

Divisions of General Practice: will they transform, or die?

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Divisions of General Practice (also known as general practice networks) are an important part of Australia's health care sector. The Australian Government has signalled that new organisations, known as Medicare Locals (MLs), will be established to play a significant role in the development and delivery of primary health care services in local communities.¹

As MLs come into being, what are some of the choices that Divisions will face?

From the past to the present: Divisions

Divisions of General Practice came into being in Australia in their current form in 1992. They exemplify an international trend towards new forms of organisation in primary care.^{2,3} Their members are typically health professionals who practise in the relevant Division's catchment area. In the 2007–08 financial year there were 110 Divisions; their combined membership exceeded 23 000 and comprised general practitioners (around 80% of members), practice nurses (7%), other practice staff (7%) and other groups including allied health professionals and medical specialists.⁴

Divisions are independent corporate entities governed by Boards of Directors. In 2007–08 there was a total of 919 Directors, 786 (86%) of whom were GPs, and 93 (10%) of whom were described as “consumer or community representatives”. The proportion of non-GP Directors doubled between 2002–03 and 2007–08.⁴

According to the Australian General Practice Network (AGPN), the national peak body for Divisions, Divisions undertake

a wide range of activities focused on improving the health of the Australian community including health promotion, early intervention and prevention strategies, health service development, chronic disease management, medical education and workforce support.⁵

“Core” activities are common to all Divisions and are funded by the Australian Government Department of Health and Ageing. Other activities attract funding from various sources and reflect the interests of Division members and the needs of the communities they serve.

Into the future: Medicare Locals

As part of its program of health care sector reform, the Australian Government has announced that

independent primary health care organisations — to be called Medicare Locals ... will be established to provide better services, improve access to care and drive integration across GP and primary health care services.¹

The origins of MLs can be traced to the recommendation in the 2009 report of the National Health and Hospitals Reform Commission (NHHRC) that “service coordination and population health planning priorities should be enhanced at the local level through the establishment of Primary Health Care Organisations”.⁶ MLs will “be independent entities (not government bodies) with strong links to local communities, health professionals and service providers” and “where possible, [they] will be drawn from those

ABSTRACT

- Divisions of General Practice are a significant part of Australia's health care sector.
- The Australian Government intends to establish “Medicare Locals” (MLs), which will assume many of the roles currently undertaken by Divisions.
- MLs will, on average, be larger than Divisions and are likely to have different ownership, governance and accountability arrangements.
- While some Divisions may find transformation into an ML an appealing and relatively straightforward option, others may wish to follow alternative paths that allow them to maintain many of their current characteristics.
- Evidence suggests that the move to MLs might jeopardise the level of clinical involvement attained by Divisions.

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Divisions of General Practice that have the capacity to take on the roles and functions expected under the new arrangements”.¹

The Australian Government expects that “the first Medicare Locals will commence operations by mid-2011 with the rest to be rolled out by mid-2012”.¹ Their functions will include:

- facilitating allied health care services and other support for people with chronic conditions;
- working with local health professionals to ensure that patients can access the full range of services they need;
- identifying people missing out on GP and primary health care, or services that a local area needs, and targeting services to fill gaps;
- supporting the delivery of targeted Australian Government programs, such as immunisation, after-hours services and mental health;
- working with Local Hospital Networks to assist with patients' transition out of hospital and, where relevant, into aged care; and
- delivering health promotion and preventive health programs targeting risk factors in communities.¹

These functions have much in common with Divisions' current activities. In light of that fact, and the government's suggestion that MLs will be “drawn from” Divisions, does the establishment of MLs signal the end for Divisions?

What might the future hold for Divisions?

Decisions by the Australian Government will play a large part in determining the future of Divisions. Nevertheless, as independent organisations, Divisions themselves also have an opportunity to consider what role they wish to play in the changed health care environment.

Possible options for Divisions include:

1. Transforming into MLs.
2. Taking an ownership stake in an ML.
3. Becoming providers of services to one or more MLs.
4. Delivering ML services under contract.

Option 1 — Transforming into MLs

As noted above, there are many similarities between the functions currently undertaken by Divisions and those envisaged for MLs. Accordingly, there may be opportunities for better-performing Divisions to transform into MLs. That does not, however, mean that existing Divisions can simply be “rebadged” as MLs.

MLs will, on average, be larger than Divisions. The AGPN, in its blueprint for primary health care organisations (PHCOs — the precursors of MLs), suggests there could be “up to 60” such bodies.⁵ The NHHRC proposed PHCO catchment populations of about 250 000 to 500 000 “to provide efficient and effective coordination”,⁶ which translates to between 45 and 90 MLs. The populations served by Divisions currently range from 16 000 to more than 600 000, with 87 Divisions (80%) serving fewer than 250 000 people.⁷ In many parts of the country, Divisions would need to merge to establish MLs of the size envisaged by the AGPN and NHHRC.

Changes to governance arrangements may also be required. The National Health and Hospitals Network agreement, recently established by the Council of Australian Governments, indicates that PHCOs should have “strong local governance, including broad community and health professional representation, as well as business and management expertise”,⁸ and the Australian Government’s first National Primary Health Care Strategy states that governance of MLs “will include people with clinical expertise that reflect the broad health professions that work within the primary health care system”.⁹ There is clearly an expectation that the proportion of non-GP Directors will continue to grow.

The theme of accountability to local communities runs strongly through the rhetoric surrounding MLs, and this will have implications for their ownership. Divisions are currently companies that are owned by their members. The Australian Institute of Company Directors’ Code of Conduct explains that a Director’s “primary responsibility is to the company as a whole”.¹⁰ That means, when the chips are down, Division Directors are expected to put their members’ interests first. If ML members were to be “primary health care providers or provider organisations” as the AGPN blueprint suggests is a possibility,⁵ where would that leave consumers’ and communities’ interests?

Indeed, the issue of MLs’ accountability to the public is brought into sharper focus by the suggestion in both the National Health and Hospitals Network agreement⁸ and the National Primary Health Care Strategy⁹ that PHCOs or MLs should also “undertake population level planning and potential fund-holding roles in areas of market failure”.

Governments commonly use private companies to deliver services, but it is rare for planning and funding decisions that directly impact on citizens’ access to publicly funded services to be assigned to private-sector bodies. Where that does occur (for example, in some European social health insurance schemes), the citizens concerned can generally exercise either “voice” (by selecting members to serve on the Board of their insurer) or “exit” (by moving to an alternative insurer) as a means of ensuring accountability.^{11,12} Ownership and governance arrangements for MLs need to offer similar opportunities.

Option 2 — Taking an ownership stake in an ML

Divisions could choose to remain as independent companies with predominantly GP membership, while at the same time seeking to exert influence over their ML. This could be achieved by continuing in their present form and taking an ownership stake in a separate ML company, possibly appointing or electing one or more members of its Board. Other primary care providers or provider organisations (as

envisaged by the AGPN blueprint⁵), or even local citizens, could also have a stake in the ownership or governance of the ML.

This option reconciles the need for broader-based MLs with the Divisions’ desire for retaining strong GP engagement, but it has some significant weaknesses:

- Divisions would lose access to any of their current “core” government funding and any other income streams that were redirected to MLs.
- Directors chosen by Divisions to serve on the Boards of MLs might struggle to reconcile their responsibilities to the Division and their obligations to the ML company.
- In common with Option 1, this option could be viewed as placing too much decision-making power in the hands of MLs that have, at best, limited accountability to the communities they serve.

Option 3 — Becoming providers of services to one or more MLs

Some Divisions might play no part in the establishment or operation of MLs. Reasons for this could include a desire to retain existing ownership and governance arrangements; an ideological dislike for, or distrust of, the ML concept; an unwillingness to merge with one or more nearby Divisions to form a body of sufficient size to become an ML; or an unsuccessful bid to fulfil the ML role in the face of competition from other Divisions.

Divisions following this course of action would face the prospect of losing their current government funding to MLs. They might, therefore, seek to recoup lost income by providing, for example, direct patient care, GP support, or management services to one or more MLs. Similar arrangements have emerged in New Zealand, where the government’s move to establish primary health organisations (PHOs) with broad community governance has led some more GP-centric independent practitioner associations to redefine their role as being to “support both general practice and in many cases perform a management services function for PHOs”.¹³

Divisions choosing to follow this course of action would, in common with those choosing Option 2, be better able to retain their existing corporate form and GP focus, but may lose income in the process.

Option 4 — Delivering ML services under contract

Under this approach, the Australian Government would contract with one or more organisations to deliver a defined range of ML services to a specified community for an agreed period of time. Thus, they would be franchises held by Divisions or other organisations. Details of services to be delivered (eg, quality standards) and the sums payable to the franchisee would be encapsulated in a formal time-limited contract. Input from consumers and health professionals would be by means of advisory structures rather than through ownership or governance arrangements.

While this option is at odds with the view of the government and others that MLs should be organisations, it offers significant advantages to all key stakeholders:

- In their role as franchisees, Divisions could retain existing ownership and governance arrangements, while continuing to receive government funding. The nature of the contract for delivery of ML services would focus primarily on outputs rather than the details of the franchisee organisation.
- The government would be able to select the most appropriate provider of ML services independently of current Divisional structures or capabilities. Formal contracts would increase transparency in

Assessment of four possible roles for Divisions of General Practice when Medicare Locals (MLs) are established

Option	Retain existing governance and ownership	Continued access to government funding	Accountability to consumers and communities
1 Transforming into MLs	No	Yes	Weak if MLs are established as companies
2 Taking an ownership stake in an ML	Yes	No	Weak if MLs are established as companies
3 Becoming providers of services to one or more MLs	Yes	Partial; depends on value of services provided	Depends on ownership and governance of MLs
4 Delivering ML services under contract	Yes	Yes	Potentially strong; achieved through contractual obligations and possibility of contract non-renewal

funding and monitoring, and poorly performing franchisees could be refused renewal or extension once the initial contract term ended.

- The public would have both voice, through mandated advisory structures, and the possibility of exit, by pressuring for non-renewal of contracts in the event of poor performance.

What are the implications for Divisions?

The Australian Government's view that MLs should be drawn from Divisions suggests that Option 1 will be its preferred model. Capable Divisions should have little difficulty transforming into MLs, but will only be able to do so if they are willing to make significant changes to their ownership and governance arrangements. They will become new organisations that bear scant resemblance to Divisions as they are currently known. GP engagement will, inevitably, be reduced.

Options 2 to 4 offer scope for Divisions to retain many of their existing characteristics, albeit, in some cases, with the likelihood of reduced funding from government.

The attributes of all four options in three areas that are likely to be of relevance to Divisions as they contemplate their future are summarised in the Box.

A recent analysis of the evolution of primary care organisations in New Zealand and England offers some salutary insights for assessing possible futures for Divisions and those whom they serve. In both countries, the benefits of clinical involvement appear to have been put at risk by developments that resulted in primary care organisations becoming “unduly bureaucratic, managerially controlled, or perceived as belonging to the wider health system rather than local clinicians”.¹⁴

Australia's Divisions, with their heavy reliance on Australian Government funding, have arguably always been part of “the wider health system” despite being owned by local clinicians. Divisions that choose to become MLs will undoubtedly become more firmly embedded in the machinery of government and may thus risk losing some of the benefits of clinical involvement. Divisions that seek to retain current levels of clinical involvement may find that other pathways prove more attractive.

Competing interests

I was formerly a Deputy Secretary in the Australian Government Department of Health and Ageing (to Feb 2009). I am currently a Director of GPpartners (the Brisbane North Division of General Practice), and have received payment as an occasional speaker at events organised by Divisions and other health professional organisations.

The views expressed in this article are my own and may not represent the views of the Directors or members of GPpartners.

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