# Evaluation and Divisions of General Practice

*Elizabeth Kalucy*

Elizabeth Kalucy
libby.kalucy@flinders.edu.au
Primary Health Care Research and Information Service, Flinders University

*Paper presented at the Australasian Evaluation Society 2004 International Conference, 13-15 October-Adelaide, South Australia www.aes.asn.au*

## Abstract

The Divisions of General Practice network of 120 locally based organisations and associated state and central peak bodies, which receives government funding of more than $130 million per annum, has developed an important role in primary care service delivery and integration in the last ten years. In April 2004 the federal government announced that a new quality and performance management system would be developed in consultation with network members.

Barriers of culture, skills and resources hinder evaluation activities in Divisions of general practice despite growing acceptance of the concept of evaluation for organisational learning and quality improvement. This paper will outline some of the key factors affecting evaluation within the Divisions network, describe the lessons learned about monitoring progress and results through the substantial existing planning and reporting system, and discuss some ideas for measuring performance in this diverse group of organisations.

## 1 Introduction

The organisation of general practice in Australia has changed considerably with the development of Divisions of General Practice as part of the federally initiated General Practice Strategy during the 1990s. The role of Divisions initially was to improve health outcomes for patients by encouraging GPs to work together and link with other health professionals to upgrade the quality of health service delivery at the local level (Department of Health and Family Services, 1998).

From small beginnings in 1992, there are currently one hundred and twenty Divisions of General Practice across Australia as well as state-based organisations and a peak body, Australian Divisions of General Practice (ADGP). These organisations now employ more than fifty general practitioners and one thousand staff members from other backgrounds. One thousand GPs have been exposed to organisational structures and governance through their membership of Division Boards, and have gained capacity in needs assessment, planning, and implementation of programs. Divisions thus represent a massive growth in organisational capacity at local level in primary care, which has previously been characterised by fragmentation and multiple small providers.

The 55 urban and 66 rural Divisions are diverse organisations in size, funding, membership and geographic location (Table 1). They receive block grant funding

from the Australian Government Department of Health and Ageing (calculated using a population-based formula) and additional specific funding from up to fourteen different sections of that department for programs such as immunisation, IT/IM, and quality use of medicines. One indication of their organisational success and integration into the system is the range and amount of other funding sources, including state, non-government and commercial organisations.

**Table 1 Division characteristics 2002-2003 (Kalucy, et al 2004)**

| Characteristic | Median (range) | Total |
|---|---|---|
| Population per catchment area | 150,742 (17,336 – 591,500) | 19,640,979 |
| Number of practising GPs | 152 (12 – 714) | 21,561 |
| Number of FTE GPs | 104 (11-460) | 14,135 |
| FTE GP: persons | 1419 (737-2972) | - |
| Number of practices per Division | 54 (3-300) | 7,780 |
| Australian Government Funding* | | |
| OBF Block grant | Range: $166,836 - $1,400,000 | $64.30 million |
| Other | Range: $1000 - $5.3 million | $45.36 million |
| External funding** | $166,647 ($500 - $1,200,919) | $27.36 million |
| Staff | | |
| GP (FTE) | 0.05 (0 – 12.75) | 42 |
| Non-GP (FTE) | 8.8 (1- 39.53) | 1218 |
| Board members | | |
| GP | 8 (3-14) | 963 |
| Non-GP | 1 (1-6) | 78 |

* Source: Department of Health and Ageing

** Source: Division self report

The Commonwealth initially provided a small block grant to Divisions, who applied for competitive project funding on an annual basis. 'Outcome-based funding' (OBF) commenced in 1999, to place Divisions on a more equitable footing across Australia and make long term planing more feasible. The funding formula is based mainly on population of the catchment area (1996 Census data) with a loading for rurality, indigenous population and disadvantage. The term 'Outcome based funding' means that Divisions' plans related to broad outcome areas, against which they reported to their State and territory offices, not that Divisions are funded according to outcomes achieved. Under the OBF agreement Divisions submit a three-year strategic plan and annual business plans for approval by the State and Territory offices of the Department of Health and Ageing. The plans cover the broad sectors of population health, infrastructure, services to GPs, services by GPs to patients and Allied health, with Divisions identifying their outcomes, strategies, activities, indicators and results.

Divisions report each year to the Department of Health and Ageing against the terms of their business plans, and their finances. They also complete an annual survey of their activities (the Annual Survey of Divisions, ASD). An unusual aspect of the Division program has been the extent to which information about their activities is publicly available. All strategic and business plans and twelve-month reports (but not financial reports) are prepared according to an agreed template so that plans and reports approved by the Department can be displayed in a searchable online database

on the PHC RIS website. PHC RIS also publishes a report on the results of each Annual Survey of Divisions.

The Review of the role of Divisions of General Practice (2003) found that the network made an important contribution to improving both the coordination of the delivery of health services to the community and the health outcomes of people they serve. Divisions of General Practice have made it possible for general practitioners to work together, health and community services to communicate and work with general practice, general practice to become more integrated into the health system at local level, and Government to achieve outcomes that are difficult to obtain through individual general practices operating in isolation.

## 2 Key factors affecting evaluation in Divisions

A newcomer to the Division network could assume that evaluation would play a key role in reporting results and achievements in an outcome based funding system. However, evaluation in Divisions is not a prominent activity for many reasons. These include culture, in particular the attitudes to evaluation within Divisions and their funding bodies; the resources available for evaluation in terms of time, funding and expertise; knowledge of useful evaluation and planning models, and data issues.

*Attitudes and culture*

Telephone interviews with a sample of Division staff about evaluation and sharing information within Divisions (Lowcay & Kalucy, 2003) reinforced the variability of evaluation practices between Divisions. Some Divisions have a history of conducting and using evaluation for benefit of Division programs, often associated with their leaders' attitudes, background and connections with academic departments. One Division CEO wrote about this in the PHC RIS newsletter "GPinfonet":

> *It is the position of Northwest Melbourne Division that it is essential that some form of evaluation occur not only for accountability purposes, but to assess the effectiveness of the Division's activities and to assist with planning for future activities.* (Searle, 2004)

However, other Division staff members saw themselves as practitioners not researchers, and believed strongly that implementing their programs was more important than evaluation. Staff also expressed the common fear of being judged by evaluations. The following quotes illustrate some of these divergent attitudes.

> *"always…part of our culture"*
> *"only when asked for"…..*
> *"never …too busy 'doing' to take the time"*
>
> (Lowcay & Kalucy, 2003)

Lack of demand for evaluation within Divisions and from funding bodies is another aspect of evaluation attitudes and culture. The OBF framework requires Divisions to report on performance indicators and complete a section on results and commentary for each activity, but Division staff members perceived that evaluation was not required to same extent as in the project funding system. Staff members believed that nobody read their reports, which therefore had little function beyond fulfilling a contractual requirement. They commented on lack of response to evaluations that

have been completed, and the fact that little use seems to have been made of evaluation results for future planning.

As a result, evaluation is not seen as useful or necessary within some Divisions, as it will make little difference to their funding or planning. This view is coloured by negative experiences with evaluations that have turned into 'wombats' – a waste of money, brains and time.

*Resources*

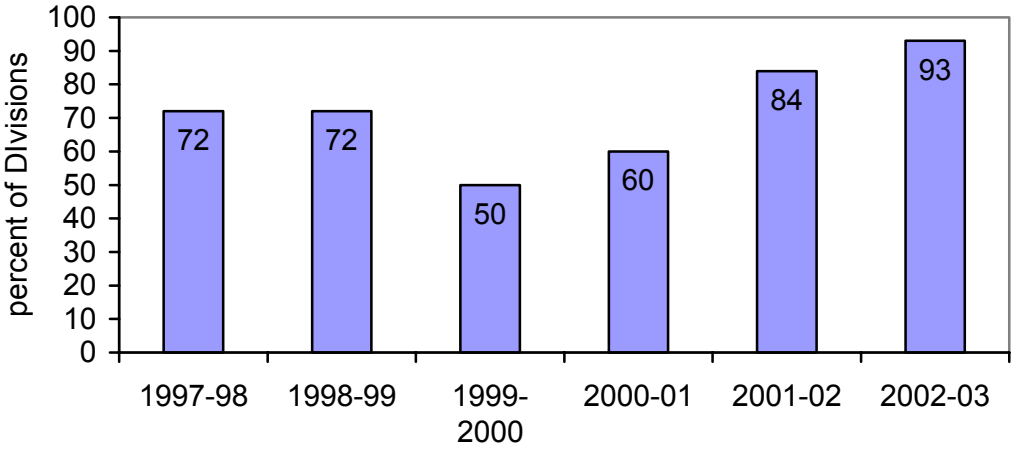
Lack of time was the major problem identified by Division staff members, together with limited funding which usually does not cover evaluation expenditure. A further problem was the scarcity of staff members with sufficient skills in evaluation, although some of the larger Divisions had been able to obtain resources for a dedicated staff member with evaluation expertise. Even staff who are willing and able to evaluate their programs are often frustrated by lack of funding and investment in evaluation. Providing evaluation training is of limited value without following up with resources to conduct evaluation.

Building evaluation capacity is of importance for both program staff and managers. Even without formal evaluation training, many managers usually had a good idea from their own informal sources and from financial statements of the success or otherwise of a program. Managers recognised their needs for improved capacity to commission and use evaluations, so they get value for money (rather than wombats). This need has also been identified in other sectors (McDonald, et al 2003).

Increasing numbers of Divisions have sought external assistance with research and evaluation recently. Although Figure 1 shows a decrease in the use of external expertise in 1999-2000, associated with the end of project funding which required external evaluation, the demand for external expertise has climbed steadily since the advent of Outcome Based Funding in 1999-2000.

Divisions obtained external expertise from numerous sources – at least 50% used other Divisions and organisations within the Divisions network, universities, private consultants, and/or organisations such as the National Prescribing Service.

**Figure 1 Proportion of Divisions using external expertise in research and evaluation** (Kalucy, et al 2004)




*Evaluation and planning models*

Evaluation is infrequently considered at the planning stage of Divisions' programs, and most Divisions have no clear definition of program theory linking activities with effects. With little evaluation capacity among their staff, Divisions expressed the need for practical simple models for evaluation and planning, to make it possible for them to achieve useful and feasible evaluation in-house with existing skills and resources. Several models that have been discussed at meetings of the Australasian Evaluation Association are Bennett's Hierarchy, the Success Case method, and program logic.

The Primary Health Care Research and Information Service ran a series of workshops on evaluation in 2003, for Divisions in different states, in response to items in the PHC RIS newsletter. Attendance at these workshops indicated Division staff had strong interest in learning about evaluation that was feasible and useful for Division purposes. Bennett's Hierarchy, or the TOP framework (Targeting Outcomes of Programs) was used as the basis of these workshops. This simple framework aroused a lot of interest and very positive responses. However, advice and mentoring to individual Divisions, and further training was required to follow up these workshops, all of which was beyond the role of PHC RIS. Some Divisions have developed good working partnerships with skilled staff in universities, to build their evaluation capacity.

*Data and information*

Deciding what data to collect is a major problem. There is often no national consensus about processes, outputs and outcomes to be measured at start of national initiatives. This makes it difficult for Divisions to select appropriate measurable indicators of activities and outcomes. It also makes it extremely difficult to make comparisons between Divisions. With appropriate planning, the implementation of national initiatives could include identification of sources of appropriate tools for assessing outputs and outcomes.

Collecting data is another issue exacerbated by lack of time, funding and skills. Divisions use data from internal and external sources. Surveys of GP and practice staff are commonly used and regarded as the most useful even though the low response rates to such surveys (usually well below 60%) resulting in a biased sample. Fewer Divisions used data from focus groups and GP audits, but two thirds of those

that did use such sources regarded them as very useful. Although many Divisions used external data such as Census, HIC and local health service data, less than half found it very useful (Table 2).

**Table 2 Data sources used to monitor and evaluate Division activities, 2002-2003**

| Data source | Number of Divisions using source | % Divisions reporting source was very useful |
|---|---|---|
| GP surveys | 113 | 64 |
| HIC data | 109 | 43 |
| Practice staff surveys | 98 | 68 |
| Census data | 86 | 43 |
| Local health service data | 73 | 41 |
| Focus groups | 66 | 67 |
| Patient surveys | 44 | 48 |
| GP medical records/audits | 32 | 63 |
| Community surveys | 31 | 39 |
| Patient registers | 30 | 53 |

A problem often raised by Divisions when they discuss evaluation of their programs is the lack of readily available appropriate population data for needs assessment, planning and evaluation. Among the issues identified by Divisions at a national workshop on data use in 2003 (JAG, 2003) were cost, lack of knowledge of available data, currency of data, lack of local data, validity of data when sample size is at regional or local area level, and lack of data on health outcomes vs plentiful data on health service use. Timeliness, level of aggregation, cost and relevance were among the issues identified by Divisions.

The best data available to Divisions are from the Health Insurance Commission, eg data on usage of items from the Medical Benefits Schedule and Pharmaceutical Benefits Schedule, and Practice Incentive payments, and from the Australian Childhood Immunisation Register (ACIR). The ACIR is widely used by Divisions and by others to indicate the rate of children immunised in the Divisional area, and the number or percent of practices that have registered over 90% immunisation coverage. ACIR information is available on-line at the level of individual Divisions, State and nationally, and is frequently cited in newsletters of Divisions and State based organisations to celebrate milestones as they are achieved. The use of the latter data by Divisions illustrates how ready many are to use good quality sources of data for feedback at practice, Division, regional and national level.

## 3 Lessons learned about monitoring progress and results

*Information sources*

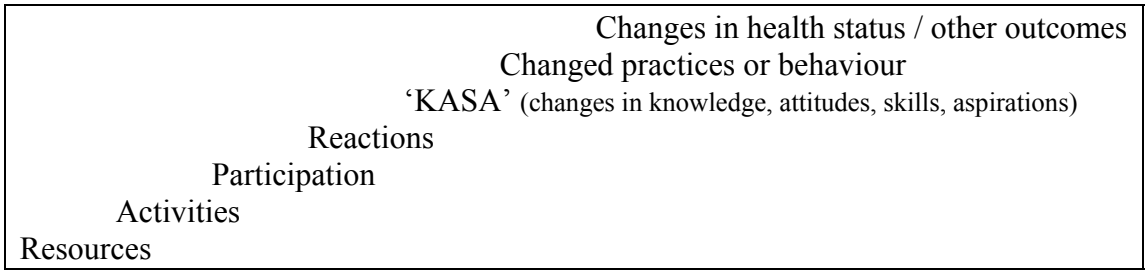
The main sources of information for monitoring progress and results of Divisions are the Annual Survey of Divisions and the Activities of Divisions database which contains all the Strategic and Business Plans and Annual reports since 1999.

The ASD provides standardised, aggregated information on activities of 100% of Divisions. The ASD provides a rich source of information on Division structures,

demographics and processes such as GPs working together, linking with other providers, involvement of consumers, services to GPs and patients. However information on Division achievements in population health is limited. The information is self reported, and reliability cannot be easily ascertained as many items are not independently verifiable. Validity is also limited by ambiguity of interpretation of the large number of questions. Even apparently straightforward concepts such as 'Full Time Equivalent GP', or 'Overseas trained Doctor' have multiple interpretations and uses.

Like the ASD, OBF plans and reports provide detailed self reported information about activities, but less information about the results and effects of those activities. The extent to which Divisions achieved their outcomes has remained elusive, as the focus of reporting has been on activity not outcomes, and the level of evaluation within Divisions remained variable.

The activity-focussed nature of Divisions reporting is illustrated by using Bennett's hierarchy as a framework to conceptualise the immediate, intermediate and long term effects of programs (Rockwell & Bennett, 2003).




A PHC RIS review of a small sample of twelve-month reports for 2002-2003 showed that most Divisions reported outputs and process measures at the lower end of the hierarchy of outcomes.

- All Divisions reported on **activities**: the numbers of documents published in newsletters, meetings, collaborations, continuing professional development events, and practice visits.
- Fewer Divisions reported on **participation**: the number or percentage of their GP members who have attended events, or of practices that the Division has visited. These figures provide some idea of the reach of the Division's activities.
- A few Divisions went further and reported on respondents' evaluation of an event, visit or the information provided, in terms of satisfaction (**reactions**) or improved **knowledge** (the first stage of KASA).
- Overall, the closest Divisions come to reporting **changes in practice** or health status was through changes in rates of activity, captured by routine national data collections such as ACIR and HIC (MBS, PIP and PBS). ACIR was possibly the best used data source.

Although lengthy, the twelve-month reports illustrate the range of Division activity as well as the difficulty of assessing its effects. Much Division effort is expended in developing and maintaining relationships with GPs and practice staff as well as with numerous health workers in primary, secondary and tertiary care. Divisions are

primarily not service providers, but agents of integration, linkages and information to address practice needs and build the capacity of general practices to address individual and population health approaches.

Some important lessons have been learned since 1999 about monitoring progress using the Divisions planning and reporting framework.

The OBF planning framework with its three-year strategic plan was found to be too static and rigid to accommodate new local and national initiatives. In terms of reporting, as indicators were linked to activities in the framework, the focus of reporting was on activities not outcomes. The lack of nationally agreed goals made it difficult to assess results of similar programs from individual Divisions or groups of Divisions at a higher level.

The concept of making Divisions planning and reporting information publicly available has been successful in part. After considerable refinement the OBF template developed by PHC RIS has provided a consistent format to make it easier for State Offices to process and approve plans and reports, and a standard structure to incorporate information into the searchable on-line database. Efficient systems meant that information was published on the on-line database within days after arrival at PHC RIS. The database now contains an almost complete record of plans and reports for all Divisions since 1999.

However, the usefulness of the on-line information was limited by the content of the plans and reports, and the large amount of information resulting from searches of plans, which are often very lengthy (60–80 pages long). Divisions have expressed their frustration with the lack of summary information that would help them in planning and adopting methods from other Divisions, about what is working best, where, for whom and in what context.

The main lessons learned about the planning and reporting framework are as follows:

- Any future framework must be flexible to accommodate an ever-changing health system.
- The planning and reporting framework must meet needs of Central and State /Territory Offices of the Department of Health and Ageing for managing contracts and accountability for results, and Divisions' requirements for a user friendly system which helps planning and reporting processes.
- Data collection tools and templates for planning and reporting must be flexible and adaptable. They must be able to remain useful in dynamic computing environment, and cope with new functions arising from national initiatives.

## 4 National Quality and Performance System for Divisions

The future role of Divisions was reviewed in 2002-2003. The Review Panel chaired by Mr Ron Phillips recommended a process to drive continuing improvement in the Divisions network. Consistent with this philosophy, more consistent and higher quality evaluation was required, combined with increased sharing of better knowledge and evidence about which Divisions approaches do or do not work and in which circumstances (Commonwealth of Australia, 2003, p.7).

The Government response to the Divisions Review Report in 2004 (Commonwealth of Australia, 2004, p.19) provides a clear statement of objectives, expectations and priorities for the Divisions sector. The response outlines the components of a new national Quality and Performance system for Divisions.

- National performance indicators
- Rolling review process
- Financial accountability
- A quality system with standards
- Peer review
- Rewarding high performers (performance funding pool)
- Promoting best practice and peer support.

The purpose of this new system is to provide better information to determine which Divisions are performing well and which are struggling, to show that Divisions are giving value for money for public funding (ie that the money is being used effectively and appropriately to improve health outcomes in community). The new system is intended to assist all Divisions improve to the same high standard (though such standards are as yet undefined), and provide better information on how Divisions are making a difference to the health system.

The Review Implementation Committee (RIC) commenced work in August 2004. A key part of the committee's work plan is the new National Quality and Performance System, in particular the National Priority Area Performance Framework and Quality Standards. The latest communiqué from the RIC identifies that initial development of performance indicators for Divisions will focus on four national priority areas: access, prevention and early intervention, better management of chronic disease, and supporting integration and multidisciplinary care. It is intended that indicators for these areas will be developed for inclusion in Divisions' funding agreements for 2005-2006 (Commonwealth of Australia, 2004).

## 5 Discussion

Performance management is the approach that the Government is adopting for the Divisions network. Performance management and evaluation are different but complementary. (Davies, 1999). Evaluation asks the 'why and how' questions as a one-off exercise, and performance management asks the 'what' questions on an ongoing manner. Performance management is accepted in current government administration, because of its focus on results achieved, related costs and performance indicators. Davies (1999) identified that governments often have negative views of evaluations, which do not meet the expectations of decision-makers. They are costly, take time, are difficult to justify in tight fiscal situations. The reports are long and complex, few people read or use them, issues of program relevance are rarely addressed as the evaluations are often more formative than summative. The information from evaluations is not timely and is seldom considered useful for resource allocation or budgeting decisions. In this context, performance management approaches are seen as more useful for decision-makers.

The performance management framework being introduced to Divisions is intended to provide more consistent and continuous information about key areas of activity than has been obtainable under the previous reporting system. If this information is to

result in improved performance, information from indicators must be interpreted wisely, using evaluation usually at local level. Building the evaluation capacity of Divisions is more necessary than ever, to complement the increased capacity to provide information for the new performance measurement system.

To implement the new system successfully means addressing the key factors affecting evaluation in Divisions. This will mean 'selling' the new system to gain support and ownership from Divisions, so that they adopt the attitude that reporting on performance indicators is part of their core business. Their perceptions of the use made of the performance indicators will greatly influence their attitudes in the longer term. Lack of the key resources of time, funding and skills could be a serious issue, as there will not be additional funding for Divisions. Implementation will require some training and development of resources to assist in skill development. Lack of evaluation and planning models could be addressed to some extent by specification of the national performance indicators, but consideration should also be given to this area in the implementation of the initiative. Access to data and information should be addressed as part of the development and refinement of national performance indicators, as this will be crucial to successful implementation.

**References**

Commonwealth of Australia, 2004, Divisions of General Practice: Future Directions. Government Response to the Report of the review of Divisions of General Practice, Canberra.

Commonwealth of Australia, 2004, September 17, Review Implementation Group, Communiqué Two. Retrieved September 29, 2004, from http://www.health.gov.au/pcd/programs/divisions/index.htm

Commonwealth of Australia, 2003, The Future Role of the Divisions Network. Report of the review of the role of Divisions of General Practice, Canberra.

Davies, IC 1999, "Evaluation and Performance Management in Government", Evaluation, vol.5,no.2, pp.150-159.

Department of Health and Family Services, 1998, General Practice. Changing the future through partnerships: Report of the General Practice Strategy Review Group, Canberra.

Joint Advisory Group on General Practice and Population Health, 2003, November 3, Workshop on population health data use within divisions of general practice, Canberra. Retrieved September 29, 2004, from http://www.health.gov.au/pubhlth/about/gp/workshop.htm

Kalucy, E, Hann, K & Whaites, L 2004, Divisions: a matter of balance: Report on the 2002-03 Annual Survey of Divisions of General Practice, Primary Health Care Research & Information Service (PHC RIS), Department of General Practice, Flinders University, Adelaide and Australian Government Department of Health and Ageing, Canberra.

Lowcay, B & Kalucy, L 2003, Sharing the Know-how: knowledge sharing between Divisions of General Practice, PHC RIS, Adelaide.

McDonald, B, Rogers, P & Kefford, B 2003, "Teaching people to fish? Building evaluation capability in public sector organisations", Evaluation, vol.9,no.1, pp.9-29.

Rockwell, K & Bennett, C 2003, May, Targeting Outcomes of Programs (TOP): A Hierarchy for Targetting Outcomes and Evaluating their Achievements. Retrieved September 29, 2004, from http://citnews.unl.edu/TOP/english/index.html

Searle, C 2004, "Evaluation – Backwards looking forward", GPinfonet, PHC RIS, vol.8,no.4,April 2004.