice. Medical and primary care associations, professional colleges and other support organisations continue to be active in assisting primary care to gain improved government and community engagement; advocating for a central role for primary care in relevant health care reform legislation; calling for greater government support through improvements in remuneration and infrastructure and creating a forum for diverse parties to collaborate in primary care change initiatives. They also ensure that competing national priorities do not make it more and more difficult to secure needed funds. These groups are described in appendix 2.

Further Information

- World Health Organization. The world health report 2008: Primary health care, now more than ever. Geneva, World Health Organization, 2008.

- Montegut AJ. To achieve "health for all" we must shift the world's paradigm to "primary care access for all". J Am Board Fam Med. 2007;20(6):514-7.

9.   Hardie E, Critchley C. Public perceptions of Australia's doctors, hospitals and health care systems. Medical Journal of Australia 2008. 189:210-214.
10. Starfield B, Shi L, Macinko J. (2005). Contribution of primary care to health systems and health. The Milbank Quarterly; 83(3):457-502.
11. McMurchy D. (2009). What are the critical attributes and benefits of a high-quality primary healthcare system? Ottawa: Canadian Health Services Research Foundation.

General Practice Diversity and Access

The majority of Australia's medical doctors are GPs with NSW having the largest number (over 7,000) and over 2,600 general practices.[12] While there are core characteristics of general practice, there are also significant variations in the size, workforce, context and capacity of individual practices across NSW, with context reflecting the geography of different regions ranging from remote and rural areas with sparse populations to outer metropolitan and the more densely populated inner-city areas. Context is also reflected in the different population groups requiring general practice services including variations in cultures, age groups and rates of chronic and acute illnesses. Change and diversity within general practice includes:

- The majority (>90%) of NSW GPs work in private practices, around five percent work in hospitals with the remaining working in '24 hour clinics', non-residential health facilities and a range of other settings, including Divisions of General Practice.[1,13]

- Practice ownership has become much less attractive than it was in the past, particularly with younger practitioners just entering the workforce.[2] Like a growing proportion of the population, NSW GPs are ageing with the average age 50 years, and males aged 65 and over comprising almost 10% of working GPs.[1]

- Currently over 44% of GPs work in practices with five or more practitioners compared to 21% in solo practice.[1]

- Over the age of 60, there are more GPs in solo practice than in the large practices while younger practitioners tend to be attracted to larger practices.[1]

- Women represent around 39% of the GP workforce in NSW and this proportion is increasing.[1]

- There has been a steady decline in the number of rural hospitals which engage GPs to provide medical care (GP Visiting Medical Officers) and decreasing numbers of procedural GPs.[14]

- Around 60% of NSW general practices have a nurse and this has the potential to increase with greater acknowledgement of the efficiency potential of nurses in general practice and government investment in this area.[15]

- NSW is a culturally and ethnically diverse state where over 400 different languages are spoken.[16] General practice consultations with patients of non-English speaking background account for around one in 10 patient presentations.[17]

- Over the past few decades, increases in the numbers of overseas trained doctors from a diverse range of backgrounds have occurred, particularly in regional and rural areas of NSW, as a result of shortages in the Australian medical workforce.[18,19]

- GPs report higher rates of perceived psychological stress than many occupational groups in Australia.[20,21]

12. NSW Health (2007) Profile of the Medical Practitioners Workforce in NSW. An overview of information from the 2007 Labour Force Survey. 30 October 2008
13. Australian Medical Workforce Advisory Committee 2005, The General Practice Workforce in Australia: Supply and Requirements to 2013, AMWAC Report 2005.2, Australian Medical Workforce Advisory Committee, Sydney
14. Dennis Pashen, Bruce Chater, Richard Murray. Australian Primary Health Care Research Institute. The Expanding Role of The Rural Generalist In Australia – A Systematic Review. November 2007
15. Australian General Practice Network - National Practice Nurse Workforce Survey 2009.
16. Australian Bureau of Statistics. Proficiency in spoken English/language by age by sex. Australia Cat No. 20680. Canberra: Australian Bureau of Statistics, 2008.
17. Janice Charles, Helena Britt, Salma Fahridin. NESB patients Australian Family Physician Vol. 39, No. 4, April 2010
18. Birrell RJ. Australian policy on overseas-trained doctors. Med J Aust 2004;181:635–9.
19. McGrath BP. Integration of overseas trained doctors into the Australian medical workforce. Med J Aust 2004;181:640–2.
20. Clode D. The conspiracy of silence: emotional health among medical practitioners. Melbourne: The Royal Australian College of GPs, 2004.
21. Jackie Holt and Chris Del Mar Psychological distress among GPs. Who is at risk and how best to reach them? Australian Family Physician Vol. 34, No. 7, July 2005

Most frequent and severe stressors in General Practice

Dr Danielle Clode (2004) Emotional health, the Conspiracy of Silence among Medical Practitioners
A review of the literature for the Royal Australian College of GPs

MOST FREQUENT STRESSORS	MOST SEVERE STRESSORS
1. Time pressure to see patients	1. Threat of litigation
2. Paperwork	2. Too much work to do in a limited time
3. Phone interruptions during consultations	3. Earning enough money
4. Too much work to do in a limited time	4. Patients who are difficult to manage
5. Intrusion of work on family life	5. Paperwork
6. Patients who are difficult to manage	6. Intrusion of work on family life
7. Home visits (in hours)	7. The cost of practice overheads
8. Earning enough money	8. Time pressure to see patients
9. Intrusion of work on social life	9. Unrealistic community expectations
10. Unrealistic community expectations	10. Negative media comments

Difficulty accessing general practice when it is needed, which is linked to a shortage of GPs (GPs), is among the major challenges facing Australia's health care system. Many general practices have closed their books to new patients, a phenomenon that is becoming increasingly common in both rural and urban areas due to one or more of the following reasons:

- High patient demand and extended wait times. The rise of multiple chronic diseases in our aging population means patients have more problems and more complex medical needs than in the past.[4] Not very long ago it was not unusual for GPs to look after 1000 patients who visited the practice once or twice a year for short term relatively simple complaints but today patients are more likely to be older and have one or more complex conditions requiring ongoing monitoring and longer consultations for the rest of their lives.

- The need to contain working hours in the practice to allow adequate time for home and residential aged care visits, and attendance at after-hours and other offsite clinics and programs. [22]

- The inability to find doctors to join the practice or fill-in for a doctor who is sick or on leave. Areas of GP workforce shortage in NSW are predominantly rural, although outer metropolitan areas are also significantly affected. Many towns and suburbs

do not have a general practice and many NSW communities have far fewer practices than they need.[11]

- GPs perception that they are unable to continue providing a level of quality service with which they are happy. The dilemma of trying to balance increasing patient demand with the provision of a high-quality service is common in general practice. For many GPs, the only answer is to turn away new patients for months, sometimes years, until natural attrition reduces the workload and patients no longer have to wait days or weeks for an appointment.

- A growing trend by doctors to give priority to their families and work life balance.

- Decreasing length of hospital stays increases the demand for GP services.

The issue of 'closed books' in rural settings can be much more difficult for patients because the choices available in finding another doctor who is located in their area are usually limited. Rural communities across NSW regularly make representations to government and report through the local media about GP workforce shortages in their area. There is no legal obligation for doctors to take on new patients who are not in need of emergency or immediate medical treatment but it is distressing for GPs and their

---

22. Kamalakanthan, A. & Jackson, S. 2006, The Supply of Doctors in Australia: Is There A Shortage? Discussion Paper No. 341, The University of Queensland School of Economics, Queensland

staff to have to turn away patients. Closed practices regularly see people with urgent health care needs and review their books often to determine if there is capacity to take on new patients. Practice staff and local Divisions of General Practice often try to assist people in finding other doctors by suggesting they try practices known to have their books open.

Media excerpt

Doors close as Hunter GP shortage hits critical

DOCTORS in the Hunter treat twice as many people as some of their Sydney counterparts and are increasingly shutting their doors to new patients due to overwhelming demand.

In some cases GPs are using fees to discourage patients, with one Lake Macquarie clinic charging $6 more than the Australian Medical Association guideline of $64 for a level B, or standard 15-minute consultation.

Figures obtained from GP Access, formerly known as the Hunter Urban Division of General Practice, show that about 40% of the region's 145 urban practices in Lake Macquarie, Maitland and Newcastle, can't cope with the demand for services and have closed their books.

A further 27% will accept new patients only if they live in the postcode of the surgery or have a relative who is an existing patient.

Source: The Herald, Nov 2009 http://www.theherald. com.au/news/local/news/general/doors-close-as-hunter-gp-shortage-hits-critical/1684348.aspx

Not having access to primary care has been found to have serious negative consequences:

- The reduced likelihood that patients will undergo preventive health examinations and screening for early disease
- How well any acute illnesses will be managed or controlled

The inability to access a GP when patients need one and declining access to GPs in some areas have been identified as important factors in the growing demand on NSW public hospital emergency departments. A 2008 study found 75% of emergency department patients cited lack of access to a GP as their reason for attending, but only 34% believed they really needed emergency treatment. It is estimated that around 40% of emergency department patients could be more appropriately cared for in general practice if it were accessible and appropriately equipped.

The establishment of new medical schools in NSW in recent years has led to an increase in the number of publicly funded university medical places and this has been associated with an increase in the number of vocational training places available for GPs in NSW, however the increases in GP numbers are not expected to fully meet the increasing community need for general practice services in the near future. Contributors to this situation include:

- The underlying reasons for inequitable distribution of general practice around the state will not be addressed with more graduates.
- Post university training needs of potential GPs are currently not adequately catered for in most public hospital budgets.[24]

Despite the existing capacity limitations of general practice in some areas in NSW, the sector is still able to address around 90% of patient health problems without referring to more costly specialist services. Australia ranks consistently high in health care quality and access measures such as life expectancy, infant mortality and preventable deaths.[25]

Through effective diagnosis and management Australian general practice improves quality of life and prevents significant morbidity and mortality. Studies confirm that patients with a regular GP have lower mortality and health care costs than those without.[26,27] Conversely, hospitalisation rates and patient severity have been found to be higher in areas with a shortage of primary care providers.[28] Areas with more primary care providers per head of population have lower heart disease and cancer mortality rates, and higher life expectancy compared with areas that have fewer general practices.[29] It has been suggested that *"using a federated approach with primary*

23. *Lack of GP access driving demand on public hospital emergency departments. http://www.health.nsw.gov.au/news/2008/20080406_00.html*
24. *Australian Medical Association. Medical student training funding welcome and must be supported by graduate training places. October 2010. http://ama.com.au/node/6129*
25. *The Organisation for Economic Co-operation and Development (OECD) Health Data 2010 http://www.oecd.org*

healthcare teams and practices working together, virtually all health problems – including mental health – could be dealt with in primary care".[30] An adequate supply of clinicians, a health care quality enhancing reimbursement structure and approaches that augment the efficiency, capacity and scope of existing general practice are needed to address the inequities in primary medical care in Australia.

Further information

- Wilkinson D, Dick ML, Askew DA. GPs with special interests: risk of a good thing becoming bad? Med J Aust. 2005 Jul 18;183(2):84-6.

- Powell Davies G, Williams AM, Larsen K, Perkins D, Roland M, Harris MF. Coordinating primary health care: an analysis of the outcomes of a systematic review. Med J Aust. 2008 Apr 21;188(8 Suppl):S65-8. Review.

ENABLERS AND CHALLENGES TO UNDERSTANDING AND WORKING WITH GENERAL PRACTICE

- The local general practice context needs to be understood before assumptions are made about what might be considered minor requests. If practices are finding it difficult to manage the care of all patients who need it, they may not have the capacity to give time to understand new programs or resources, or participate on committees, respond to surveys or undertake a range of other tasks requested on a regular basis by well-meaning groups and services.[31]

- The responsibility a general medical practice bears to its community is to operate responsibly, care for its patients appropriately and address the stewardship of its businesses to support employees, associates and financial obligations. Additional support is usually required for practices to work outside existing commitments.

- The provision of cost free short or long term human resource support including practice nurses, care coordinators and others that have an agreed role and where space and capacity and time for training is available, have been found to be valuable to practices that are at risk of, or are overwhelmed by, patient demand.[32]

- Systems and software that provide efficiencies in quality care provision are useful when adequate training, ongoing support and maintenance is available.[33]

- Some people, including ageing retirees that move to new locations, will have significant problems accessing general practice. Ensuring information resources such the available local public and private acute, community, preventive and screening services in the area will assist general practices and patients.[34]

- While there is overall a lack of ongoing data on the extent of general practices that are closed to new patients at any one time, some Divisions of General Practice collect and make this information available to their local communities.

26. *Maeseneer et al., Provider Continuity in Family Medicine: Does It Make a Difference for Total Health Care Costs? Annals of Family Medicine 1, no. 3 (2003): 144–148*

27. *P. Franks and K. Fiscella, Primary Care Physicians and Specialists as Personal Physicians: Health Care Expenditures and Mortality Experience, Journal of Family Practice 47, no. 2 (1998): 105–109.*

28. *Sanderson,C and Dixon, J Conditions for Which Onset or Hospital Admission Is Potentially Preventable by Timely and Effective Ambulatory Care. Journal of Health Services Research and Policy 5, no. 4 (2000): 222–230.*

29. *Safran D et al., Linking Primary Care Performance to Outcomes of Care. Journal of Family Practice 1998,47: 213–220*

30. *The Future Direction of General Practice - A roadmap. Royal College of GPs. London 2007*

31. *General Practice NSW Expert Reference Group (details in the acknowledgement section)*

32. *Powell Davies G, Williams AM, Larsen K, Perkins D, Roland M, Harris MF. Coordinating primary health care: an analysis of the outcomes of a systematic review. Med J Aust. 2008 Apr 21;188(8 Suppl):S65-8. Review.*

33. *Schoen C, Osborn R, Huynh PT, Doty M, Peugh J, Zapert K. On the front lines of care: primary care doctors' office systems, experiences, and views in seven countries. Health Aff 2006 Nov-Dec;25(6):w555-71.*

34. *Southern DM, Young D, Dunt D, et al. Integration of primary health care services: perceptions of Australian general practitioners, non-general practitioner health service providers and consumers at the general practice-primary care interface. Eval Program Plann 2002; 25: 47-59.*

General Practice Funding

Most general practices in NSW are small business with an average of three to five GPs. The income of a practice is derived mainly from Medicare fee for service arrangements, patient fees and a smaller proportion coming from government incentive payments.[35]

Most GPs earn their income via: a share of profits as a partner/owner of the practice and/or a percentage of the gross billings they generate with the remainder being a facility fee paid to the practice (contractor) and/or are salaried per session (half day). There are many variations and combinations of these three main schemes e.g. depending on how practice incentive payments are handled.[31]

Often work outside direct patient contact is without remuneration. Some GPs elect to work in salaried or contractor positions in practices they do not own for a variety of reasons including not wishing to be involved with the business aspect of private practice, preferring to limit their work hours for personal or lifestyle reasons, or desiring flexibility in their future employment options.[36] There is growing support for this model, particularly among younger and recently graduated doctors.[37] This may result in the nature and character of the general practice work force changing appreciably in the future.

The increased level of postgraduate training and continuing medical education which vocational registration requires, has led to critical questions about the comparative rates of remuneration among GPs and other medical specialists with some specialists earning up to eight times that of GPs with similar time spent in post graduate study. Advocates for general practice and GPs themselves regularly call for more equitable payment across the medical fields.[38]

Medicare Australia http://www.medicareaustralia.gov.au/ (formally the Health Insurance Commission) is an Australian government agency that works in partnership with the Department of Health and Ageing to achieve the Australian Government's health policy objectives. The health programs administered by Medicare Australia include Medicare, Pharmaceutical Benefits Scheme, Australian Childhood Immunisation Register, Australian Organ Donor Register, General Practice Immunisation Incentives Scheme and the Practice Incentives Program.[39]

Medicare is Australia's universal health insurance scheme that allows Australians to receive free or subsidised medical treatment by a range of health care providers. Medicare essentially aims to subsidise health care services provided by GPs to help improve equal access by all Australians. The subsidy is paid to the patient.

Under Medicare, privately practising doctors, including GPs are able to elect to take the Medicare benefit as full payment for a service from a patient (a practice known as bulk-billing) or to also charge a patient fee on top of the Medicare rebate. Medicare rebates are set by the Australian Government as schedule fees that are paid to patients to assist them with the cost of professional medical care and treatment.[40] Schedule fees are the amount the government is willing to pay for each Medicare Benefits Schedule or consultation item (fee-for-service). This may be half the amount recommended by professional bodies such as the AMA.[41] A schedule fee does not determine the amount a health professional can charge for providing the service.[42] Medical practitioners are free to set their fees for their professional service. The difference between the Medicare rebate and the fee charged to the patient is commonly referred to as an 'out-of-pocket cost'.

The availability of bulk billing services varies across the state. A considerable number of general practice's bulk-bill pensioners, children and concession card holders, while charging a higher patient fee for other patients. While about 40 per cent of the population holds health care cards of one sort or another, this group uses a greater

35. Britt H, Miller GC, Charles J, Henderson J, Bayram C, Pan Y, Valenti L, Harrison C, Fahridin S, O'Halloran J, 2009. General practice activity in Australia, 2008–09. General practice series no. 25. Canberra: AIHW.
36. Addressing GP Recruitment and Retention Issues in Rural Victoria – Report on Community Consultations, February, 2006 Rural Workforce Agency Victoria
37. Report - Senate Select Committee on Medicare - First Inquiry. Chapter 3. Medicare - healthcare or welfare? Commonwealth of Australia 2003. www.aph.gov.au/senate/committee/medicare_ctte/fairer_medicare/report/index.htm
38. Medicare needs 'real action' to 'move forward' to better serve patient needs. AMA Family Doctor Week 19-25 July 2010 http://ama.com.au/node/5844
39. Medicare Australia http://www.medicareaustralia.gov.au/
40. Primary Health Care Reform in Australia. Report to Support Australia's First National Primary Health Care Strategy. Commonwealth of Australia 2009
41. Australian Medical Association. Fees List Online http://ama.com.au/node/4092
42. Medicare Benefits Schedule Book. Diagnostic Procedures and Investigations. Category 2. Operating from 01 November 2010. Australian Government. Department of Health and Ageing. Commonwealth of Australia 2010

proportion of all GP services.[43] Bulk Billing doctors are more common in less affluent areas, but can be rare in better off and some rural areas in NSW. Overall only about 20% of GP services in NSW are billed above the Medicare Benefit schedule fee. The Australian Medical Association encourages medical practitioners to determine patient fees based on individual practice costs – "The cost of running medical practices which varies across the country includes employing practice staff and operating expenses such as computers, rent, electricity, general insurance and professional insurance".

While bulk billing entices many practices with low transaction costs and assured cash flows, the current fees do not reflect the growing costs of running a practice, including wages and rising insurance, administrative and bureaucratic costs and responsibilities. Practice costs vary widely depending on location, patient population, local market conditions, staff employed and equipment.

As a result, there is often a need to increase income through various strategies including patient fees and/or increasing patient throughput with a resultant reduction in consultation time with each patient.[32] The most common or 'standard' GP consultation is known as a Level 'B' and usually lasts less than 20 minutes but in many bulk billing clinics may be much less than this.

The recent escalation in chronic disease prevalence which requires health care to have a greater focus on more comprehensive and often coordinated care involving other health professionals has led to incremental changes in Medicare funding approaches in general practice. The Enhanced Primary Care (EPC) MBS items were introduced in 1999 to improve the health and quality of life of older Australians, people with chronic conditions and those with multi-disciplinary care needs.[45] The EPC items provided a Medicare rebate for GPs to undertake or participate in health assessments for older people, and care planning and case-conferencing services for patients with chronic conditions and complex needs. Other MBS assessment items have been implemented in more recent years to cover targeted populations including Indigenous people, aged care residents, refugees, people with intellectual disabilities and 45-49 year olds at risk of developing chronic disease.

Media excerpt

Bulk Billing gets dumped

THE owner of the biggest medical centre in the Hills has rolled back bulk-billing and will now charge patients $30 above the patient Medicare rebate for a standard weekday consultation and $40 at the weekend.

Primary Health Care, the owners of Castle Towers Medical Centre, will still bulk-bill children under 16 years and pensioners, but will make ordinary working people pay the upfront fee. The move signals a nationwide campaign by Australia's largest medical centre operator to reduce bulk-billing rates after the privatisation of its 87 centres in NSW, SA and ACT.

Kristen Campise. Hills News, Sep 2009 http://www.hillsnews.com.au/news/local/sport/general/bulkbilling-gets-dumped/1625366.aspx

43. *Australian Medical Association. Calls for proper indexation of the Medicare Benefits Schedule and no further cuts to Medicare rebates http://ama.com.au/node/5950*
44. *RACGP 2001 Relative Values*
45. *History of key MBS primary care initiatives 1999-2010. http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-History*

Medicare item claim example

REASONS FOR PRESENTATION	MEDICARE CLAIMABLE SERVICES	NON-MEDICARE CLAIMABLE SERVICES
Check if unemployed women is pregnant and complete new forms for welfare system	Professional attendance by a GP at consulting rooms lasting less than 20 minutes - level B consultation - $34.30 (+ $9.00 bulk billing incentive payment), including any of the following: • taking a patient history; • performing a clinical examination; • arranging any necessary investigation; • implementing a management plan; • providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation	• Reading blood test results • Phone consultation with a patient e.g. explaining test results • Recording blood test results in clinical notes (only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added at a later time, such as reports of investigations) • Complete welfare forms • Complete other relevant forms e.g. referral to peri-natal service, parent programs etc

In 2004 MBS items were introduced for a limited range of services provided by practice nurses when acting for, and on behalf of, a GP. In the same year MBS rebates for a range of allied health and dental services were also introduced for patients with chronic conditions and complex care needs being managed by their GP under a multi-disciplinary care plan. Chronic Disease Management (CDM) items were introduced in 2005 to replace the existing EPC care planning items. The term 'EPC plan' is now obsolete.[46] The CDM items were developed to better enable GPs to manage the health care of patients with chronic medical conditions, including patients who need multi-disciplinary care.

In 2006 MBS items for GP mental health plans and psychological therapy items were introduced. Changes to MBS primary care items in May 2010 which focused on new time and complexity based remuneration saw the package of CDM measures reduced from 85 MBS items to 33. The structure for health assessments review of CDM plans and Team Care Arrangements, and GP Multidisciplinary Case Conference items were changed and fees rationalised. Descriptors for a number of general consultation items were revised to clarify that doctors may address one or more health related issues in one consultation. General practice feedback indicates that the rationalisation of the CDM package has in general meant a reduction in returns to GPs undertaking these items. For detailed information on each of the currently available incentives go to: www.health.gov.au and use the A-Z Index to go to 'C' and select 'Chronic Disease Management Medicare items'. Alternatively, contact Medicare Australia on 132 150 (for GPs) or 132 011 (for patients).

The Practice Incentives Program (PIP)[47] was developed by the Australian Government to encourage general practices to improve the perceived quality of care provided to patients. PIP is a part of a blended payment arrangement for eligible general practices. PIP payments

---

46. MBS Primary Care Items. Removal of Enhanced Primary Care (EPC) Terminology. Commonwealth of Australia http://www.health.gov.au internet/main/publishing.nsf/Content/mbsprimarycare-removalofepc

47. Medicare Australia. Practice Incentives Program (PIP) http://www.medicareaustralia.gov.au/provider/incentives/pip/index.jsp

go to the practices rather than to individual doctors. This means that where GPs are employed rather than practice owners they do not (unless they have negotiated it) receive the PIP payment. PIP practice payments are in addition to income earned by GPs and the practice, such as fee-for-service Medicare rebates and patient payments. PIP payments are principally dependent on the number of practice patients. For a practice to be eligible to receive payments through the PIP they must either be accredited, or working towards accreditation that meets the requirements of the Royal Australian College of GPs' Standards for General Practices.

Currently PIP is made up of 13 different incentives, including rural, outcome-based, disease and population group specific and others to support practices to employ practice nurses and allied health workers.[47] Practices can apply for as many of the incentives as they are eligible for and may spend their payment as they wish, though usual taxation rules apply.

Service Incentive Payments (SIPs) are made to practitioners working within a PIP practice for the provision of specific care to patients with Type 2 Diabetes and Asthma. These incentive payments can also be claimed by a practitioner for screening women between 20 and 69 years, who have not had a cervical smear within the four years and for Aged Care Access Incentive payments to encourage GPs to provide more services in Residential Aged Care Facility. For detailed information on each of the currently available PIP and SIP incentives go to: http://www.medicareaustralia.gov.au/provider/incentives/pip/index.jsp

The changes to general practice funding arrangements via the Medicare Australia framework have introduced significant administrative complexity for general practice. Overall less than 10% of general practice remuneration comes from Medicare Australia's incentive payment schemes (varying significantly between general practices); with time and additional personnel costs associated with adopting the schemes the most commonly cited reasons for poor uptake. It is estimated that around 5% of total practice income is spent on the administrative and related costs of incentive funding programs.

The prevailing view is that incentive payments are primarily accessed by larger practices with sufficient IT and staff resources to complete the administrative demands of the schemes. GPs that practice by themselves or with a small number of other doctors and/or no additional support are at a comparative disadvantage when it comes to accessing incentive funding programs. Some GPs in larger practices perceive the incentive funding schemes to be gratuitous form-filling and opt for a fee-for-service approach to billing.[31] Still others consider the payment schemes to be designed only to check on the perceived quality of general practice service provision.[31] Medicare funding arrangements will continue to be closely examined and transformed, particularly in the context of health system reform efforts.[50]

Medicare Australia's Compliance Program monitors the practice profiles of medical practitioners operating within the Medicare System.[51] One of the elements of the compliance program is the random audit. Random audits are undertaken each year in around 4% of practitioners who provide Medicare services in Australia. Audits are performed to ensure practitioners are complying with the requirements of the MBS including the production of records to substantiate MBS billings. A financial penalty operates in circumstances where Medicare Australia determines the matter being reviewed does not warrant referral to Professional Services Review or criminal investigation under the Health Insurance Act 1973. Many GPs feel they are potential targets of unfair auditing and those that have been audited report feeling intimidated by the process.

48. Harris MF, Zwar NA. Care of patients with chronic disease: the challenge for general practice. Med J Aust. 2007 Jul 16;187(2):104-7.
49. Report - Senate Select Committee on Medicare - First Inquiry. Chapter 3. General Practice Incomes and the viability of Practice in Australia www.aph.gov.au/senate/committee/medicare_ctte/fairer.../c03.doc
50. Australian Medical Association. Health financing. 16 February 2011. http://ama.com.au/node/6400
51. Medicare Australia Compliance http://www.medicareaustralia.gov.au/provider/business/audits/index.jsp

ENABLERS AND CHALLENGES TO UNDERSTANDING AND WORKING WITH GENERAL PRACTICE

- Time is money for general practice. Fair remuneration for GP time should be offered up front when inviting involvement in external programs and initiatives. This can signify that stakeholders have made some effort to develop an understanding of the general practice context and support ongoing relationships.[31]

- Increases in the Medicare rebate have failed to keep pace with the rise in the costs of running a GP service with increased patient throughput often used to make up the shortfall. Where this and other barriers exist, it may not be feasible for patients to be offered additional advice or services beyond their original reason for presentation unless a strategy is negotiated and agreed between relevant players.[31] Working with Divisions of General Practice and adequately resourcing the establishment and funding of nurse clinics (in practices with adequate infrastructure) and off or on-site group education courses (where GPs can refer relevant patients) have proven very successful in instances where sustainability of the add-on services can be assured. [31]

- More GPs utilise the MBS incentive payment programs when given support to do so, including appropriate item identification, clear summaries of the conditions to be met to claim the item, the provision of templates that satisfy any necessary patient information collection, billing instructions and comparative summaries of evidence based benefits of providing the services to patients relative to usual general practice care. [31]

- Where calls for comment on new health care policies become available, stakeholders external to general practice may wish to incorporate the need for general practice policy improvements, including the need for fair and fully negotiated funding arrangements. Unless general practice has the capacity to deliver on its requirements, the health system generally is at high risk of failing. [31]

Further Information

- Michael J Taylor, Dell Horey, Charles Livingstone and Hal Swerissen. Decline with a capital D: long-term changes in general practice consultation patterns across Australia. MJA 2010; 193 (2): 80-83. http://www.mja.com.au/public/issues/193_02_190710/tay10240_fm.html

- David Pierce. Identifying and addressing barriers to the use of enhanced primary care plans for chronic disease in rural practices. Aust. J. Rural Health (2009) 17, 220–221 http://www.agpn.com.au/data/assets/pdf_file/0015/15018/Pierce-D---Identifying-and-addressing.pdf

Education and Training

The skills of Australian GPs encompass prevention, pre-symptomatic detection of disease, early diagnosis, diagnosis of established disease and other clinical problems such as injury, management of disease and injury, management of complications, rehabilitation, palliative care and counselling.[52]

Australian general practice medical training is a postgraduate vocational training program for medical graduates wishing to pursue a career in general practice and/or rural and remote medicine in Australia.[53] The program is a three or four year full-time registrar training program culminating in a fellowship exam which covers a broad range of clinical and non-clinical areas. In this way general practice fellowship is comparable to any other specialist training.

To maintain recognition as a GP requires ongoing professional development accredited by the two main GP Colleges either the Royal Australian College of GPs[54] (RACGP) or the Australian College of Rural and Remote Medicine[55] (ACRRM). These programs are continually evaluated and improved based on feedback from the profession. Effective continuing professional development is currently understood to be educational activity that results in quality improvement in clinical practice. A minimum of 130 Quality Improvement & Continuing Professional Development (RACGP-QI&CPD) or 100 Professional Development (ACRRM-PD) points must be obtained every three years to ensure a GP is eligible for vocational registration which attracts higher Medicare rebates for the care provided to patients. These programs encourage GPs to participate in education that is likely to maintain and improve patient care standards.

When GPs care for patients in certain contexts - typically within rural and remote areas - there are a clear set of additional skills, competencies and professional values that are required in order to provide safe and appropriate care. ACRRM refers to this unique scope and nature of general practice as 'Rural and Remote Medicine'. The clinical scope, practices and values that characterise rural and remote medicine within the medical specialty of general practice are outlined in the curricula and professional standards that are set and maintained by ACRRM. GPs who achieve these standards are recognised through the award of Fellowship of ACRRM. Fellows of ACRRM receive full vocational recognition and are able to practice in any location throughout Australia.

The majority of GPs take advantage of the RACGP QI&CPD Program. All program participants are encouraged to undertake a range of different activities covering the content of five domains of general practice to address individual learning needs. The five general practice domains 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 organisation and legal dimensions. The QI&CPD Program offers GPs access to a range of activities and provides flexible learning styles such as online, face-to-face, small group learning and self-directed education. It also supports individual learning needs and offers the following modules: active learning modules, supervised clinical attachments, individual learning plans, research projects, higher education courses and small group learning activities. The NSW Divisions of General Practice are, to a large extent, facilitating these programs.

The RACGP QI&CPD Program for the 2011-2013 triennium

A minimum of 130 points is required for the triennium and must include two category 1 activities and completion of a basic cardiopulmonary resuscitation (CPR) course.

Category 1 activity options include: quality improvement activities (e.g. clinical audits and PDSA cycles); small group learning, supervised clinical attachments, research etc. Category 2 options include basic CPR and Accredited Provider Category 2 Activities. The 2011-2013 Triennium Handbook provides detailed information on the QI&CPD Program http://qicpd.racgp.org.au/media/39262/qicpd_program_handbook_2010_locked.pdf

The 2011-2013 triennium requires that all Category 1 and 2 activities include particular design elements, including but not limited to:

- The primary objective is to improve patient care

- The content must observe the highest ethical standards

- The content must be of a high clinical standard which is evidence based and supported by accepted medical theory

- Use a range of presentation and engagement modes

52. The Royal Australian College of GPs. What is general practice? Definition of general practice and GPs, 2005. Available at: www.racgp.org.au/whatisgeneralpractice.
53. Australian General Practice Training http://www.gpet.com.au/
54. RACGP http://qicpd.racgp.org.au/
55. Australian College of Rural and Remote Medicine https://www.acrrm.org.au/

- Account for prior knowledge, skills, attitude and behaviour

- Identification of one or more domains of general practice (refer to page 54 of the 2011-2013 Triennium Handbook)

- Identification of specific interest areas covered in the educational content

- Provide opportunity for GPs to complete a 'GP adverse experience feedback' form for submission to the QI&CPD Program evaluation upon completion.

For information on all design components required in the development of Category 1 and 2 activities in this triennium refer to page 8 of the 2011-2013 Triennium Handbook: http://qicpd.racgp.org.au/media/39262/qicpd_program_handbook_2010_locked.pdf

The RACGP is working with the Australian Practice Nurse Association and the Australia Association of Practice Managers to ensure that practice managers and practice nurses who participate in RACGP accredited activities receive appropriate recognition within their own professional CPD programs.[56]

GPs attend organised continuing medical education events for a range of reasons including the opportunity for informal networking with colleagues.

The use of pharmaceutical company sponsorship to assist general practice education is common and the relationship between general practice and the pharmaceutical industry continues to be a source of comment and some concern.

The main apprehension about the involvement of the industry in continuing medical education has been the clouding of the distinction between promotion of the industry's products and the provision of impartial education. Divisions of General Practice routinely encourage and facilitate the development of independently organised, non-sponsored, as well as sponsored continuing medical education in general practice. When they organise pharmaceutical sponsored events they generally do so following Division agreed guidelines on the use of pharmaceutical company sponsorship.

Media Excerpt

Lavish dinners not needed for GP education

GPs are happy to give up their free time to attend educational events even if they are not offered "lavish" incentives by drug companies, according to a group of Western Australian health professionals.

The group has challenged the perception that doctors will only attend different conferences or events if they are "duchessed" with costly catering, in a study presented at the GP10 conference in Cairns.

They say that the Cancer Council's GP conference has not accepted sponsorship from pharmaceutical companies since 2007 but its attendance has not diminished despite a fall in the amount of money spent on catering and the venues. And they insist the format of the events is similar to pharmaceutical sponsored events with guest speakers, food and non-alcohol drinks on offer. "If the event has good content then GPs will attend"

Gemma Collins 6minutes 12 October 2010

---

56. *Quality Improvement & Continuing Professional Development Program 2011–2013 triennium Information guide. http://qicpd.racgp.org.au/media/38898/qicpd_flyer.pdf*

ENABLERS AND CHALLENGES TO UNDERSTANDING AND WORKING WITH GENERAL PRACTICE

- There is no shortage of accredited educational activities for GPs and investigating those available may eliminate the need, cost and time to develop another.[31]

- Expertise as a general practitioner includes the need for knowledge of a large body of information and procedural skill across a wide range of areas. Education is more likely to be of value if GPs are given sound evidence based rationale for the need to know or be update on a particular topic.[57]

- Involve GPs in diagnosing their own educational needs. [31]

- Involve GPs in planning the delivery methods and content of CPD activities.

- Accredited educational programs that are educationally coherent, engaging and convincing will support medical practitioners maintain high professional standards throughout their careers.

- GPs value learning that integrates with the demands of their everyday working life. [31]

- General practice CPD programs place greater emphasis on activities that are based on adult learning principles, promote high clinical, scientific and ethical standards, and enhance knowledge and skills that impact significantly on the behaviour of GPs in relation to improved quality of care of their patients.

- The RACGP QI&CPD Program particularly values teaching and awards points to GPs involved in teaching and supervision.[54]

- The RACGP now requires developers of education activities (individual GPs and providers) to address the systems that create safeguards for patient safety more explicitly in all education activities. [54]

- Ensure GP education is properly constructed and targeted, general overviews attract less interest and lectures alone are unlikely to change professional practice. Facilitate learning through interactive workshops and other methods (e.g. small group learning) rather than didactic education as it is learning that leads to change in practice not teaching.[6]

- Acknowledging the diversity of the GP role, research indicates that multi-faceted interventions that include education and reinforcement from different sources as components are likely to be the most effective in changing desired clinical practice.[58]

Further Information

- A Framework for Continuing Professional Development of Vocationally Trained GPs and Specialists. A Report on the Project Conducted by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists on Behalf of the Committee of Presidents of Medical Colleges www.cpmc.edu.au/docs/cpd_dec2003_finalreport.pdf

- John Fraser. How to plan, deliver and evaluate a training session. Australian Family Physician 33(6):385-480

- Felicity Goodyear-Smith et.al GPs' Perceptions of Continuing Medical Education's Role in Changing Behaviour Education for Health, 16:3, Nov 2003, 328 – 338

---

57. Légaré F, Ratté S, Stacey D, Kryworuchko J, Gravel K, Graham ID, Turcotte S. Interventions for improving the adoption of shared decision making by healthcare professionals (Review). 2010 The Cochrane Collaboration

58. Felicity Goodyear-Smith, Melanie Whitehorn and Ross Mccormick. General Practitioners' Perceptions of Continuing Medical Education's Role in Changing Behaviour Education for Health, Vol. 16, No. 3, November 2003, 328 – 338

Divisions of General Practice

The Divisions of General Practice Program, which commenced in 1992-3 is part of the Australian Government's General Practice Strategy.[59] The NSW Divisions of General Practice Network comprises General Practice NSW (GP NSW) and the Divisions of General Practice which are regionally based across NSW. GP NSW is the state based support and education organisation for Divisions of General Practice in NSW. GP NSW is an active organisational member on a wide range of state level health advisory, research and program specific groups, and regularly informs policy on General Practice and broader primary health care issues by gaining input from across the Network to inform its recommendations.

Divisions of General Practice are the recognised institutions that support general practice in Australia.[60] Divisions are independent organisations incorporated as companies or associations and are staffed by paid employees (some who may be GPs) under the control of a Board of Directors. There is great diversity in the geographical size, number of GPs and population within Division boundaries as well as differences in resources and infrastructure with many becoming increasingly complex organisations with significant levels of funding, often from sources outside the Australian Government.

Differences in local circumstances and the resultant priorities of each Division mean that not all Divisions implement the same programs and reforms to the same degree and/or in the same time frame. Although GP membership of Divisions is voluntary, around 94% of Australian GPs are members of their local Division.[61] Divisions are strongly connected to other organisations, providers, community groups and bureaucracies within their communities, most often through membership of committees and collaborative projects.

In general terms the role of Divisions is to:

- Improve health outcomes by strengthening primary health care to meet the health needs of specific local communities

- Provide services and support to general practice at the local level

- Encourage GPs to network and communicate with each other as well as other health professionals and the local community

- Ensure a consumer focus within general practice and ensure all Australians can access a high quality health system

- Address the professional development and education needs of GPs

- Give GPs a representative voice with local health services planning and other health agencies

Divisions have been instrumental in providing a broad range of support strategies and development opportunities for general practice over the past 18 years.

The overall scope of Division activity is diverse and includes facilitating continuing professional development for GPs and general practice staff, accreditation, practice management, workforce solutions and a range of other foundation roles. While Divisions maintain a strong focus on supporting GPs and their practices, including providing professional development and networking opportunities, they have also contributed significantly to:

- The design, testing and ongoing delivery of effective patient focussed integrated care via care coordination models that promote flexible, comprehensive health care.

- Electronic delivery and integration of health care information to support the best possible health care delivery. The ability to transmit clinical information reliably is a basic building block for the widespread use of an electronic medical record.

- Population health including better defining and characterising local community health needs, and health promotion and preventive activities through programs such as immunisation, indigenous health and prevention of type II diabetes and consumer involvement. Their programs have supported a greater number of people affected by chronic disease to benefit from lifestyle education and self-management courses/groups.

The role of NSW Divisions of General Practice to assist in developing the capacity and performance of general practice provides the opportunity to develop and trial new ways of working with general practice. As a result, many innovative projects, covering a broad

59. Primary Health Care Reform in Australia. Report to Support Australia's First National Primary Health Care Strategy. Commonwealth of Australia 2009
60. Australian General Practice Network 2008, What Divisions Do: A Snapshot of the General Practice Network 2006-2007, 20 April 2010
61. The Australian General Practice Network. A stronger network, a stronger voice. AGPN 2006
62. Scott, A. & Coote, B. The Value of the Divisions Network. Full Technical Report, 20 April 2010, http://www.agpn.com.au/__data/assets/pdf_file/0019/19306/20070208_rep_Melb-Institute---Value-of-Network-study.pdf

range of health issues and population groups have been undertaken with general practice.

A showcase of numerous innovative projects is provided in the GP NSW publication Stories of Innovation in Health Partnerships which can be found at: www.gpnsw.com.au/divisions These case studies reveal the broad scope of activities that NSW Divisions of General Practice undertake to improve the health of people in their community. Selected excerpts of projects highlighted in this publication are provided below:

Talking Heads
Sutherland Division of General Practice

Sutherland Division of General Practice partnered with the local adult and youth mental health services to raise awareness of co-morbid mental health and substance use issues in young people and improve knowledge of how this can be managed. Recruiting and training young people as peer educators to engage with other young people at community events was intended to raise awareness and de-stigmatise co-morbidity among young people. Insights gained from these engagements will be used to increase understanding of health and youth work professionals of co-morbidity among young people.

Murdi Paaki Dog Health, Good Health
NSW Outback Division of General Practice

Studies have shown that in some of the most remote outback Indigenous communities in NSW, dogs have little or no access to veterinary treatment and carry illnesses that can spread to the community. The Division secured funding from the Aboriginal Medical Service and collaborated with the RSPCA and the Greater Western Area Health Service, Population Health Unit to conduct this project. Nine communities within the Division received two dog clinics where dogs and cats were given health checks, sterilisations and some were euthanized. Primary schools within the Division were also visited by the RSPCA to provide education to the children and the community about animal health.

Primary Health Care Reform

Australia's future general practice and primary health care system is to be built on and around primary health care organisations. These organisations (named Medicare Locals by the Australian Government) are to be created largely from the existing General Practice Divisions Network which has had a key role in achieving important health priorities in Australia, such as its world recognised immunisation rates. Building on the good work of Divisions, these organisations will be established to help to better connect general practice and other primary health care services in Australia. The establishment of regional primary health care organisations is one of the key recommendations from the National Health and Hospitals Reform Commission to strengthen Australia's primary care system.[63]

Behind these health care reforms is the rapidly increasing number of people with multiple, interacting chronic conditions that need diagnosis and lifelong monitoring, treatment, and support to be properly managed and develop the knowledge and skills to manage their own health between visits. Within this environment, the current high cost health system, which places greater emphasis on unplanned hospital care than on community-based primary and preventive care, is no longer viewed by health care providers, policymakers and politicians as the ideal model for organising and providing health care.[64]

The Australian Primary Health Care Research Institute defines primary health care as:

Primary health care is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation.[65]

A supportive and coordinated team of clinicians including general practitioners, nurses, specialists, allied health and other professionals and support services has been shown to make it easier for patients to get the services they need and increases opportunities for providers to focus on wellness, prevention, and patient education.[66] Policy and investments in this model of care in general practice have grown in recent times, including funding strategies that support team work, collaboration and communication, and reforms which assist in the provision of primary health care by improving access to allied health services in general practice and in the community.[67]

According to the report to support Australia's first National Primary Health Care Strategy,[68] compared to current arrangements, further changes are needed to:

- improve access and reduce disparities in access to services for disadvantaged
- populations and in under-serviced areas;
- develop and implement effective and integrated models of care in delivery of primary health care services;
- support and encourage greater flexibility in service provision including through opportunities afforded by technology;
- develop infrastructure to support and expand comprehensive primary and ambulatory health care to facilitate effective primary health care; and
- ensure service changes are monitored and evaluated.

The nationwide network of Medicare Locals will support GPs and other health professionals to improve the delivery of primary health care at the local level.[69]

63. *A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission – June 2009. http://www. health.gov.au/internet/nhhrc/publishing.nsf/Content/nhhrc-report*

64. *A National Health and Hospitals Network for Australia's future – Delivering Better Health and Better Hospitals www.yourhealth.gov.au/ internet/yourhealth/publishing.nsf/content/report-redbook*

65. *Australian Primary Health Care Research Institute, cited in Primary Health Care Reform in Australia: Report to Support Australia's First National Primary Health Care Strategy (September 2009)*

66. *Powell Davies G, Harris M, Perkins D, Roland M, Williams A, Larsen K, McDonald J. Coordination of care within primary health care and with other sectors: A systematic review. Research Centre for Primary Health Care and Equity, School of Public Health and Community Medicine, UNSW 2006.*

67. *Overview: Australia's First National Primary Health Care Strategy www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/ report-primaryhealth*

68. *Primary Health Care Reform in Australia. Report to Support Australia's First National Primary Health Care Strategy. Commonwealth of Australia 2009*

Particular roles of Medicare Locals include:

- Facilitating allied health care and other support for people with chronic conditions, as identified in GP care plans;

- Working with local health care professionals to ensure services co-operate and collaborate with each other so that patients can easily and conveniently access the full range of services they need;

- Identifying groups of people missing out on GP and primary health care, or services that a local area needs, and better target services to respond to these gaps;

- Working with Local Hospital Networks to assist with patients' transition out of hospital, and where relevant into aged care; and

- Delivering health promotion and preventative health programs targeted to risk factors in communities.

Further Information

- National Health Reform: Delivering a Better Deal for Patients http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/Home

- Improving Primary Health Care for All Australians. Commonwealth of Australia 2011 http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/improving-primary-health-care-for-all-australians-toc

ENABLERS AND CHALLENGES TO UNDERSTANDING AND WORKING WITH GENERAL PRACTICE

- Divisions of General Practice and Medicare locals, as they become established, should always be the first contact point for anyone wishing to communicate and/or work with general practices at a regional level.

- General practice largely understands the work and trusts the commitment of local Divisions but may not have the sentiment or time for other organisations, especially if approached in a manner that does not fit with their day-to-day realities or when ill-informed or unreasonable requests are made.[31]

- Divisions can support a sound understanding of general practice, provide advice, and with adequate support, can assist the development and implementation of activities and programs in general practice.[70]

- As there is little flexible funding available within the Divisions Program there is not a lot of capacity within Divisions to work outside their contracted programs without additional support. Additional ad hoc funding sometimes allows Divisions to recruit necessary staff to work to new programs and initiatives, and purchase essential resources and training where required.[31]

- Poor health is now more often multifactorial, predominantly preventable and increasingly expensive. The current fragmented approach to health care will not be able to deliver on future need and will continue to drive policy change in primary care that supports health care partnerships. However policy changes in general practice are most often associated with greater funding complexity and administrative and liaison burden which are not readily taken up by general practice or may be utilised only to comply with minimum government requirements.[71]

- Supporting general practice to understand and adopt policy and funding changes through education; system and practice staff support; providing direct remuneration and other useful incentives; showcasing how early adopters have embedded changes in every day practice and how patients and the practice can benefit is more likely to encourage change.[31]

69. Improving Primary Health Care for All Australians. Commonwealth of Australia 2011
http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/improving-primary-health-care-for-all-australians-toc
70. Anthony Scott and William Coote. Whither Divisions of General Practice? An empirical and policy analysis of the impact of Divisions within the Australian health care system. MJA 2007; 187: 95–99
71. Professor Doris Young, Professor Jane Gunn, Dr Lucio Naccarella. Funding Policy Options for Preventative Health Care within Australian Primary Health Care Discussion Paper. August, 2008. Department of General Practice, The University of Melbourne
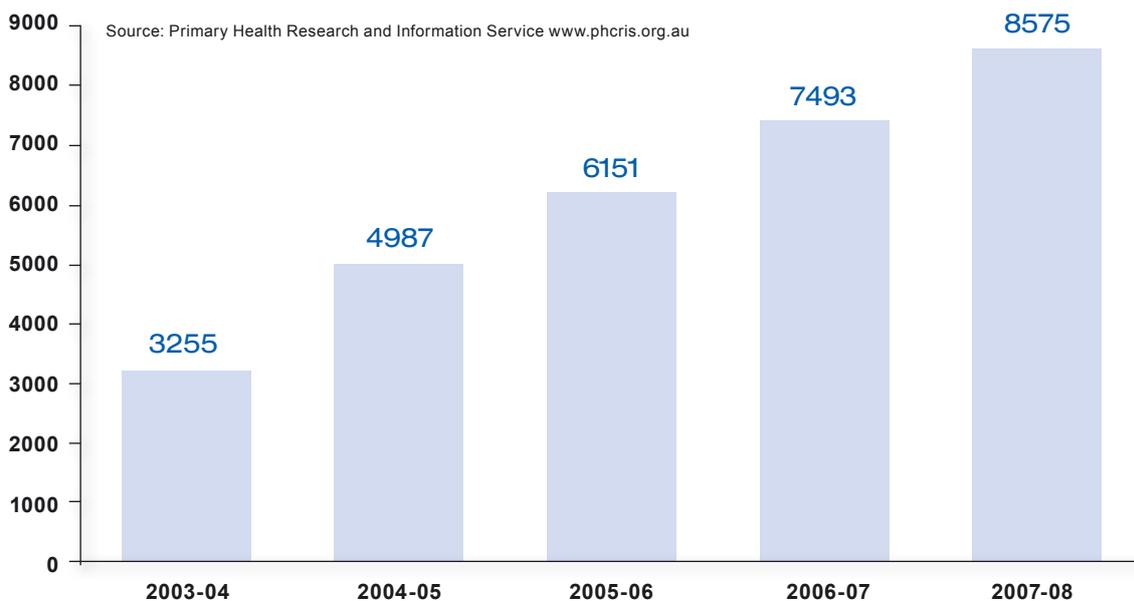
Nursing in General Practice

Introduction

A general practice nurse is a registered or enrolled nurse who is employed by, or whose services are retained by, a medical general practice. A general practice nurse can also be a nurse practitioner i.e. a nurse with expanded skills, experience and knowledge who has completed post-graduate studies (either a Master's or a Doctoral degree) and is an accredited expert in their field, but this is much less common.

According to the Australian General Practice Networks - National Practice Nurse Workforce Survey 2009,[72] there are just over 8,900 nurses working in General Practice in Australia, with around 2,400 in NSW general practices, 57% of practices employ at least one nurse. This rate has not changed significantly since 2005 when 58% of practices employed at least one nurse.[73] However, the number of nurses working in general practice has increased, indicating that more practices have a greater number of nurses than previously.[74]

Number of practice nurses in Australia

Source: Primary Health Research and Information Service www.phcris.org.au

Year	Number
2003-04	3255
2004-05	4987
2005-06	6151
2006-07	7493
2007-08	8575

Some of the characteristics of the Australian practice nurse workforce in 2009 include:

- Almost 85% were registered nurses

- 80% of nurses employed in general practice were aged over 40 years

- 80% were employed part-time and around one third were employed in at least one other nursing job

- The proportion of practices employing one practice nurse was almost 25% while those with more than five nurses was almost 7%

- Forty-nine percent of practice nurses were employed in major Australian cities, 19% in inner regional Australian practices, 18% in outer regional practices and 14% were located in practices in remote and very remote Australia

One of the main reasons for nurses choosing to work in general practice is that it is better suited to a work-life balance than nursing in hospitals or other settings that may require shift work, overtime and on-call demands.[75]

---

72. *Australian General Practice Network - National Practice Nurse Workforce Survey 2009.*
73. *Jolly, R. 2007. Practice nursing in Australia. Parliament of Australia Parliamentary Library Research Paper no. 10, 2007 08. Canberra: Commonwealth of Australia.*
74. *Primary Health Care Research & Information Service http://www.phcris.org.au/*
75. *McCabe et al. (2005). 'Nursing Careers: What motivated nurses to choose their profession?' in Australian Bulletin of Labour 31(4): 385-406.*

Roles

There is no single definition of what the practice nurse role should encompass. Beyond the activities covered by the available government financial incentives, GPs may delegate any aspects of the clinical workload of the practice that fits within the training and qualifications of the practice nurse. Nurses may also be involved in the business of the practice including managing the accreditation process and setting up practice systems. The role of the nurse in each practice is largely shaped by the professional capacities of the nurse, the practice patient population, the prevailing funding drivers for practice nursing and available practice and local community resources and services.[76]

Practice nurses have been reported to be involved in a wide range of activities including health assessments and chronic disease management such as monitoring patient health, managing patient recall registers and conducting diabetes assessment and education clinics.[43] Reports indicate that the majority of practice nurse activity is procedural in nature such as blood pressures, wound care, immunisation provision, ECGs, injections, spirometry, audiometry and others. Preventive health counselling, general health advice and education and advice about treatment are to date comparatively uncommon for practice nurses to undertake.

Nurses are reported to be valuable in ensuring the smooth flow of patients through the practice and minimising the need for GPs to conduct procedures and dressings during the consultation time.[44] Some practice nurses who have the necessary training run specialty clinics in or outside the practice, for example in diabetes assessment and education. The nurse may provide health care visits in the home and other community settings such as residential aged care facilities. More information on practice nurse activity can be found at: www.fmrc.org.au/beach.htm[77]

Funding

For a considerable time, registered and enrolled nurses were employed in a limited number of general practices in Australia. Recently the employment and role of nurses in general practice has been supported via Australian government financial incentives through Medicare Australia and the Practice Incentives Program (PIP). To participate in

the PIP Practice Nurse Incentive,[78] general practices must be accredited or registered for accreditation against the Royal Australian College of GPs Standards for General Practices.[79]

The PIP Practice Nurse Incentive aims to encourage general practices to employ practice nurses and/or Aboriginal health workers. Participating practices must ensure that the practice nurse and/or Aboriginal health worker and/or allied health professional has a clear, unambiguous and agreed role description consistent with the qualifications of the nurse and the legislative framework of the state or territory in which they are employed. These conditions include ensuring that the nurse has support systems, such as access to relevant training and development. This need is further supported by the requirements of the National Registration Scheme for health practitioners which was established in 2010 and requires nurses to undertake 20 hours of continuing professional development per year which must be relevant to their context of practice.[80]

Also currently available to encourage nursing in general practice are a number of Medicare items that apply to a practice nurse undertaking particular tasks and others that allow funding when the practice nurse assists a GP in providing specific care. The full details of these Medicare items can be found at: www.health.gov.au/mbsonline. Proposals have recently been put forward by the Australian Government for a change in the way practice nurses are funded. Block payments to cover some of the employment costs of one or more practice nurses and a discontinuation of some of the Medicare item numbers for specific practice nurse activities are planned. The rationale provided for the proposed change is that it will allow practices to tailor the role of the practice nurse to the needs of the particular patient population rather than being limited to a large extent to the Medicare funded activities. Some doctors have expressed concern that the proposed funding changes will not be enough to cover the costs of practice nurses and are warning they may have to shed nursing staff when the changes are introduced in January 2012. In a 2010 AMA member survey,[81] 48% of participating general practices said that they were likely to be worse off as a result of the changes, with outer urban, regional and rural practices predicting to be hit the hardest by the planned changes. The Australian Practice Nurse Association disputes this, suggesting a revision of payment models, such as the task based fee-for-

76. M. Laurent, D. Reeves, R. Hermens, J. Braspenning, R. Grol and B. Sibbald. Substitution of doctors by nurses in primary care. Cochrane Database of Systemic Reviews, 2004, Issue 4 www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD001271/frame.html
77. Australian General Practice Statistics and Classification Centre. Bettering the Evaluation and Care of Health www.fmrc.org.au/beach.htm
78. Practice Incentives Program (PIP) – Practice Nurse Incentive (PNI). Medicare Australia http://www.medicareaustralia.gov.au/provider/incentives/pip/payment-formula/practice-nurse-incentive.jsp
79. Royal Australian College of GPs Standards for General Practices http://www.racgp.org.au/standards
80. National Registration and Accreditation Scheme http://www.ahwo.gov.au/natreg.asp
81. Practice nurse policy needs constructive consultation to be fully effective - AMA survey July 2010. http://www.ama.com.au/node/5877

service model, which currently prevents extension of roles and prevents realisation of the full-potential of practice nurses.[82] The AMA argues that funding arrangements should support GPs to delegate work based on the GP's judgement of the skills and expertise of the practice nurse.

Barriers

There are numerous barriers[83] to the further expansion and development of the nurse workforce in Australian general practice, including:

- Limited understanding of some GPs about the practice, patient and/or cost benefits of employing a nurse.

- Concerns about medical indemnity and liability due to confusion about the scope of practice nurses and the regulations and laws under which they practice.

- Lack of physical space in the practice.

- The fee structure of general practice makes it difficult for the GP and practice nurse to have time away from patient care to consult each other and build the necessary team environment.

- Some GPs feel threatened by the reported increasing responsibilities of nurses working in general practice and the potential of them becoming 'substitutes' for GPs.

- Limited recognition of general practice nurses outside the general practice setting.

- Practice nursing is a slowly developing specialisation with unclear career paths and many nurses choosing the general practice environment to accommodate family commitments seeing the work as a convenient job rather than a career.

- A largely unstructured approach to the wages and conditions of practice nurses with practice nurses often being paid less than those working in the acute care sector.

Practice Managers

Practice managers also play a vital role in general practice and are supported by divisions and organisations such as the Australian Association of Practice Managers. [84] They are generally responsible for the operational management of a practice, including:

- Human resource management - supervision of staff, management of staff meetings and other internal communications, OH&S, induction of new staff.

- Financial performance - accounts, financial reporting, payroll etc.

- Practice efficiency - manage the provision of practice services to medical practitioners, ordering and purchasing of practice consumables, maintenance of appropriate stock levels, patient filing systems and records integrity, practice manuals, practice accreditation.

- Asset maintenance - equipment and asset registers, organising maintenance and repairs, IT systems maintenance.

Practice Managers may have qualifications that include a Certificate IV or Diploma level, or higher.[84]

Division support for general practice staff

Practice nurse and manager support programs are key areas of work of Divisions of General Practice. Divisions assist practices to employ, train and retain staff. Practices are provided with opportunities for practices nurse and manager professional development and relevant information workshops and seminars.[31] Practice orientation and peer networking support opportunities for practice nurses and managers are also facilitated by Divisions. Many Divisions support team work in general practice through on-site staff professional development sessions. In addition to this, Divisions assist GPs to understand the financial benefits of employing a practice nurse and how to maximise financial efficiencies with their employment.[31]

Conclusion

Over the last decade, practice nurses have become essential in the operation of many Australian general practices and with this have come an increasingly diverse nurse workload and high demand for nurses with more skills and broadening roles. Research suggests that a large proportion of the work in the areas of health promotion and prevention, and regular monitoring and training patients to manage chronic conditions such as asthma, diabetes, arthritis and heart disease can be

82. The Australian Practice Nurses Association http://www.apna.asn.au/
83. Dr Rhonda Jolly. Practice nursing in Australia Research Paper no. 10 2007–08. Social Policy Section. 17 September 2007. Parliamentary Library. Commonwealth of Australia
84. Australian Association of Practice Managers

undertaken by nurses who are supported by GPs. There are concerns for the future of the nursing workforce in Australia generally. The workforce is ageing and despite government programs to increase undergraduate nursing places and encourage nurses to re-enter the workforce, the numbers are declining proportional to need.

Further information

- Nursing in General Practice. Australian General Practice Network. http://generalpracticenursing.com.au/

- General Practice Nurses. The Royal Australian College of GPs. http://www.racgp.org.au/nursing

- Nursing in General Practice Project. Royal College of Nursing, Australia http://www.rcna.org.au/chapters/general_practice_nursing

- Nursing in General Practice. The Primary Health Care Research and Information Service http://www.phcris.org.au/infobytes/nursing_gp.php

ENABLERS AND CHALLENGES TO UNDERSTANDING AND WORKING WITH GENERAL PRACTICE

- Over the past decade there has been a growing recognition of the contribution nurses make in general practice and they are now largely accepted as an important resource to support the services of GPs.[83]

- Care provided in general practice will increasingly require greater levels of health promotion, chronic disease monitoring and care of older patients. This will involve the innovative use of existing resources including other health professionals, particularly practice nurses. Practice nurses will be called on to undertake a greater range of functions including working outside the practice with external care and other service providers who are able to support practice patients.[83]

- Like practice managers, nurses across different practices have varying influence in determining access to GPs. More often than not they are an important link between the patient and the GP, and between requests made from external groups and the GP.[31]

- Nurses have access to practice systems and data that may support research, and the development and evaluation of local population health and other initiatives.[31]

- General practice nurses can be supported by external groups and agencies through the design and certification of primary care relevant, cost free professional development opportunities that are accessible after hours such as web based learning initiatives.[31]

85. Keleher, H. et al (2007), 'Practice Nurses in Australia: Current Issues and Future Directions' MJA 2007; 187 (2): 108-110

Information and Communication Technology

The World Health Organisation acknowledges that "over the last decade, the need to develop and organise new ways of providing efficient health-care services has been accompanied by major advances in information and communications technology" and defines e-health as "the use, in the health sector, of digital data - transmitted, stored and retrieved electronically - in support of health care, both at the local site and at a distance"[86]

Computerisation in general practice

The Australian healthcare industry has historically lagged behind many other industries in its use of information technology and while there has been considerable progress in the uptake of this technology by the industry overall in recent years there are no obligatory standards or approaches to ensure system and process interoperability (the ability of diverse systems and groups to work together or inter-operate).[87]

There are some health care sectors that are well advanced in their use of information / communication technology compared to others in Australia. Most notable is general practice where significant progress has been encouraged through Australian Government funding programs such as the Practice Incentive Program.[88] Practice support and e-health programs delivered by Divisions of General Practice[89] and practice accreditation requirements also support improvements in information and communication management in general practices. Additionally, general practice has been provided incentives to transact electronically with Medicare Australia for claims, payments and other business-related transactions.

Nearly 89% of GPs have access to a computer in their major practice address.[56] A range of different management and clinical systems are used by Australian general practices.[90] Administrative tasks remain the most common use of computers in general practice including the collection of patient contact details, issuing bills and receipts, and word processing. Other uses include prescribing medications, clinical data storage, patient history and progress notes, allergy alerts and accessing the Internet. Just over half of computerised practices report the use of email and Internet regularly. Relevant staff including GPs, practice managers, receptionists and nurses are typically trained in the effective use of computer programs used in general practice. Overall, comprehensive computer use is more likely in a large multi GP practice rather than a smaller or solo GP practice; when the GPs have recently graduated or are female, and in large rural centres and other regional areas compared to urban areas.

Although it can be time consuming, many GPs find the Internet useful in providing patients with further information to support what they have been told in the consultation such as handouts and anatomical diagrams; to assist in shared decision making; to consult medical reference information and to find information about local health services that might be useful for their patients. Patients are increasingly consulting the Internet to search for information about their health and to prepare for and/or supplement consultations with their GP.[91] The Internet can provide patients with valuable support material but can also lead to the wrong self-diagnosis and/or misunderstanding about prescribed and recommended treatments. Another result of this growing patient practice is that GPs are more encouraged to use electronic based resources themselves.

Electronic clinical data

To date general practice patient data is most commonly situated in one place and is effectively under the control of a single practice, the responsibility for the data lies with the management of the practice including responsibility for data integrity and ensuring confidentiality. General practice clinical data is used for a range of purposes including medical research, disease registries, medical education, public health surveillance, planning patient services, risk management, quality control and medical complaint/misconduct investigation. Aggregating individual clinical data up to the level of the practice population has been used to add a population focus to the work of many practices. This is a steadily developing aspect of practice management. In general, medical

86. World Health Organisation. ehealth www.who.int/eht/eHealthHCD/en/
87. NEHTA. Referrals - Environmental Scan Overview. Final - November 2009. v1.0
88. Practice Incentives Program (PIP) - Medicare Australia http://www.medicareaustralia.gov.au/provider/incentives/pip/index.jsp
89. The Information Management Maturity Framework (IMMF),developed and implemented in partnership between DoHA and AGPN is such an example. See http://www.agpn.com.au/site/index.cfm?display=26317 (Accessed 23 May 2009)
90. Henderson J, Britt H & Miller G (2006) Extent and utilisation of computerisation in Australian general practice. Medical Journal of Australia 185 (2): 84-87
91. Callen, J., Bevis, M. & McIntosh, J. 2005, 'Patients' perceptions of GPs using computers during the patient-doctor consultation', Health Information Management, vol. 34, no. 1, pp. 8-12

information is recorded by the practitioner without patient input into what is documented.

Clinical software programs such as Medical Director and Best Practice can provide considerable efficiencies in a practice. There are an increasing proportion of general practices in Australia using computers rather than paper to record at least some aspects of patient consultations. A large 2006 Australian survey study[92] found that 90% of practices used a clinical software package. GPs used clinical packages for prescribing (98%), checking for drug–drug interactions (88%), recording a reason for prescribing (65%), to order laboratory tests (85%), run recall systems (78%), and record progress notes (64%). Less frequently used functions included generating lists of patients needing vaccines (43%) and taking the same medication (39%). In this study less than 20% of GPs who used a clinical package accessed computerised information during the consultation. A large number of GPs still have paper based patient records or hybrid models of patient electronic and paper records.

While different clinical software programs feature various tools to support GPs, commonly used programs contain or have the capacity to offer templates for medical, welfare and WorkCover certificates, referral letters and forms to assist in chronic disease management such as the GP Management Plan and the Team Care Arrangement. Other useful tools built into the software systems include those that support clinical assessment, receipt and storage of pathology results, and patient and practice information resources. Prompts, warnings, and links to additional information to assist the GP decision-making process and streamline work practices are also available if the system is set-up appropriately and the practitioner takes notice of them. There is a growing impetus for practices to set up electronic patient registers to support patient recall and to help track clinical outcomes and assess practice performance against agreed clinical management guidelines.[93] It has been argued by some GPs that these programs can compromise the doctor-patient relationship to implement what is best for the individual patient.

e-Health funding

The aim of the Practice Incentive Program (PIP) eHealth funding incentive[57] is to ensure general practice is equipped, as technology continues to develop, to securely exchange information with other providers such as discharge summaries, pathology and specialist reports, send electronic referrals and pathology orders and prescribing electronically (clinical information that allows the identification of patients should not be sent without secure encryption). Patient information sent and received electronically will be able to be added directly into a patient's electronic health record when systems are set-up appropriately.

This incentive encourages practices to keep up-to-date with the latest developments in eHealth. To be eligible for the PIP eHealth Incentive, practices must:

- either be accredited, or working towards accreditation for the Royal Australian College of GPs' Standards for General Practices

- have a secure messaging capability, which is provided by an eligible supplier

- have (or have applied for) a location/site Public Key Infrastructure (PKI) certificate for the practice and each practice branch, and make sure that each practitioner from the practice has (or has applied for) an individual PKI certificate

- provide practitioners from the practice with access to a range of key electronic clinical resources.

Most practices view the incentive payment as a partial reimbursement of the costs associated with maintaining a computer system.

e-health support in general practice

Recognising that there is significant diversity in the available infrastructure, capacity and interest of general practices to support ehealth, the Australian Government funds Divisions of General Practice to foster the uptake and advancement of ehealth in general practices, and to collaborate with other stakeholders to facilitate the process and support the potential benefits to general practice of ehealth. Even though the funding is small and largely piecemeal, Divisions place great effort to support general practices to:

- Effectively use computer technology in the management of the practice and encourage uptake of ehealth incentive funding

92. McInnes, K, Saltman, D and Kidd, M (2006) GPs'' use of computers for prescribing and electronic health records: results from a national survey, in MJA 185(2) 88-91
93. Managing chronic disease: what makes a general practice effective? Centre for Primary Health Care and Equity, UNSW 2006 www. health.vic.gov.au/pcps/downloads/careplanning/practice_capacity_research.pdf

- Establish and maintain electronic databases containing information to inform and improve patient care

- Support the set-up of secure electronic data exchange and other relevant information effectively and efficiently across the health care sector

- Use and have access to relevant best practice diagnostic and treatment information

- Support a clear and common understanding of ehealth, technology advancements and privacy and data protection laws and what they mean in practice.

Barriers to computer use in general practice[94,95,96]

Technical Difficulties/Computer Skills

- Lack of on-site computer skills - if staff aren't adequately trained some of the benefits of computers may be missed

- IT technical support professionals have limited expertise in clinical software

- Lack of access to suitable high speed Internet, software programs may not be compatible with each other or with updated versions held by others

- Inadequate system back-ups.

Time/workload/cost

- Computerisation is costly, whether measured in terms of capital expenditure, training, maintenance, length of consultation or organisational change.

- The cost of establishing computer systems means there is a temptation to buy lower cost systems which often operate slowly and are then expensive to repair.

- Time and cost involved in organising and up-grading systems and multi-user licenses

- The time it takes to enter data or resources on a computer can potentially result in longer consultations.

- Time, cost and accuracy issues in converting paper based resources

Reliability

- Lack of consensus in some practices resulting in individual GPs using different systems for recording health information e.g. some are all computer based, others are paper based, others use both computer and paper records

- System integrity and loss of data. Some practices keep back-up paper copies of patient records and protection against power surges but many don't have the capacity to do so.

- Some practices service patients in multiple locations and need to maintain two or more clinical records of the same patient.

Doctor-Patient relationship

- The perception that the doctor can easily 'disengage' the patient by disproportionate concentration on the computer and not the patient. While becoming less common, there is some concern that use of computers and electronic resources during the consultation will act as a barrier between the GP and their patient and impact negatively on their relationship. Studies suggest that around one quarter of patients feel that their doctor is distracted by the use of computers during the consultation.

Interoperability between health care providers

Across Australia a growing number of e-health patient information transfer and other projects are emerging in local regions in primary and acute care settings. They are largely small scale and use a variety of platforms. Many are delivering localised benefits such as electronic discharge information. Some are being established to support patient recall systems and reduce unplanned hospital admission. Without coordination, there is the real risk of duplication of effort and expenditure that has the potential to create a wide range of e-health solutions that are not interoperable or scalable across the health system.

Patient referral to appropriate health care provider's as required helps continuity of quality care coordination by ensuring care is provided by the right person at the right time. According to a late 2009 The National E-Health

94. Western, M.C., Dwan, K.M., Western, J.S., Makkai, T. & Del Mar, C. 2003, 'Computerisation in Australian general practice', Australian Family Physician, vol. 32, no. 3

95. Schattner, P., Mathews, M. & Pinskier, N. 2008, 'Promoting e-communication: Lessons from a feasibility study', Australian Family Physician, vol. 37, no. 3, pp. 185-188

96. Starfield B (2008) The future of primary care: refocusing the system. New England Journal of Medicine 359(20):2087, 2091

Transition Authority (NEHTA) environmental scan[97], general practice is the dominant creator of patient referrals to other health care providers:

- General practice generates around 13 million referrals per year.

- The majority of these (approximately 12 million) go to specialists and allied health providers.

- GPs are also the dominant receivers of reports from referred-to clinicians, with approximately 7 million post referral reports received per annum.

- Referral activity involving hospitals is comparatively very small.

- The proportion of GP referrals that are computer generated from clinical systems is estimated to be up to 66% (compared to only around 10-20% for specialist referrals).

- Handwritten (or dictated and typed up by the practice's office staff) is estimated to be at least 33%.

- Electronically transmitted (e-referral) is estimated to be only between 1-2%.

Beyond the barriers to using e-technology in general practice, there are also barriers to electronic communication between health care systems in Australia, including:

- For many health care providers resource restraints and improving their internal computer systems is seen as a priority over developing the use of computers for communication with external systems. The NEHTA report[97] identified a range of challenges and barriers exist that would need to be addressed for e-referrals to be successfully implemented in Australia, primarily the low level of Information / Communication Technology use in specialist and allied health practices, given the significant volume of referrals involving these groups. A similar situation was found to exist for aged and community care where Information/Communication Technology investment has also been relatively low.

- While not being unique to referrals, the inconsistency in levels of information and communication technology progress across the health system presents a barrier to effective participation in e-health services, such

as e-referrals, that require advanced information/communication Technology capabilities at the end points, e.g. for a GP and an allied health provider, for effective interoperability.[97]

- For GPs who travel between practices, there is still the problem of transferring information between practices in a timely and confidential manner.[31]

- While information is increasingly transferred electronically via encrypted files or virtual private networks between members of an inter-professional team, and between hospital and community settings, currently electronic transfer of health information cannot often occur between healthcare providers and organisations due to poor interoperability.[97]

- There are no readily available up-to-date directories providing the electronic contact information of health care providers in Australia which means there is an immediate disconnect in the communication network.[98]

- Lack of a uniform or standard diagnostic terminology and no nationally agreed specifications for the content of electronic reports, care plans and referrals.[97]

- The poor quality and comprehensiveness of patient data (both demographic and clinical) that is present in some general practice systems increases the risk that incomplete data may enter the shared e-health environment.[99]

97. NEHTA. Referrals - Environmental Scan Overview. Final - November 2009. v1.0
98. General Practice NSW. General Practice Network – Health Service Providers Directory. http://www.gpnsw.com.au/programs/ehealth/service-directory
99. Brouwer HJ, Bindels PJE and Van Weert HC. Data quality improvement in general practice. Family Prac 2006 23:529–536.

ENABLERS AND CHALLENGES TO UNDERSTANDING AND WORKING WITH GENERAL PRACTICE

There is considerable diversity in IT infrastructure and organisational capacity in Australian general practice. General practice does not have access to the day-to-day support services and systems that are commonly available from the information technology departments of large organisations. Overall, general practice requires assistance across a range of ehealth and technology areas.[31] Offering support in these and other areas of need may influence general practice involvement in external programs and activities:

- Support with regards to hardware and software purchases and upgrades; assistance with everyday IT issues; high speed Internet access support; on-line and on-site knowledge and skills training; relevant software and program access, system security, and secure messaging and data backup capacity etc.[31]

- Integration of patient management guidelines into existing clinical software programs and representation of clinical knowledge in fast user friendly formats.

- Synthesis and provision of new research evidence on an ongoing basis in reliable, free and easy to use formats.

- Decision support tools that are available at the time and location of clinical decision making.[100]

Other potential considerations when working with general practice include:

- There is an indication that a number of general practices originally set up their IT infrastructure to gain eligibility for the ehealth PIP incentive but have since failed to use it or significantly underuse it. Practices may be more likely to be interested in participating in an IT or ehealth program or initiative if there are limited set up costs, so targeting practices with systems already in place may support greater involvement.[31]

- Practices are more likely to be interested in working with external groups if they design programs that align with the general practice environment. For example, external care providers and services can utilise existing or work with and/or fund Divisions of General Practice to develop relevant electronic referral templates that are compatible with and can be uploaded into existing clinical software.[102]

- Reliable electronic directories of health and welfare services that may be suitable and affordable for patients with chronic conditions are becoming increasingly important to general practice.[31]

- It is important to remember that while electronic systems can assist in prompting GPs about disease prevention and screening, and improve chronic disease management by generating recall letters for patients who need regular review, they require manual set-up for each patient based on individual health care needs.[103]

- System set-up and review against patient's ongoing health care needs are time consuming activities that may not be acted on if time or the patients request for care at a particular consultation does not permit a focus on it.[101]

- A level of desensitisation to electronic alerts that are of little immediate clinical significance or inappropriate for a particular patient has been reported by GPs.[31]

- Always seek Division advice when considering initiatives that rely on patient electronic record and/or clinical system changes in general practice.

100. Trivedi MH, Kern JK, Marcee A, Grannemann B, Kleiber B, Bettinger T, et al. Development and implementation of computerized clinical guidelines: barriers and solutions. Methods Inf Med 2002;41:435-42.

101. Kensaku Kawamoto, Caitlin A Houlihan, E Andrew Balas, David F Lobach. Information in practice. Improving clinical practice using clinical decision support systems: a systematic review of trials to identify features critical to success. BMJ, doi:10.1136/bmj.38398.500764.8F (March 2005)

102. Bolger-Harris, H., Schattner, P. and Saunders, M. 2008, 'Using computer based templates for chronic disease management', Australian Family Physician, vol. 37, no. 4, pp. 285-288

103. Bennett JW, Glasziou PP. Computerised reminders and feedback in medication management: a systematic review of randomised controlled trials. Med J Aust 2003;178:217-22.

Further information

- Australian Government Department of Health and Ageing 2009, eHealth incentives: Guidelines, viewed 3 May 2010. http://www.gpnsw.com.au/__data/assets/pdf_file/0010/622/EH_Guidelines.pdf

- RACGP. General Practice ehealth http://www.racgp.org.au/policy/eHealth_Policy.pdf

- Australian General Practice Network (AGPN) - AGPN eHealth. http://www.agpn.com.au/programs/ehealth-and-information-management/agpn-ehealth-conference-2010

- General practice and e-health reform. MJA July 2010 http://www.mja.com.au/public/issues/193_02_190710/van10637_fm.html

- Chen, Y., Brennan, N. & Magrabi, F. 2010, 'Is email an effective method for hospital discharge communication? A randomised controlled trial to examine delivery of computer-generated discharge summaries by email, fax, post and patient hand delivery', International Journal of Medical Informatics

- The Commonwealth Fund 2009, Doctors vs. doctors with IT support- Who's better? http://www.commonwealthfund.org/Content?Newsletters/Purchasing-High-Performance/2009/June-18-2009/Feature-Articles/Doctors-vs-Doctors-with-IT-Support-Whos-Better.aspx

General Practice Accreditation

Introduction

Externally evaluated standards are designed to increase public accountability of organisations. Institutional health care standards cover such areas as structures (e.g. building codes and staffing resources) and process such as safety and care delivery (e.g. whether or not patients receive safe indicated care).[104] Standards are generally responsive to changes in the evidence base. Accreditation is an accepted and important element in quality improvement activities in health care systems throughout Australia.[105] The activity of preparing and undergoing accreditation has been shown to promote change in health care organisations through detailed reflection on organisational practices.[106] There is a lack of evidence available for the effectiveness of accreditation with regard to patient outcomes.[105]

Prevalence

Accreditation in general practice is a voluntary process of organisational assessment. The Royal Australian College of GPs' (RACGP) sets the accreditation Standards for General Practices with the support of an open consultation process.[107] The standards are designed to ensure compliance with legal, safety and other requirements of general practice and provide a mechanism for feedback and quality improvement support. General practices in Australia who wish to become accredited must register with one of two independent, recognised agencies. The table below shows the estimated prevalence of accredited general practices in NSW. Accredited practices have the largest proportions of GPs and undertake the majority of patient consultations.

Process

The process of practice accreditation is lengthy and involves several steps which practices must complete. Accreditation information summarising the process steps is sent to practices 12 months prior to the expiry date of their current accreditation. Practices who are not currently accredited must register with one of the accreditation organisations and are given 12 months to complete the accreditation process which involves:

1. The practice undergoes a self-assessment process evaluating their practice against an agreed set of standards

2. Surveyors visit the practice to assess it against these same standards

3. The surveyor completes a report and submits it to one of the accreditation organisations

4. The Accreditation Review Committee considers the report and decides whether to grant accreditation to the practice

5. The practice is notified of the availability of their report

6. The practice receives ongoing support from staff at the accreditation organisation

7. Accreditation is valid for three years, after which time the process begins again.[68]

During the accreditation review, the practices' performance or capacity to perform is assessed against the RACGP

	NUMBER[108]	NSW PRACTICES %
Total General Practices in NSW	2782	100.00
Fully accredited practices	1528	54.92
Practices registered or accredited	1793	64.45
Practices registered for accreditation	265	9.53
Practices not registered and not accredited	989	35.55

104. Caroline A Brand, Joseph E Ibrahim, Peter A Cameron and Ian A Scott. Standards for health care: a necessary but unknown quantity. MJA 2008; 189 (5): 257-260

105. Martin Fletcher The Quality of Australian Health Care: Current Issues and Future Directions Occasional Papers: Health Financing Series. Volume 6. Commonwealth Department of Health and Aged Care. Commonwealth of Australia 2000

106. Greenfield D, et al. Health sector accreditation research: a systematic review. Int J Qual Health Care 2008; 20: 172-183.

107. The Royal Australian College of GPs National Expert Committee on Standards for General Practices 2010, RACGP standards for general practices.

108. Registered and Accredited Practice numbers were sourced from www.qip.com.au/DivisionStatistics.asp?aqds=NSW (AGPAL) and personal communication (GPA) and were accurate as of 22nd July 2010. The numbers of general practices in NSW were sourced from PHCRIS and were accurate as of 30th June 2008. http://www.phcris.org.au/products/asd/keycharacteristic/SBO_AGPN_Key_Characteristics.xls

standards.[109] The specific requirements of general practices as outlined in the standards are mostly focused on material resources, facilities, equipment, the range of services and the processes that are used in providing patient care. These areas are typically in the direct control of practice staff and therefore, able to be modified. The standards cover issues such as: patient services; the rights and needs of patients; safety, quality improvement and education; practice management; and physical factors. The requirements of the standards have implications for the set up and every day running of general practice.

Standards

The RACGP Standards for General Practices 4th Edition[109] has criteria that provide opportunities for partnerships with general practice. Some of these criteria are outlined below:

- Standard 1.3: Health promotion and prevention of disease - the practice provides health promotion and illness prevention services that are based on patient need and best available evidence.

- Standard 1.5: Continuity of care - the practice provides continuity of care for its patients.

- Standard 1.6: Coordination of care - the practice engages with a range of relevant health and community services to improve patient care.

- Standard 3.2: Education and training - the practice supports and encourages quality improvement and risk management through education and training.

All accredited practices will have a commitment to the ongoing training and education of their GPs. They are required to participate satisfactorily in the RACGP Quality Improvement and Continuing Professional Development Program or an equivalent program and complete CPR training every three years.

Enablers

Practices that achieve accreditation can be seen to have accomplished a status and point of difference from other non-accredited practices. Accreditation indicates to the community that the practice is of a high quality.[110] Other factors which make accreditation a desirable activity for general practice to undertake include:[31]

- Accreditation makes practices eligible to access

funding from Medicare Australia's Practice Incentive Program and from activities such as student teaching.

- Gives a sense of accountability to the media and the community.

- Improves the organisational quality of the practice which can facilitate the efficient delivery of services.

- Providing a safeguard against the vulnerabilities and failings of practice equipment, policies, procedures, external systems, patients, GPs and other practice staff.

- A reduction in the medico-legal insurance premiums of practices.

- Available support through Divisions of General Practice to achieve accreditation or re-accreditation.

Barriers

Despite the benefits of practice accreditation, there are also barriers to becoming accredited, including the following:

- Perhaps the most significant barriers to practice accreditation are the time and cost of the process.[111] With the ever increasing pressures on GP time, accreditation is becoming more and more difficult especially for small practices with fewer administrative staff. Although the cost of accreditation is based on the number of FTE GPs working at the practice, the per-patient costs of accreditation are much greater for small and rural practices in comparison to medium and large practices. The costs are also determined by the surveyor team preferred by the individual practice (for example, a single GP, two GPs, a practice manager or a practice nurse surveyor), the number of accreditation cycles that have been undertaken by the practice and whether the practice has chosen an electronic or paper based assessment. The costs of accreditation are both direct (such as changes that need to be made to practice process and equipment to meet accreditation standards) and indirect (through lost time). The financial cost of accreditation for general practices is an under-researched area but three studies[112,113,114] on accreditation of other health care facilities judged the costs to be high for individual organisations and questioned whether accreditation was an appropriate use of resources.

109. RACGP Standards for general practices: a template for quality care and risk management in contemporary Australian general practices http://www.racgp.org.au/standards
110. Quality and accreditation in health care services. A global review . World Health Organization. Geneva 2003
111. Buetow S, et al. Accreditation of general practices: challenges and lessons Qual Saf Health Care 2003;12:129–135

- The process and purpose of accreditation remains poorly understood by some GPs who are concerned with their professional autonomy being infringed by what some perceive as a largely bureaucratic process.[111]

- Although there is a widespread perception that practice accreditation results in improved patient care, there is little clear evidence that this is the case. A recent study of 19 public and private hospitals around Australia has found health service accreditation may reflect organisational culture but is not significantly correlated with quality of care as measured by clinical performance indicators. Others argue that tangible benefits such as the requirement for reliable sterilisation procedures, effective and safe vaccines through reliable vaccine storage and improved medical records are argument enough to necessitate accreditation in general practice.

Accredited practices are also shown to offer their patients an expanded range of health care services, e.g. arrangements for after-hours cover, and systems for the follow up and review of tests and results.[31]

- Some general practices are also excluded from accreditation. Practices providing specialist services such as skin cancer clinics are not recognised by the RACGP as providing a general practice service and are ineligible for accreditation although most of these clinics are staffed by GPs.[31]

- Practice accreditation rates tend to be lower in low SES areas where patients have less ability to meet the costs of a patient fee. For example, South West Sydney has the highest rates of bulk billing in Australia. In these practices there is little 'fat' in the general practice business system to deploy staff accreditation activities.[31]

ENABLERS AND CHALLENGES TO UNDERSTANDING AND WORKING WITH GENERAL PRACTICE

- RACGP standards provide a credible way to describe, acknowledge and assure the quality of general practices.

- With around 65% of NSW practices either accredited or working towards accreditation, focusing on the requirements outlined in the RACGP Standards provides opportunities for working with general practice across areas such as health promotion, evidence based practice, chronic disease management and training provision.

- While there are various opportunities for practices to satisfy accreditation requirements, ensuring a thorough understanding of the standards and identifying opportunities within them can potentially serve as levers to attract general practice involvement in specific programs and initiatives.

- Working with Divisions and deliberately designing programs and resources that leverage aspects of accreditation that practices find difficult, costly or time consuming may support uptake and collaboration.[31]

- General practice can be supported with training and workforce capacity development associated with accreditation requirements.

- The real potential for a collaborative approach to satisfying general practice accreditation requirements is yet to be realised including the design and implementation of quality processes outside the practice.[31]

- There is a need for the costs associated with practice accreditation to be sufficiently acknowledged and managed through mechanisms such as grants for practices to meet the administrative and equipment costs of compliance and free training and support for practice staff.[111]

112. Grenade L, Boldy D. The accreditation experience: views of residential aged care providers. Geriaction (2002) 20:5–9.

113. Fairbrother G, et al.. EQuIP accreditation: feedback from a Sydney teaching hospital. Aust Health Rev (2000) 23:153–62.

114. Rockwell D, et al. The cost of accreditation: one hospital's experience. Hosp Community Psychiatry (1993) 44:151–5

115. Jeffrey Braithwaite, et al. Health service accreditation as a predictor of clinical and organisational performance: a blinded, random, stratified study. Qual Saf Health Care 2010;19:14-21

116. Dr Andrew, Cremorne. Accreditation does not improve care. www.6minutes.com.au

117. Wilkinson, D., Dick, B.M. & Askew, D.A. 2005, 'GPs with special interests: Risk of a good thing becoming bad?', Medical Journal of Australia, vol. 183, no. 2, pp. 84-86

118. Greg Ford From A Fairer Medicare to Medicare Plus: What are the Implications for the Future of Bulk-billing and Medicare? http://www.healthissuescentre.org.au/documents/items/2008/04/206393-upload-00001.pdf

Further information

- GPA Accreditation Plus http://www.gpa.net.au/

- Australian General Practice Accreditation Limited (AGPAL) http://www.qip.com.au/

- Accreditation for the Divisions of General Practice Network. National Quality and Performance System. The Australian General Practice Network http://www.agpn.com.au/programs/accreditation-for-the-divisions-of-general-practice

- Primary Health Care Research and Information Service 2009, SBO key division of general practice statistics 2007-2008

- Heywood, L.H. 'Principles-based accreditation: The way forward?', Medical Journal of Australia 2007,vol. 186, no. 7, pp. S31-S32

General Practice as an Information Target

Introduction

GPs and practice staff have a diverse range of information needs. Information is required regularly on a range of areas including[119] (but not limited to):

- New developments in family medicine
- Routine patient care
- Drug alerts
- Government policy and regulations relating to health care
- Practice organisation and management
- Communicable disease-specific information
- Professional development
- New medical equipment

Throughout the past three decades health information has expanded at extraordinary rates and general practice is far from being starved of this information. One medical author describes the situation as:

"There is too much, often conflicting, information that is not easily digestible, insufficiently evidence-based, and not delivered in a timely, effective or coordinated manner"[120]

General practice often becomes inundated with information from a large number of different sources. Some of the material lacks specificity and is largely irrelevant to primary care.[31] Advances in information dissemination such as push technologies (information sent electronically to recipients without it being requested) have increased the amount of information received by general practice.[31]

The common assumption that simply developing and making information available to general practice will lead to understanding, uptake and application is naive. Findings in the academic literature on information access and use in general practice includes:[121,122,123,124]

- Around 90% of Australian GPs have access to a computer in their major practice address and over 60% of GPs report accessing Internet-based clinical information in their work environment and consider the Internet an important information source

- Incorporating links into medical software, desktop reminders and/or email reminders have been shown to increase information uptake.

- The provision of uninvited information has not been shown to be effective in changing physician behaviour.

- Large reviews have found the most common responses in studies investigating barriers to GPs accessing online information resources are a lack of time to search for information and limited search skills.[125,126,127]

- Other barriers to accessing and using information of any kind include lack of awareness of available information resources or forgetting about their availability, reimbursement concerns, lack of relevancy and transferability of research to clinical practice, distrust of available information, and disruption of established work-flow patterns.[128,129]

- These reviews also found that text books and asking a colleague were important information sources for GPs.[119,126]

- Research evidence summarised into practical and accessible formats has been shown to increase understanding and practical uptake.[130]

119. Gonzalez-Gonzalez, A. I., Dawes, M., Sanchez-Mateos, J., et al. (2007). Information Needs and Information-Seeking Behavior of Primary Care Physicians. Ann Fam Med 5: 345-352

120. Davis D, et al. Solving the information overload problem. MJA 2004; 180: S68–S71

121. Davis D, O'Brien MA, et al. Impact of formal continuing medical education: do conferences, workshops, rounds, and other traditional continuing education activities change physician behavior or health care outcomes? JAMA1999; 282: 867-874.

122. Davis DA, Thomson MA, Oxman AD, Haynes RB. Changing physician performance. A systematic review of the effect of continuing medical education strategies. JAMA 1995; 274: 700-705.

123. Oxman AD, Thomson MA, Davis DA, Haynes RB. No magic bullets: a systematic review of 102 trials of interventions to improve professional practice. CMAJ 1995; 153: 1423-1431.

124. Henderson J, Britt H & Miller G (2006) Extent and utilisation of computerisation in Australian general practice. Medical Journal of Australia 185 (2): 84-87

125. Davies K. The information-seeking behaviour of doctors: a review of the evidence. Health Info Libr J. 2007 Jun;24(2):78-94.

126. Nancy L Bennett, Linda L Casebeer, Robert Kristofco and Blanche C Collins. Family physicians' information seeking behaviors: A survey comparison with other specialties BMC Medical Informatics and Decision Making 2005, 5:9

127. Bennett NL, Casebeer LL, Kristofco RE, Strasser SM: Physicians' Internet Information-Seeking Behaviors. Journal of Continuing Education in the Health Professions 2004, 24(1):31-38.

128. Druss B, Marcus S. Growth and decentralization of the medical literature: Implications for evidence-based medicine. Journal of the Medical Library Association. 2005;93(4):499-501.

Professional information support for Australian general practice

There is a broad range of information producers that support general practice and a variety of resource types from journal articles to government reports to newsletters.

Information sources currently referred to frequently by general practice include systems such as Medical Director, on-line and print text books, clinical literature search engines such as PubMed, locally produced journals such as Australian Doctor, Australian Family Physician, Medical Observer and Australian Prescriber; electronic and/or print newsletters from GP, Nursing and Practice Manager professional bodies and medical education experts such as ThinkGP, and organisations such as Divisions of General Practice, and the daily on-line update from 6minutes. Any new information channel would need to show a high likelihood of providing direct and immediate benefits to solving general practice patient care problems if it wanted to attract widespread uptake.[131,132,133]

Other important information sources for general practice staff include professional education and targeted forums and conferences that bring staff up-to-date on relevant issues.

ENABLERS AND CHALLENGES TO UNDERSTANDING AND WORKING WITH GENERAL PRACTICE

- Seek an understanding of the competing demands on general practice and where new information might 'fit' in terms of priorities and realistic expectations of uptake/use.[31]

- When disseminating information to general practice, to ensure adequate reach and exposure, always use familiar, commonly used communication channels (such as those named above).[31]

- Information is more likely to be perceived as relevant to general practice if it is seen as responding to its particular circumstances, is matched to its business environment, offers needed support to understand and/ or contribute to better patient care or practice management and includes a website that can be accessed for further information.[134]

- Substantial information does not need to be provided up front. Relevant information will take into account questions that are important to practices including: Is the issue common to my practice, and is the intervention feasible in this setting? Does the information focus on an outcome that my patients care about? To ensure this is the case, include a GP in the main editorial team.

- A dedicated training program in a speciality area may assist the use of information in practice.[133]

- Developing information resources for general practice should involve advisors from that group in all phases of the project - from needs analysis to planning through to evaluation.[31]

- Prior to developing a new information resource for general practice determine the actual need for the resource. A similar resource may exist that satisfies the perceived or expressed need for the information.[31]

- Many Divisions and other groups transmit health information via educational activities and see this as an important strategy in increasing understanding and changing general practice staff behaviour around new guidelines or health priorities and issues. Liaise with the Divisions and/or their support organisations to gain information on current program areas to identify opportunities for linking with or enhancing existing activity.

129. Brian S. Alper (2006) Usefulness of Online Medical Information Am Fam Physician 2006 Aug 1; 74(3): 482-485.

130. Alper BS, White DS, Ge B. Physicians answer more clinical questions and change clinical decisions more often with synthesized evidence: a randomized trial in primary care. Ann Fam Med. 2005;3:507–13.

131. Leggat PA, Seelan ST. Resources utilized by GPs for advising travelers from Australia. J Travel Med. 2003 Jan-Feb;10(1):15-8

132. Anne Magarey. Information scanning for GPs. Australian Family Physician Vol. 36, No. 1/2, January/February 2007

133. 4. Haug JD. Physicians' preferences for information sources: a meta-analytic study. Bull Med Libr Assoc 1997;85(3):223–32.

134. Dawes M, Sampson U. Knowledge management in clinical practice: a systematic review of information seeking behavior in physicians. Int J Med Inform. 2003;71(1):9-15.

Further information

- Alper BS, Hand JA, Elliott SG, et al. How much effort is needed to keep up with the literature relevant for primary care? J Med Libr Assoc. 2004 Oct;92(4):429-37.

- Padma Moorjani and Heather Fortnum. Dissemination of information to GPs: a questionnaire survey BMC Family Practice 2004, 5:27

- Matthew W. Kreuter et al. Tailored and Targeted Health Communication: Strategies for Enhancing Information Relevance. Am J Health Behav. 2003;27(Suppl 3):S227-S232

Responsible Partnering

Introduction

The extent to which different healthcare professionals and groups work competently together can affect the quality of the health care that they provide. It has been found that partnering in health care can have a significant beneficial influence on relationships and project outcomes.[136] The evidence suggests that partnerships are more likely to be sustained if they have a clear mission with realistic expectations, are patient centred, provide regular communication, share responsibility for decision making, have rules for management and good leadership, and acknowledge the successes of all involved.[137,138] Published examples of partnering failure are rare and it cannot be assumed that partnering success is guaranteed. The balance of benefits and costs of partnering depends on individual circumstances and also on the attitude and culture of potential partners.

General practice leadership

Successful partnering with general practice requires leadership and commitment. Simply bringing professionals together does not routinely lead to collaboration. Leadership that drives clear objectives of the collaboration and outlining roles and responsibilities is required. This leadership can be drawn from those wanting to work with general practice, GPs themselves, other stakeholders or a body that can be formed with representatives from each of these groups. Divisions of General Practice (Divisions) are important leaders within the general practice environment. Divisions know the characteristics and priorities of the practices in their area and are experienced in visiting practices, providing them with education, training and other support and have expertise in working with general practice. Divisions most often constitute the best single organisational link through which collaboration can be initiated. Practices and GPs would become overwhelmed with correspondence and requests if every group wanting to work with them approached them directly. Divisions supporting the adaptation of programs to individual practices' needs and priorities rather than imposing a 'one size fits all' approach allows practices to better support collaborative programs. For these reasons, the involvement

and leadership of Divisions is vital when wanting to partner with general practices and effective partnerships must be developed with them. This can be done by indicating how the initiative is relevant to the needs of their member practices, recognising them as program partners and providing the necessary resourcing required to dedicate staff and other support to the initiative.

Establishing partnerships with general practice

Partnerships with general practice are generally established on a voluntary basis and they do not just happen, they are built. The difference in structure, role and funding of private general practice, hospitals and public allied health services can make partnering difficult. The effectiveness of these relationships is often determined by local factors such as the work of local Divisions of General Practice, the relationships between key individuals involved and the capacity of each organisation. The success of a partnership with general practice depends to a great degree on the strength of the project around which it is organised. A new partnership may require starting with a small, more manageable project while keeping the goal of addressing larger and more substantive issues in the long term.

Recent shifts in Australian health policy have sought to move towards more multi-disciplinary team based care to address chronic disease with general practice increasingly required to coordinate and organise acute and chronic care services.[139] Multidisciplinary meetings with an external facilitator, who uses strategies to encourage collaborative working, is associated with reported improvements to care.[135] The closer the culture of two groups and the greater the understanding between them the easier it is likely to be for them to communicate, build relationships and work collaboratively. Collaboration between general practice and other health care providers gives each a better understanding of the services of the other. Studies have shown that when a general practice has a good understanding of those they may work with, they are more likely to engage with them.[140]

136. Zwarenstein M, Goldman J, Reeves S. Interprofessional collaboration: effects of practice-based interventions on professional practice and healthcare outcomes. Cochrane Database of Systematic Reviews 2009, Issue 3.

137. Australian Institute for Primary Care: Evaluation of the Primary Care Partnership Strategy, La Trobe University; 2002.

138. Weech-Maldonado R, Benson KJ, Gamm LD: Evaluating the effectiveness of community health partnerships: a stakeholder accountability approach. J Health Hum Serv Adm 2003, 26(1):58-92.

139. Kent Buse, K & Harmer, A. M (2007) Seven habits of highly effective global public–private health partnerships: Practice and potential, Social Science & Medicine 64, pp. 259–271

140. Chronic Disease Management (CDM) Medicare Items.
http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare-chronicdiseasemanagement

Those wanting to work with general practice need an understanding of the environment in which they operate in if their efforts are to be effective. GPs face numerous demands such as high practice workload and the requirement to discuss, detect and treat a patients' illness in short consultation times. These factors force GPs to focus on the core business of the practice and may make them reluctant to participate in any additional activities. The fee for service payment structure in general practice makes it difficult for practices to participate in much of the "behind the scenes" work that is required to communicate and engage in partnerships and take the time to understand its value and expectations. More detail about the general practice environment can be found in other sections of this guide. General practice is routinely asked by a range of different groups and organisations to partner for a variety of purposes. It is often useful to investigate current successful partnerships and examine their processes and structures. Examples provided in this guide are not inclusive.

The same principles and skills it takes to develop working relationships with patients, carers and staff apply to establishing effective partnerships with general practice. Most organisations and groups already have these necessary skills and are using them as part of core business which places them in an ideal position to initiate partnerships with general practice. Depending on the type of partnership needed, the following may be important in building effective partnerships with general practice: [31]

Understanding

- Learn general practice limitations e.g. what it can and cannot do, what data and information it may be willing and able to share, and under what circumstances.

- Communicate an understanding of how, by working with general practice, partners will be better able to implement strategies that are most likely to work in the community. Give meaning to the proposed activity in terms of patient need, wellbeing and ultimate health outcomes.

- Ensure the partnership genuinely makes good sense to all involved. All partners need to recognise and accept the need for the partnership.

- Check there is commitment for achieving the overall purpose of the partnership, including departing from 'business as usual' if required.

- Acknowledge the existence of separate organisational aims and objectives and their connection to jointly agreed aims and objectives.

- Identify, and if necessary, communicate and address the impacts the partnership may have on each organisation's internal operations and organisational culture, and each organisations clients/staff.

- Allow for an adequate time period to build understanding and trust.

- General practice needs to be given adequate training when new programs or initiatives are introduced.

Communication

- Approach potential general practice partners in an open and transparent way.

- Be familiar with the practices in the region before communicating with them e.g., work with the local Division to understand their current capacity and limitations.

- Liaise with the Division about the most appropriate method of communicating with the practices.

- Make all correspondence relevant and where ever possible keep communication short, concise and clearly defined.

- Use common terminology and prepare before all communication with practice staff.

- Where relevant create a mechanism for ongoing, honest and open communication that evolves with the relationship and development of systems of work.

- Work with the Division to organise meetings at times suitable for the GP e.g., lunchtime, early evening and other times that suit the practice and meet at the general practice location wherever possible.

- Where links with external organisations are required, identify a person within each practice who is willing to assume responsibility for this.

Practicalities

- Preliminary questions to consider include the breadth of what the partnership may accomplish and the scope of the partnership activities.

- Determine who in general practice needs to be involved e.g., GPs may be better placed than others to be involved in clinical interventions and/or research. Allow for remuneration to cover time out of the practice for participating practice staff.

- Determine agreed strategies, action plans and responsibilities.

- Decide other practicalities for the partnership such as how long the collaboration will exist, decision making processes, meeting frequency, membership rules, and participation between meetings by subcommittees or planning groups.

- Ensure there is equal participation in decision-making. Ideally genuine concern for each other's success and support for each other to reach agreed goals would exist.

- Establish a commitment and mechanism to quickly identify and resolve differences and issues as they arise.

- Balance requirements and flexibility within the structure and operation of the partnership. Develop a stable foundation for the activities of the partnership while allowing sufficient flexibility for these components to develop and evolve in response to external and internal demands.

- Identify any doubts in partners of how successful the project is likely to be. A major fear of general practice is the potential for negative patient reaction. This should be suitably addressed early.

- Provide opportunities for capacity building within general practice (training/skills development, staff and other support) to allow for successful adoption of strategies and a true sharing of resources.

- Set up continuous evaluation to assist and improve future collaborations.

ENABLERS AND CHALLENGES TO UNDERSTANDING AND WORKING WITH GENERAL PRACTICE

- Put time into gaining essential knowledge about general practice, what it does, how it works, its context, its funding arrangements, the challenges it faces and its goals.

- Express commitments early through practical support for the partnership in terms of resources, staff and/or other support.

- Medicare and other incentive payments are generally not enough to ensure effective collaboration with general practice. More pro-active facilitation, in-kind support and resourcing of partnerships are often required.

- The burden of paper work is already significant in general practice; perceived additional administration may prevent commitment to a proposed partnership. Design initiatives that minimise the time burden and paper work requirement of practice staff and GP.

- Recruit or finance the recruitment of a staff member in the local Division to be specifically responsible for relationship management and program support. This helps to coordinate communication between the partners and ensure effective implementation of ground rules and protocols for working together. It also ensures that relationship management is given focused time and attention to gauge and track the health of the partnership over time. Individual practice support for interventions is important as involvement will be easy for some practice but hard for those with limited resources and teamwork structures.

Examples of effective partnering with general practice

Collaborative Aboriginal and Torres Strait Islander health program

What did the partnership involve?

The Mid North Coast Division of General Practice in NSW has had a long history of involvement and contribution to the development of Aboriginal and Torres Strait Islander health. The key to the success of the initiatives has been the development of a close working relationship and collaborative programs with local Aboriginal Community Controlled Health organisations along the Mid North Coast of NSW. The Division is a formal partner of the Galambila Aboriginal Health Partnership, a cooperative framework established by local interested stakeholders responsible for the establishment of the Galambila Aboriginal Health Clinic at Coffs Harbor. Each partner made a commitment to the development of the clinic: the Mid North Coast Area Health Service provided accommodation for the clinic, transport for improved access and Aboriginal Health Staff. The Division coordinated the employment of local GPs with an interest and understanding of Aboriginal Health issues. NSW Health and the Office of Aboriginal and Torres Strait Islander Health (OATSIH) provided seed funding for the clinic. Durri Aboriginal Medical Service provided administrative support and acted as the auspicing body for the clinic. Yarrawarra Aboriginal Corporation provided program participants to assist with clinic operations such as transport and administrative support. Community representatives provided direction in the clinic development.

What are the results?

Strong association with the Division resulted in support for the provision of clinic doctors and development of a range of collaborative Aboriginal Health projects across the Division aimed at strengthening service capacity and improving outcomes for the Aboriginal Community, including supporting Galambila with:

- Governance assistance and management and administrative services support

- GP Services

- Post-natal depression services

- Psychologist and psychiatrist services

- Accreditation support

- Executive recruitment and strategic planning facilitation

- Engagement of Galambila staff in division program advisory groups

The impact of the collaborative partnership has seen growth of the Galambila Aboriginal Health clinic from operating three half days per week and averaging about 250 patients per month to now operating on a full time basis, average patient throughput over 650 presentations per month. The clinic now provides aboriginal people access to a wider range of multidisciplinary general practice, specialist and allied health services. It also assists clients with referral to other specialist and allied health services and provides patient transport to the clinic and specialist services.

Mid North Coast Division of General Practice http://www.mncdgp.org.au/program/aboriginal_health

Collaborative Medication Management Services: Improving Patient Care

What did the partnership involve?

Commonly experienced medication-related problems can be identified and resolved by closer collaboration between GPs and pharmacists. A divisional liaison officer was employed to assist implementation of the project within six participating Divisions of General Practice. The liaison officers recruited GPs and pharmacists within the Division to participate and facilitate the interaction between them. GPs were recruited through Division newsletters and meetings with the divisional liaison officers, while a mailout was used to recruit pharmacists. Participating GPs who were able to recruit at least 10 of their patients to participate in the project were eligible for RACGP clinical audit points.

As part of the project, collaboration between the patients' GP and community pharmacist took the form of a case conference where the patients' medical condition and prescribed medications could be discussed. Home visits with each patient were then undertaken by the pharmacist to educate the patient about the medications they are taking, dosing and other issues relevant to each patient. A report on this visit was then discussed by the GP and pharmacist and a suitable medication plan for the patient developed.

What are the results?

The study showed that a collaborative medication management service could be successfully implemented through Divisions of General Practice and was acceptable to all participants. Problems relating to medication use were common among the patient participants in this study but as a result of the project, 81% of problems were resolved, well managed or improving at follow-up. Patients

had positive views of health providers collaborating to provide their care. Liaison Officers were found to be integral to the program's success.

Gilbert, A.L., Roughead, E.E., Beilby, J., Mott, K. & Barratt, J.D. 2002, 'Collaborative medication management services: Improving patient care', Medical Journal of Australia, vol. 177, pp. 189-192 http://www.mja.com.au/public/issues/177_04_190802/gil10660_fm.html

Ryde Hospital Admission Alert Fax for GPs

What did the partnership involve?

The Admission Alert Fax is a project targeting patients admitted to Ryde Hospital through their Emergency Department (ED) where an Admission Alert Fax is sent to each patient's nominated GP, with patient consent, detailing the date of admission, the patient admission ward, and the admitting medical officer's name and medical staff pager numbers. The fax also requests relevant clinical information and/or care plans from the patient's GP. The project supports better communication about medical history, current medications, adverse reactions, and test results and other relevant health and social information early on in the patient journey and aids communication between the hospital and general practice to improve the patient's transition from hospital to home. Project implementation is assisted through the Northside GP Collaboration Unit, a joint initiative between the Division and Northern Sydney Central Coast Area Health Service.

The impetus for this project was the result of two local GP surveys which found that GPs were not being informed when their patients were admitted to, or had died in hospital; that avoidable adverse reactions were occurring due to lack of consultation with GPs about medication changes; and that there was inefficient and delayed treatment due to duplication of recently performed tests.

What are the results?

Feedback to the hospital from general practices included confirmation that the patient was known to the practice, provision of team care arrangements, health summaries and specialist letters. The next phase is the transition to standard practice/hospital policy and determining responsibility for troubleshooting beyond project funding.

GP Network Northside www.gpnn.org.au

Examples of ineffective partnering with general practice

Fragmented patient care

General practice is the primary provider of continuous care for patients. Knowledge of the whole person and health problems along the lifespan are important in planning and managing a patient's care. Continuous or long term informed care is associated with a number of benefits including compliance with treatments, reduced number and duration of hospital admissions, reduced duplication of tests and improved patient satisfaction. Care continuity is most important for patients with a chronic or serious illness.

Disruptions to continuous care can occur when health care is delivered by other providers who fail to communicate their findings and/or details of care provided back to the general practice. Patients, especially those with chronic illnesses are increasingly seen by an array of care providers in a wide variety of organisations, raising concerns about fragmentation of care. High quality continuity of care requires that the care provided by others be comprehensively documented and coordinated with the patient's GP.

Hospitals have become focused on providing acute care to high need patients with little input from general practice. Early patient hospital discharge that has shifted complex acute care to general practice means communication between the hospital and general practice is more important than ever. In some places hospitals have become networked, creating a more complex set of organisations for GPs to navigate.

General practice attempts at accessing timely and relevant patient information on an ongoing basis from hospitals have generally failed. The provision of discharge summaries by hospitals is unreliable in terms of frequency, quality and timeliness. There is also an absence of detailed information, such as discharge care plans, for example, accompanying discharge summaries. Other common problems occur as a result of information about patients not being shared even within a referral service; legibility or inadequate updates on the status of patient referrals by GPs to other care providers including hospitals. The absence of this information means the capacity of general practice to provide high quality continuous care for the

141. de Jong JD, Groenewegen PP, Westert GP. Mutual influences of GPs in partnerships. Soc Sci Med. 2003 Oct;57(8):1515-24.
142. Haggerty, J, et al Continuity of care: a multidisciplinary review BMJ 2003; 327 :1219
143. Becker MH, Drachman RH, Kirscht JP. A field experiment to evaluate various outcomes of continuity of physician care. Am J Public Health 1974;64:1062?70.

patient is greatly diminished. In some instances this has led to poor patient outcomes.

Reverse referral

Cost prohibits access to allied health for many Australians. The Medicare item 723 - Co-Ordinating the Development of Team Care Arrangements - is for patients with a chronic or terminal medical condition who require ongoing care from a multidisciplinary team consisting of their GP and at least two other health or care providers. According to Medicare conditions to claim Item 723, a chronic medical condition is "…one that has been or is likely to be present for at least six months, including but not limited to asthma, cancer, cardiovascular disease, diabetes mellitus, musculoskeletal conditions and stroke. The services under this item are generally provided at lower or no cost to the patient.

To develop team care arrangements for a patient, at least two health or care providers who will be providing ongoing treatment or services to the patient must collaborate with the GP. Each of the health or care providers must provide a different kind of ongoing care to the patient. Even if patients do have an obvious chronic illness, such as diabetes, it doesn't necessarily mean that the patient is eligible for or requires allied health treatment through this Medicare item which has created unnecessary problems for general practice. Some health care providers encourage their patients to go to their GP for a care plan so the health provider can receive Medicare rebates and not have to charge the patient. If the patient does not have a legitimate chronic condition or complex healthcare needs, signing a care plan could lead to the Medicare Professional Services Review fining the GP and/or the GP receiving disciplinary action from their Medical Board. GPs have raised concern about inappropriate reverse referral of patients from medical specialists, dentists, psychologists, speech pathologists, osteopaths and other Allied health disciplines.

In some cases when told they do not qualify for a care plan, patients get angry or upset with the GP who must act according to the conditions of the Medicare Benefits schedule item. To ensure a productive and positive relationship with general practice, other health care providers should communicate directly with the GP and develop a detailed understanding of the eligibility criteria for relevant Medicare items and the consequences for the GP of inappropriate referral. If in doubt health care providers should contact Medicare.

Excerpt: Reverse referral crackdown

Medicare and the Professional Services Review (PSR) are concerned about the increasing problem of so-called 'reverse referrals', where patients and allied health professionals pressure GPs for care plans in order to claim a Medicare benefit. PSR director Dr Tony Webber says there are no figures on the percentage of inappropriate care plans – for access to treatment such as psychological or dental care – but he says the practice is probably "reasonably widespread".

In the latest PSR annual report 2008-09, Dr Webber says patients and allied health professionals, including dentists, have increasingly been putting pressure on GPs to provide a team care arrangement (item 723). "In many of the cases PSR examined, the patient's condition did not warrant use of this item," he says.

"Some allied health practitioners have told patients to see their doctor to 'get the paper work done'. "This puts GPs in a difficult situation. If the doctor accedes to a patient request for an unjustified team care arrangement, the doctor may be required to repay any benefit paid for that item."

RACGP vice-president Dr Morton Rawlin says it is quite appropriate for a physiotherapist to request him to prepare a care plan for a patient they have treated for some time for a chronic problem, but not for an allied health professional to simply tell his or her patient: "Go to your GP and you can get five free visits." He says for patients, there is always the temptation to pressure their GP if they can see an opportunity to "get something for free".

On the front line, GP Dr Kodikkakathu Saratchandran, from St Albans, Victoria, says it's not only allied health professionals who are prompting patients to seek care plans, but other patients who have taken advantage of the scheme who tell their friends to ask for the same access.

Leigh Parry.
Medical Observer, 23rd Apr 2010

http://www.medicalobserver.com.au/news/reverse-referral-crackdown

Conclusion

The public, private and non-profit sectors are increasingly turning to collaborative endeavours to meet the complexities of health care and service delivery. Productive partnerships can help reshape the health care environment to better meet the needs of patients. Finding and developing new ways of working and creating a new culture around attitudes and values will support practical progress.

Further information

- Valerie Wildridge, Sue Childs, Lynette Cawthra et al. How to create successful partnerships—a review of the literature. Health Information and Libraries Journal 2004 21, pp.3–19

- Elston, J. & Fulop, N. Perceptions of partnership: a documentary analysis of health improvement programmes. Public Health 2002, 116, 207–13.

- Glendinning, C. Breaking down barriers: integrating health and care services for older people in England. Health Policy 2003, 65, 139–51.

- Grone, O. & Garcia-Barbero, M. Integrated care: a Position Paper of the WHO European Office for Integrated Health Care. International Journal of Integrated Care June 2001.

Appendix 1

Stories of Innovation in Health Partnerships

NSW Divisions of General Practice are continuously developing and testing new and innovative ways of delivering illness prevention and health care in general practice that address the diverse social and health needs of their local community. The sharing of best practice approaches among general practice, health care providers, decision makers and local communities are integral to the process of developing more effective systems of delivering innovative, holistic and patient focused health care.

The Stories of Innovation in Health Partnerships provides an introduction to some of the many initiatives of NSW Divisions and provides an opportunity to share insights, ideas and effective practices. This resource will be useful for those wishing to invest in similar programs as it stimulates creativity, provides ideas for others to adopt change and illustrates how partnership projects have contributed to reducing the burden of illnesses within communities. The wide range of organisations, strategies and different stages of implementation represented in this resource demonstrate the diverse ways organisations can work together to make meaningful improvements in health care and service delivery in their local communities.

This resource can be found online at
http://www.gpnsw.com.au/divisions

STORIES OF
INNOVATION
IN HEALTH
PARTNERSHIPS

gp

General Practice Support Organisations

A diverse range of general practice support and representative organisations exist in Australia (some of which are described below). While not all of these organisations constantly agree on primary care policy and there is a degree of competition to be the principal voice of general practice, a number of important groups have recently joined together to form a unified voice. United General Practice Australia (UGPA) formed in 2008 and is the coalition of a number of the peak groups representing general practice in Australia. UGPA brings together the Royal Australian College of GPs, the Australian Medical Association, the Australian General Practice Network, General Practice Registrars Australia, the Australian College of Rural and Remote Medicine (ACRRM), and the Rural Doctors Association of Australia to establish a united voice for Australia's general practice on key issues. UGPA was formed to provide united leadership to buffer and act for general practice in a continually changing professional, political and social environment.

Many general practice organisations come together at state, national and regional forums and conferences yearly to be informed on emerging and available primary health care clinical and non-clinical interventions and relevant policies, and build and maintain essential networks. Regular forums are hosted by the RACGP, Australian General Practice Network, the Primary Health Care Research and Information Service and the Australian Practice Nurses Association to name a few.

Royal Australian College of GPs

http://www.racgp.org.au

The Royal Australian College of GPs (RACGP) NSW/ACT Faculty is the professional organisation for GPs, registrars and medical students in NSW that focuses on the safety and quality of general practice. Services provided by the RACGP include assessing doctors skills and knowledge, supplying ongoing professional development activities, developing resources and guidelines, helping GPs with issues that affect their practice and development standards that general practices use as part of the accreditation processes. The RACGP sets the standards for general practices. Over 24,000 GPs participate in the RACGPs Quality Assurance and Continuing Professional Development program, making it the largest medical professional development program in Australia. Each month, over 37,000 GPs and physicians read Australian Family Physician, the RACGP's peer reviewed journal. The RACGP's professional education and training website

gplearning, has over 300 activities covering a broad range of topics and issues.

Australian College of Rural and Remote Medicine

http://www.acrrm.org.au

The Australian College of Rural and Remote Medicine is responsible for setting professional standards for training, assessment, certification and continuing professional development. It also plays an important role in supporting medical students and junior doctors considering a career in rural practice.

Australian Medical Association (NSW)

http://www.amansw.com.au

The Australian Medical Association (NSW) is the state's peak independent medico-political lobbying body. The AMA (NSW) is dedicated to providing its members with representation on a variety of medical issues, professional services and commercial benefits. The AMA NSW plays a role in the formation of public health and hospital policy in NSW. Policy formulation is overseen by a 29 member Council consisting of doctors from across the state representing various specialties and geographic zones.

Australian Indigenous Doctors' Association

http://www.aida.org.au/

Australian Indigenous Doctors' Association (AIDA) is a not-for-profit, non-government organisation dedicated to the pursuit of leadership, partnership and scholarship in Aboriginal and Torres Strait Islander health, education and workforce. There are currently an estimated 140 Aboriginal and Torres Strait Islander doctors and 137 Aboriginal and Torres Strait Islander medical students in Australia. AIDA advocates for improvements in Indigenous health in Australia and encourages Aboriginal and Torres Strait Islander people to work in medicine by supporting Indigenous students and doctors.

Rural Doctors Association NSW

http://www.rdansw.com.au

The Rural Doctors Association (RDA NSW) is one of seven state members of the Rural Doctors Association of Australia. Membership of RDA (NSW) is open to all NSW's rural doctors. RDA NSW identifies, promotes and works with government to ensure appropriate implementation of solutions to the current rural workforce shortage. Activities range from those targeted towards high school students, through to GP retention grants including Anaesthetic and Obstetric Incentive Grants. The national body, the Rural

Doctors Association of Australia, utilises input from its member states to lobby very effectively at a federal level. It is a significant contributor to the many committees which oversee changes that impact on general practice

NSW Rural Doctors Network

http://www.nswrdn.com.au

The NSW Rural Doctors Network (RDN) is a not for profit membership organisation of about 700 Doctors and is designated by the Australian Government as the Rural Workforce Agency in New South Wales (NSW). RDN aims to provide the highest possible standard of health care to rural and remote communities through the provision of a competent and continuing medical workforce in rural and remote NSW. RDN receives annual funds from the Australian Department of Health and Ageing to develop and administer the Rural and Remote General Practice Program in NSW. This program aims to attract, recruit and retain GPs in rural and remote communities.

Australian Practice Nurses Association

http://www.apna.asn.au

The Australian Practice Nurses Association (APNA) is the peak professional membership organisation for practice nurses working in general practice. APNA provides numerous benefits to its members including: state based Practice Nurse Clinical Education conferences focusing on the latest professional and clinical issues affecting practice nurses; access to free or discounted courses online, regular e-News to keep up to date with the latest industry and clinical news and events happening in the profession nationally and locally; advocacy for nurses working in general practice; access to an online library of the latest research, clinical developments and professional resources, nation-wide phone and email support and advice about anything related to practice nursing.

Australian Association of Practice Managers

http://www.aapm.org.au

The Australian Association of Practice Managers (AAPM) is a non-profit, national association recognised as the professional body supporting effective Practice Management in the healthcare profession. The organisation represents and unites practice managers and the profession of Practice Management throughout the healthcare industry; promotes professional development and the code of ethics through leadership and education and provides specialised services and networks to support quality Practice Management. AAPM offers access to information or professional resources that assist Practice

Managers to improve the performance of a practice. AAPM offer advice and direction on staff issues, management principles, awards and conditions. Information is also available on equipment, equipment repair facilities, practice financing and a range of other topics.

Culturally and Linguistically Diverse Medical Group Representation

There are a number of medical associations that represent different culturally and linguistically diverse medical groups in Australia, these include, but are not limited to:

Australian Indian Medical Graduates Association

http://www.aimga.org.au/about.asp

The Australian Indian Medical Graduates Association is an association of doctors in Australia, which works to protect and enhance the professional interests of its members, and promotes harmonious relationship among its members, between its members and members of other medical associations in Australia and helps create a good citizenship among its members. Membership is open to all doctors, whether qualified in an overseas medical school or an Australian medical school.

Australian Chinese Medical Association (NSW)

http://www.acma.org.au/

The aims of the Australian Chinese Medical Association are to promote the professional standards for its members; provide a forum for professional and social exchange amongst members; promote and conduct continuing medical education and research; respond to community issues affecting its members; acquire knowledge and respond to health issues affecting the Australian Chinese community; contribute to deserving charitable causes and organisations and promote mutual understanding and liaison with other medical organisations

Vietnamese-Australian Medical Association

http://www.viet-ama.org/

The Vietnamese-Australian Medical Association is a not-for-profit organisation created by and for Registered Medical Practitioners of Vietnamese descent that live in Australia. This organisation strives to consolidate the existing spirit of solidarity among these Medical Practitioners; provide the best quality of patients care; organise and participate in Quality Assurance and Continuing Professional

Development (QA & CPD) activities in accordance with Australian Health Authority's guidelines; and contribute to charity work to help the disadvantaged in Australia as well as overseas.

Australian Doctors Trained Overseas Association

http://www.adtoa.org/index.pl

The Australian doctor's trained overseas association provides support to members seeking to gain professional registration in Australia. Information on assessment and education requirements, financial aid, policy and employment and other relevant support is provided.

General Practice Academic Units

The funding for Australian general practice research via General Practice Academic Units has gradually increased over the past 30 years. The Units are typically located within Universities. Some of the topic areas that the Academic Units focus their research on include: the health and wellbeing of doctors, medical students and other health professionals; primary health care provision, evaluation and development and health equity. They also build capacity for primary care research to be undertaken by other organisations.

- GP academic units NSW:
- School of Public Health & Community Medicine, University of NSW
- Dept General Practice, University of Sydney
- Centre for Primary Health Care & Equity, University of NSW
- Discipline of General Practice, Newcastle University

A number of other university departments also do related research and development work, for example schools of public health and the university departments of rural health.

Appendix 3

AUSTRALIAN GENERAL PRACTICE INFORMATION SOURCES

General

PHCRIS Acronyms
http://www.phcris.org.au/products/acronyms.php

An extensive list of acronyms for Australian general practice and primary health care

Australian Family Physician
http://www.racgp.org.au/afp

The official peer reviewed journal of the Royal Australian College of GPs.

Policy

Report to Support Australia's First National Primary Health Care Strategy
http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nphc-draftreportsupp-toc~nphc-draftreportsupp-ch3

This report provides background for the Draft Strategy's directions as well as providing evidence to support future investment in, and reform of, the primary health care system.

A Framework for Continuing Professional Development of Vocationally Trained GPs and Specialists
http://www.cpmc.edu.au/docs/cpd_dec2003_finalreport.pdf

This report describes work conducted by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists to construct a framework for the Continuing Professional Development of medical practitioners in Australia.

General Practice Service Delivery

PHCRIS
http://www.phcris.org.au/index.php

A national primary health care organisation working to generate, manage and share information and knowledge that contributes to policy and improves performance in Australian primary health care.

The BEACH Project
http://www.fmrc.org.au/beach.htm

Collection of information about clinical activities of general practice in Australia including characteristics of the GPs, patients seen, reasons people seek medical care and problems managed.

General Practice Activity in Australia 2009-20010
http://www.aihw.gov.au/publications-detail/?id=6442472433

A publication produced by the Australian Institute of Health and Welfare. This report presents results from the twelfth year of BEACH program, a national study of general practice activity.

General Practice Activity in Australia 2008-2009
http://www.aihw.gov.au/publications/index.cfm/title/11013

A publication produced by the Australian Institute of Health and Welfare reporting on results from the 2008-2009 BEACH project.

General Practice Activity in Australia 2008-2009: Practice Nurse Activity
http://www.aihw.gov.au/publications/gep/gep-25-11013/gep-25-11013-c13.pdf

Chapter 13 of the report focuses on practice nurse Medicare claims, practice nurse activities, problems managed with nurse involvement and recent changes in practice nurse activity.

General Practice Workforce

Australian General Practice Workforce in Australia: Supply and Requirements to 2010
http://www.ahwo.gov.au/documents/Publications/2005/The%20general%20practice%20workforce%20in%20Australia%20-%20summary.pdf

This summary report presents the key findings of the Australian Medical Workforce Advisory Committee General Practice Workforce Review.

Australian Health Workforce Online
http://www.ahwo.gov.au/index.asp

Provides information and updates on Australia's health workforce, health workforce planning and activities of the National Health Workforce Advisory Committees.

National Practice Nurse Workforce Survey Report 2009
http://generalpracticenursing.com.au/__data/assets/pdf_file/0003/23817/National-Practice-Nurse-workforce-survey-report-PDF.pdf

Report by the Australian General Practice Network providing a comprehensive national compilation of information and statistics regarding employed general practice nurses.

Nursing in General Practice: A Guide for the General Practice Team
http://www.nrgpn.org.au/index.php?element=RCNA+Nursing+in+GP+Guide

This resource provides guidance on roles and responsibilities and legislative, regulatory, employment and human resource issues to assist general practices to effectively include a nurse within their general practice team.

2008 Labour Force Survey
http://www.health.nsw.gov.au/pubs/2009/pdf/medicalprofile_2008.pdf

NSW Health report profiling the medical practitioners workforce in NSW in 2008.

General Practice Funding

AMA Fees List
http://www.ama.com.au/feeslist

Information provided by the Australian Medical Association to assist medical practitioners determine their own fees (Note: Some links are accessible to AMA Members only).

Medicare Item Reports
https://www.medicareaustralia.gov.au/statistics/mbs_item.shtml

Produces statistical reports on individual requested items in the Medicare Benefits Schedule.

Medicare Statistics
http://www.health.gov.au/medicarestats

Contains summary data relating to Medicare for the last quarter, together with data for earlier quarters and financial years.

MBS Online
http://www.health.gov.au/internet/mbsonline/publishing.nsf

This website provides a searchable list of the Medicare Benefits Schedule (all of the Medicare services subsidised by the Australian government).

Education and Training

How to plan, deliver and evaluate a training session
www.racgp.org.au/afp/200406/14730

This is an article in the Australian Family Physician (Vol 30[6]: 385-480) which discusses the teaching of practical procedures in general practice. An example of an educational session about the management of shoulder conditions for general practice registrars is used to illustrate the planning, delivery and evaluation of such training sessions.

eHealth

National eHealth Strategy
http://www.ahmac.gov.au/cms_documents/National%20E-Health%20Strategy.pdf

This is a summary of the National eHealth Strategy developed in 2008.

National E-Health Transition Authority
http://www.nehta.gov.au/

Concerned with developing better ways of electronically collecting and securely exchanging health information. Website provides information about eHealth and barriers to its development.

Medical Director
http://www.hcn.com.au/Products/Medical+Director

More information and guide to using Medical Director software.

Best Practice
http://www.bpsoftware.com.au

More information about using Best Practice software.

Appendix 3 continued

Other State Guides for Working with General Practice

Working with general practice department of human services position statement and resource guide
http://www.health.vic.gov.au/communityhealth/gps/position_resource.htm

This position statement and resource guide were developed by the Victorian Government Department of Human Services.

A guide to working with general practice
http://www.gptasmania.com.au/content/Document/Policy%20and%20Position%20Statements/POLS_POLICY_%20A%20Guide%20to%20Working%20with%20General%20Practice%20Final%20(2).pdf

This resource guide was developed by General Practice Tasmania.

Principles of general practice engagement
http://www.gptasmania.com.au/content/Document/Partnerships/PART_POLICY_20071002_Principles%20for%20GP%20Engagement%20V1.pdf

This guide contains practical advice to support improved collaboration between the Department of Health and Human Services, Tasmanian GPs and Divisions of General Practice.

Glossary of commonly used terms and acronyms

AAPM – Australian Association of Practice Managers

ABHI – Australian Better Health Initiative

ABS – Australian Bureau of Statistics

Aboriginal – A person of Aboriginal descent who identifies as an Aboriginal and is accepted as such by the community in which he or she lives. Department of Health and Ageing http://www.health.gov.au/internet/main/publishing.nsf/content/glossary

ACCHS – Aboriginal Community Controlled Health Service
A primary health care service providing holistic, comprehensive and culturally appropriate health care to the local Aboriginal community which initiated and operates the service

Accreditation – Being granted recognition for meeting designated standards for structure, process and outcome

ACRRM – Australian College of Rural and Remote Medicine

AFP – Australian Family Physician

AGPAL – Australian General Practice Accreditation Ltd

AGPN **–** Australian General Practice Network

AH&MRC of NSW – Aboriginal Health and Medical Research Council of New South Wales

AHPs – Allied Health Professionals

AHW – Aboriginal Health Worker

AIHW – Australian Institute of Health and Welfare

Allied Health Professional – A professional working in health care other than the areas of medicine, nursing and health administrations who qualifies for professional registration

AMA – Australian Medical Association

AMS – Aboriginal Medical Service

APCC – Australian Primary Care Collaboratives

APNA – Australian Practice Nurses Association

ARIA – Accessibility Remoteness Index of Australia

ATSI – Aboriginal and Torres Strait Islander

BEACH – Better Evaluation and Care of Health

Bulk-billing – The process by which a medical practitioner or optometrist sends the bill for services direct to Medicare, so there is no cost to the patient.

CALD – Culturally and Linguistically Diverse

Chronic Disease – A disease that has been or is likely to be present for six months or longer

CDM – Chronic Disease Management

CDSM – Chronic Disease Self-Management

CPD – Continuing Professional Development

Divisions of General Practice – Regionally based independent organisations that are part of the NSW Divisions of General Practice Network. Divisions work to enhance communication and integration between GPs and the wider health system, and improve the health of the community by supporting General Practice collaboration with other health professionals in the delivery of quality health care.

DoHA – Department of Health and Ageing

eHealth – The use, in the health sector, of digital data - transmitted, stored and retrieved electronically - in support of health care, both at the local site and at a distance

EHR – Electronic Health Record

General Practice – The provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities

General Practitioners – A medical practitioner who is qualified and competent to work in general practice

GPMP – General Practitioner Management Plan

GP NSW – General Practice New South Wales Health A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity

Health Care – Services provided to individuals or communities to promote, maintain, monitor or restore health

Health Promotion – The process of enabling people to increase control over and improve their health. It involves the population as a whole in the context of their everyday lives, rather than focusing on people at risk for specific diseases, and is directed toward action on the determinants or cause of health.

Integration – The linking together of two or more service providers and/or agencies to address the individual's or family's preventive, treatment, and maintenance health needs in a coordinated and comprehensive manner.

MBS – Medical Benefits Schedule

Medicare – Australia's universal health insurance scheme that allows Australians to receive free or subsidised medical treatment by a range of health care providers. The health programs administered by Medicare Australia include Medicare, Pharmaceutical Benefits Scheme, Australian Childhood Immunisation Register, Australian Organ Donor Register, General Practice Immunisation Incentives Scheme and the Practice Incentives Program

NEHTA – National E-health Transition Authority

NGO – Non Government Organisation

NHHRC – National Health and Hospitals Reform Commission

NHMRC – National Health and Medical Research Council

Nurse practitioner – A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practice.

Out-of-Pocket Costs - The difference between the Medicare rebate and the fee charged to the patient

Pharmaceutical Benefits Scheme – A national, government-funded scheme that subsidises the cost of a wide range of pharmaceutical drugs, and that covers all Australians to help them afford standard medications

PIP – Practice Incentives Program

Population Health – The health of a population which is typically measured by health statistical indicators

Preventative Care – The elimination or reduction of the onset of health problems, linked to the positive view of health

PM – Practice Manager

Practice nurse (PN) – A practice nurse is a registered nurse or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice. Practice nurses deliver primary health care in a general practice setting.

Primary Care – A term used to describe a range of clinical services (predominantly GPs but also practice nurses, community health care nurses and community pharmacists) that are normally the first point of contact for patients

Primary Health Care – Incorporates primary care but also includes a more comprehensive range of multidisciplinary services (including allied health professionals, indigenous health workers and health promotion workers) operating at the community level

QI&CPD – Quality Improvement and Continuing Professional Development Program

RACF – Residential Aged Care Facility

RACGP – Royal Australian College of General Practitioners

RARAC – Rural and Remote Area Classification

RDA NSW – Rural Doctors Association NSW

RDN – Rural Doctors Network

RN – Registered Nurse

Standards for General Practices – The RACGP Standards for General Practices are used by general practice accreditation agencies, but the principal aim is to provide a tool for practice staff to assess the care provided in their own practice

TCA – Team Care Arrangement

VRGP – Vocationally Registered General Practitioner

Vocational Registration – Vocational registration can be attained by fulfilling the RACGP QA&CPD criteria (combination of educational activities and assessment of practice each three year period). Vocationally registered GPs have access to special Medicare item numbers and higher Medicare rebates

General Practice NSW

General Practice NSW was established to work at a state level to support and promote the work of NSW Divisions Network, to maintain good working relationships with relevant public, private and not-for-profit stakeholders and to maximise the capacity and influence of NSW Divisions in the health care sector.

General Practice NSW objectives:

Leadership

Coordinate activities across Divisions that add value to the health system.

Promote a continuous improvement culture across NSW Divisions.

Identify funding opportunities to develop the business of NSW Divisions.

Facilitate information sharing and networking between Divisions.

Representation and Advocacy

Raise the profile of Divisions and the vital role of general practice in the delivery of primary health care.

Ensure that general practice is represented in planning and implementation of health services in NSW.

Establish collaborative relationships with other centers of influence in the health sector.

Program Support

Develop programs, provide support and promote activities across health priority areas that are responsive to member needs.