5.8 Table 8: Summary of results by author

Evidence criteria

1= Objective patient data
2= Administrative data
3= Patient reported data
4= Provider reported data

Research quality criteria

A1= National administrative data
A2= Local administrative data
B1= Quantitative methods representative sample of the initiative related population
B2= Quantitative methods unrepresentative sample
C= Qualitative methods

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
AUSTRALIA				
Divisions of General Practice				
(Rogers WA and Veale B 2000); Study date: 1996/97-1988/89; Evidence & Quality criteria: 4 B2				
Expenditure on mental health, diabetes, cardio-vascular disease, injuries and cancer decreased after shift to block grant funding method changed, however, the number of projects being run in these areas increased & increased spending on immunisation - due to dedicated funding. Overall, there was a decrease of over 40% in spending on the six national health priority areas.				

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
Other factors that affected which projects were funded included: support from divisional GPs; opportunities to involve maximal numbers of GPs and for providing services to GPs; best possibilities for achieving change; realistic and measurable outcomes Changes in funding procedures which use nominated outcomes as the major accountability mechanism may produce unexpected and unintended results, including significantly decreased expenditure in areas with outcomes which are hard to define and measure; but which are important for health improvement				
(Review Panel 2003); Study date: 2002/03; Evidence & quality criteria: 4 B2				
Strong engagement of GPs as members & as Board participants; however little involvement of non GP providers/consumers in governance Non aligned boundaries with other health services	Improved coordination of delivery of health services			

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
and size has limited effectiveness and collaboration with other health services, including primary health care The way in which the Divisions' network has grown and developed has resulted in significant differences in their focus and performance, with the major disparity in relation to the extent to which they play a wider role in primary health care				
(Kalucy, Hann et al. 2005); Study date: 2004; Evidence & quality criteria: 4 B1				
The majority of Divisions are providing population health information to GPs to assist in recalling patients for treatment, a substantial increase from 52% in 2002/03 Little involvement of non GP providers/consumers in governance Most Divisions are also providing accreditation support services to practices Most Divisions had formal arrangements for	In 2003/04 about half the Divisions provided direct patient services in mental health and/or diabetes, and almost all funded access to allied health professionals through for example More Allied Health Services, Better Outcomes in Mental Health Most Divisions have established chronic disease programs especially for mental health, diabetes, asthma, cardio-vascular disease, cancer, chronic illness & arthritis with slight			

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
collaborating with community and hospital based services, & in 2003/04 there was an increase in Divisions with formal mechanisms to engage indigenous health services Collaboration across Divisions is also occurring, with one third having reciprocal agreements with other Divisions Divisions had increased their support for Practice Nurses professional development, chronic disease management & facilitating networks Rural Divisions of General Practice continue to play an important role in recruiting GPs & providing/ coordinating locum services Most divisions provide Information Management/Information Technology support for practices & practice management support.	reduction eg in shared care programs & increase in prevention activities, both associated with changes in government funding In 2003/04 26% of Divisions had programs to improve access for residential aged care residents to GP services; and less than 20% addressed financial/locational barriers to accessing GP services, but 50% were involved in addressing after hours access			

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
Primary Care Partnerships				
(Australian Institute for Primary Care & Centre for Development and Innovation in Health 2002); Study date: 2002; Evidence & quality criteria: 3 B2, 4 B1;				
Significant change management, restructuring within agencies, education, training, support for development & implementation of service coordination tools/systems				
(Australian Institute for Primary Care 2003); Study date: 2003; Evidence & quality criteria: 3 B2; 4 B2				
	Improved service coordination, especially for HACC			
(Australian Institute for Primary Care 2005); Study date: 2005; Evidence & quality criteria: 3 B2; 4 B2				
Variety of governance structures – not one best model Main area of little change related to consumer participation in the Partnership Improved planning for health promotion across the catchment & continued over time Unresolved issues around resourcing for most Primary Care Partnerships, including staff time Improved working	Increased use of care plans amongst intense service users between 2002-2005		Consumer satisfaction with professionals was high and did not change between 2002-2005	

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
relationships and communication across member agencies over time Difficulty in having good working relationships with central & regional level at same time Communication between GPs & other primary health care providers in the network improved, but clarity & timeliness of communication more variable. one third still at early stage by 2005 Improved systems for service coordination, especially the Service Coordination Template Tool, developed over time Good progress re development of protocols & systems for facilitating access to services				
Primary Health Care Networks				
(Jan Smith + Associates P/L 2005); Study date: 2004/05; Evidence & quality criteria: 4 C				
The NSW primary health care networks were more a series of discrete projects to meet local	More coordination with other service providers through use of documented care plans,			

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
needs, but these developments were isolated and fragmented rather than connected or integrated/coordinated with other initiatives and thus were not about system changes Some focus on addressing workforce shortages in rural areas through use of supervised clinical student placements, pooling Network resources to purchase additional speech pathology services System impediments limiting the capacity of the primary health care networks included lack of agreement about their purpose, extent to which they complement rather than duplicate existing collaborative structures and initiatives, lack of shared governance, lack of visibility and influence, of coordination roles, strategic support & promotion from the Department of Health, membership benefits, roles & responsibilities,	use of single assessments and integrated referral pathways			

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
appropriate alignment with other boundaries for planning				
Community health services				
(Swerissen H, McMillan J et al. 1998); Study date: undated; Evidence & quality criteria: 4 B2				
Just under one half (44%) of Victorian community health services offered a general practice service on site, with just under 30% provided by private practitioners who used the Community Health Centre premises. Just under a one third had GPs on staff that were employed for specific programs, eg family planning, rather than for general medical practice Approx one third of Victorian Community Health Services had developed eligibility protocols for one or more of their services, in addition to standard government access criteria, with most common restrictions being income based, followed by target group. However only two Community Health Services had considered systematic and ongoing involvement of GPs in the				

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
development of these protocols Both Community Health Services and Divisions of General Practice expressed dissatisfaction with their relationship				
(Burgell Consulting Pty Ltd, O'Leary & Associates et al. 2002); Study date: 2000/01; Evidence & quality criteria: 4 B2				
No preferred model for GP engagement in Community Health Services salaried, private practice co-location have potential to achieve outcomes & achieve break even financial performance Limited formalised/structured program collaboration between GPs and other Community Health Services staff eg use of common assessment frameworks, client assessment tools, planned service development meetings. However, informal collaboration is frequent Client information systems & performance monitoring arrangements impede effective collaboration	GP service delivery in Victorian Community Health Services demonstrated capacity to meet complex primary care needs of socially disadvantaged groups. Variation re the extent of involvement in full range of programs/service types. Infrequent involvement in prevention GPs in Victorian Community Health Services are likely to refer their clients to allied health professionals than their colleagues in private practice Work in collaboration with Community Health Services, other community services in response to complex social health	GPs in Community Health Services more likely to service disadvantaged groups & clients with complex heath needs including mental health and drug and alcohol, than their colleagues in private practice. GPs in Victorian Community Health Services often provide the only affordable and accessible medical services for low income residents in rural and remote communities		Great variation in cost performance suggest that in comparison with private practice colleagues, GPs in Victorian Community Health Services they provide longer consultations associated with greater level of needs and complexity

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
	problems			
(Bayram C, Ng A et al. 2006); Study date: 2005; Evidence & quality criteria: 4 B1				
Community Health Services GPs were more likely to work in larger practices with 5+ GPs	Almost half GPs in Community Health Services had other health professionals involved in their care Community Health Services GPs made more referrals to allied health professionals, reflected in higher rates to pharmacists Community Health Services GPs were more likely to bulk bill all patients 64.8% compared with BEACH GPs in Vic 20.8% Trend towards increased number of indirect encounters ie patient not seen by the GP	Patients more likely to be younger and middle aged patients, hold Commonwealth concession card & be from non-English speaking backgrounds - suggestive of seeing more disadvantaged group		No significant differences in ordering rates of pathology tests or imaging
GP Funding - Enhanced Primary Care Enhanced Primary Care incentive				
(Wilkinson, McElroy et al. 2002a); Study date: 1999/2001; Evidence & quality criteria: 2 A1				
		Steady increase in uptake of Health Assessments over 2000/01, stabilising at around 13,000 per month. From a slow start, the number of care plans increased rapidly in 2001 to about 15,00 per month,		

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
		associated with introduction of Practice Incentive Payments to encourage uptake and steady but slow increase in numbers of case conferences reaching 8-9,000 per month		
(Wilkinson, McElroy et al. 2002b); Study date: 1999/2001; Evidence & quality criteria: 2 A1				
		Evidence of higher uptake in rural areas of Health Assessments in relation to need		
(Wilkinson, McElroy et al. 2003b); Study date: 1999/2001; Evidence & quality criteria: 2 A1				
		No evidence of differential uptake in disadvantaged areas ie lower rates, even though they have fewer doctors		
Author; (Blakeman, Harris et al. 2001a); Study date: 2000; Evidence & quality criteria: 4 B2				
Ltd practice capacity to use the items, eg age sex registers in early days of Enhanced Primary Care incentive, considered an important factor in low level of uptake				
Author (Blakeman, Harris et al. 2001b); Study date: 2000; Evidence & quality criteria: 4 B2				
Major barriers to coordination of care included lack of established communication channels with other health care				

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
professionals				
(Wilkinson, Mott et al. 2003a); Study date: 2001/02; Evidence & quality criteria: 2 A1, 4 B2				
Lack of teamwork within practices/access to other multidisciplinary providers was identified as a barrier to care planning claims Lack of engagement of and support for allied health providers within Enhanced Primary Care incentive claims Many practices have established new systems including use of information technology to conduct their health assessments & care planning,	Variable uptake of Enhanced Primary Care incentive by practices, with a minority of practices accounting for majority of claims Practices are making more use of Practice Nurses. Satisfaction with Enhanced Primary Care incentive was high amongst consumers and GPs Still not optimal claims at 12 months post introduction	Generally low uptake of case conferencing claims	Satisfaction with Enhanced Primary Care incentive was high amongst consumers Consumers generally satisfied with care plans, helping them to feel they had control over their own health, kept other providers informed and was reassuring	
(Blakeman, Zwar et al. 2002); Study date: 2001; Evidence & quality criteria: 4 C				
	Improved communication with other health professionals & more comprehensive and consistent care		Provider reported improved patient understanding of their condition, & increased patient satisfaction	
(Naccarella, Tacticos et al. 2005); Study date: 2002; Evidence & quality criteria:4 C				
Divisions of General Practice capacity to support implementation of Enhanced Primary Care incentive is variable, but included employing				

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
Enhanced Primary Care incentive coordinators and Practice Nurses to do health assessments.				
(Lewis, White et al. 2003); Study date: undated; Evidence & quality criteria: 4 B2				
			Subjective improvement in quality of care, knowledge of their condition & management reported by elderly patients & those with chronic conditions	
(Urbis Keys Young 2005); Study date: 2005; Evidence & quality criteria: 2 A1; 4 B1; 3 C				
Few number of accredited Home Medication Reviews pharmacists Variable level of contact between the GP and consumer after the Home Medication Reviews report has been delivered. The pharmacy does not consistently receive a copy of the Medication Management Plan Almost all Divisions of General Practice have MMR facilitators, which provide support for GPs Economic analysis limited by lack of reliable outcomes data	Referrals have been considerably lower than was estimated in 2001.	Between late 2001-April 2005 there were over 70,000 Home Medication Reviews conducted across Aus Groups under serviced include CALD, indigenous, people living in rural and remote areas. Approx 74% of Home Medication Reviews have been for people aged 65 and over, 62% for women		.
GP Funding – Service Incentive Payments				

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
(Georgiou, Burns et al. 2004); Study date: 2002; Evidence & quality criteria: 4 B1 & 4 A1				
Average ratios of diabetes Service Incentive Payment claims to estimated diabetes prevalence was higher in Divisions of General Practice with more disadvantaged population & more of their GP members in large practices ie more than five GPs	Service Incentive Payment claims to estimated diabetes prevalence was not associated with proportion of practices using practice nurses			
GP Funding - Access to Allied Psychology Services				
(Winefield, Marley et al. 2003; Kohn, Morley et al. 2005); Study date: 2001/02; Evidence & quality criteria:3 B2 &4 B2				
			Consumers appreciate improved access to high quality care and believe has transferred into better outcomes.	
(Hickie, Pirkis et al. 2004); Study date: 2003/04; Evidence & quality criteria: 2 A1 & 4 B1				
In first 15 months, approx 15% of GPs had been certified as eligible to participate				
(Kohn, Morley et al. 2005); Study date: 2003/05 Evidence & quality criteria: 1 A2 & 4 B1				
GPs have cited a number of benefits re advantages re collaboration with allied health professionals and increased referral options. allied health professionals cite improved relations with GPs and improved referral base	By 2005, 2980 GPs have made referrals to 1040 allied health professionals since projects began – a dramatic increase in participation rates by both GPs & allied health professionals over time, from 417 GPs making referrals to 118 allied	By 2005, 26,440 patients had accessed the program – an increase from an average of 11.5 per day in 2003 to 46.1 per day in 2005 The profile of consumers has remained fairly consistent over time, & is	Providers report that consumers appreciate improved access to high quality care and believe has transferred into better outcomes Co-payments identified by consumers as a potential a barrier to access and	

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
	health professionals July-Sept 2003 to 1266 and 627 by April-June 2005.	well aligned with the target group that projects are designed to reach.	source of dissatisfaction	
(Vagholkar, Hare et al. 2006); Study date: 2004/05; Evidence & quality criteria: 1 A2 & 4 B 2				
	The predominant reasons for referral were depression and anxiety.		Patients appeared to improve after completing their treatment: in general from severe levels of depression and anxiety to normal or mild levels.	
(Pirkis, Morley et al. 2005); Study date: 2005; Evidence & quality criteria: 4 B1 & 2 A2				
Variety of contractual arrangements for retaining allied health professionals No models emerged as being associated with higher levels of access – all performing equally well, and have been adapted over time to meet local needs				
(Morley, Kohn et al. 2006); Study date: 2003/05; Evidence & quality criteria: 4 B1 & 2 A2				
A mix of models are being used, depending on local contexts & needs Rural projects more likely to implement direct referral systems 64% c/f 38% in urban projects & less likely to use register systems 17% c/f 32% in urban projects. Direct referral	Average project related case-load is higher for rural allied health professionals	Higher uptake rates in rural areas	No difference in rural/urban outcomes- both positive	

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
tends to operate where allied health professionals is co-located with the GP Greater tendency for rural projects to employ allied health professionals 37% c/f 21% urban Workforce issues differ for urban and rural projects. Urban projects experience challenges in workforce shortages, availability and coordination with other serves; whereas rural projects have experienced difficulties in attracting allied health professionals and a lack of training and support for GPs				
Practice Nurses				
(Healthcare Management Advisors P/L 2005); Study date: 2004; Evidence & quality criteria: 4 B1 & 4 B2				
Increase in uptake of 40% since Feb 2002, increases in the number of Practice Nurses employed in practice of about 30%, 80% of Practice Nurses & GP saw Role of Practice Nurse as linkage between practice and other services, particularly other primary health care	Increase in number of sessions conducted by Practice Nurses of about 25 Greater throughput of patients in 70% of practices with Practice Nurses when had own appointment systems & saw patients following the GP	↓ waiting time 50% of practices		More likely to be viable & sustainable in larger practices (qualitative information) GP opinions re fees - 13.8% increase - 4.4% decrease - 61.6% no change

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
services and other community services. Provided opportunities for rural GPs to link more effectively with the range of health professionals required to support the care of their patients In 2003, all Divisions of General Practice offered Practice Nurse training and support programs up substantially from previous years, and 94% of Practice Nurses were supported by their Divisions of General Practice. This training & support component has permitted a range of 'best-practice' support models to be developed, including Divisions of General Practice contracting Practice Nurses to GPs. However awareness amongst GPs, of the training and support projects was not high +ve impact on quality of primary health care provision, through accreditation, sterilisation techniques, improved recall systems for chronic	Increased available GP time 45% of practices +ve impact on quality of primary health care provision, through role in HA, care planning for aged and chronically ill			

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
conditions Uptake of scholarship scheme has been lower than intended knowledge of scheme not widely spread, with up-skilling more popular than re-entry component More clinical role focus than previously incentive payments perceived as affecting role				
(Watts, Foley et al. 2004); Study date: undated; Evidence & Quality criteria: 4 B2				
Heterogeneity, yet underlying similarities re roles: specialist generalist role, not unlike GPs, including: clinical care, clinical organisation, practice administration, liaison Model of the role characterised by flexibility & adaptability, shaped by a range of factors including professional characteristics of the Practice Nurse, the practice's patient population, business orientation of the practice, localised practice and community resources, national level structural				

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
arrangements Training/ongoing education largely informal, and ad hoc, delivered by Divisions of General Practice & tailored towards GP environment, focussed on National Health Priority Areas Minimal education available to assist GPs to work effectively as a team with Practice Nurses				
GREAT BRITAIN				
Primary Care Groups/Trusts **No results for impact on access, health outcomes, other parts of the health system**				
(Craig, McGregor et al. 2002); Study date:1998-99; Evidence and Quality Criteria: 4 B2				
Shifts from secondary to primary care, small, non strategic piecemeal, not underpinned by resource shifts & primary care commissioning not seen by HA & Trusts as a major driver of change				
(Alborz, Wilkin et al. 2002); Study date:1999/2000; Evidence and Quality Criteria: 4 B1				
Most have structures for community & consumer consulting, but not very effective yet, early days in Primary Care Group/Trust development				
(Dowswell, Wilkin et al. 2002a); Study date:1999; Evidence and Quality Criteria: 4 B2				

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
Nurses reported that they had not been well prepared for their new role on the board and perceived that their influence on decision making was limited.				
(Dowswell, Harrison et al. 2002); Study date:1999/2000; Evidence and Quality Criteria: 4 C				
Most GPs recognise the centrality of Primary Care Groups in management and accountability. However few believed that they would be much affected personally. GPs see the creation of Primary Care Groups to be associated with some erosion of autonomy through application of management through the Primary Care Group but they are unlikely to resist actively				
(Holtom 2001); Study date:1999/2000; Evidence and Quality Criteria: 4 C				
Barriers for greater intersectoral collaboration between Primary Care Group & social services include differing boundaries. History of suspicion and lack of consultation between HA & GPs				
(Regen and Smith 2002); Study date:1999/2000; Evidence and Quality Criteria: 4 B2				

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
Most early progress re Primary Care Group/Trust involved commissioning of community services & primary/secondary interface, and intermediate care, rather than secondary care More needs to be done to shift the focus of GPs from primary care issues and the delivery of GP services towards the wider health improvement agenda. While nurses represented on boards, their level of influence was less than GP members Low participation in Primary Care Groups by non board member GPs	3/4s of those interviewed reported specific local service developments to improve health that were directly attributed to the work of their Primary Care Group/Primary Care Trust.			
(Thomas, Coleman et al. 2003); Study date:1999/2000; Evidence and Quality Criteria: 4 B1				
	Limited uptake of complementary and alternative medicine services in Primary Care Groups/Primary Care Trusts			
(Wilkin, Gillam et al. 1999); Study date:1999/2000; Evidence and Quality Criteria: 4 B1				
Early days with Primary Care Groups and little progress with developing information management systems, commissioning,				

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
developing health improvement plans, partnerships with other services, engagement with primary care professionals other than GPs. However good progress on clinical governance Key obstacles included inadequate infrastructure, support from HA, information management and the pace of change.				
(Willcocks 2003); Study date:1999/2000; Evidence and Quality Criteria: 4 C				
Some progress of Primary Care Groups/Trusts in influencing culture change in relation to clinical governance - consistent with strong national focus on clinical governance				
(Dowswell, Wilkin et al. 2002b); Study date: 2000; Evidence and Quality Criteria: 4 B1				
In most areas Primary Care Trust's were consulting with nurses to develop policy. The impact of this was variable, being greater for health improvement and clinical governance than for prescribing or service commissioning	Majority of Primary Care Trusts were developing nurse led services to improve access			
(Glendinning, Coleman et al. 2001); Study date: 2000; Evidence and Quality Criteria: 4 B1				
One third of Primary Care Groups/Trusts still have no				

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
subgroup that handles commissioning. In those with a sub group, membership is heavily biased towards GPs, community nurses. Other practice staff less well represented. Only two fifths of sub groups involve reps from social services. Most focus on consultations with social services about commissioning community health services. Greatly improved relationships between GPs & social workers, community health services & social workers in over one third Primary Care Groups/Trusts Boundary differences remain a barrier to aligning planning & delivery of health services				
(Gillam, Abbott et al. 2001); Study date: 2000; Evidence and Quality Criteria: 4 B1				
Primary Care Groups/Trusts have made progress in developing capabilities to undertake health improvement role, but face shortages of skilled staff in this area, eg	By 2000, most common health improvement initiatives funded by Primary Care Groups/Primary Care Trusts were community development projects,			

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
public health. Greater commitment to addressing poverty/deprivation as priorities apparent in 2000. Coronary heart disease & mental health were most common targets for health improvement both priorities of National Service Frameworks & national performance indicators.	leisure, exercise/recreation programs both 32% & support for carers 27%			
(Wilkin, Gillam et al. 2001); Study date:2000; Evidence and Quality Criteria: 4 B1				
Progress in developing information management systems, with more staff and a greater focus, but this still remains inadequate. By 2000 more progress in some areas: with more nurses being consulted, efforts to consult local communities, mainly through Community Health Councils, but little progress in involving lay people, NGOs, or local authorities in the work of Primary Care Groups Commissioning has become a high priority	By 2000, many Primary Care Groups/Trusts had introduced initiatives to improve access, most commonly through out of hours services, nurse led services, pharmacist led services, information on self care, telephone advice lines and improvements for poorly serviced areas			

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
influenced by the National Service Frameworks. In relation to clinical governance, practices are sharing information and participating in collective learning activities With primary care development, the integration of practice and community nursing has assumed a high priority; with priorities for primary care investment including prescribing support, information technology equipment, nursing staff, clinical governance and medical staff				
(Regen, Smith et al. 2001); Study date: 2000; Evidence and Quality Criteria: 4 B2				
More progress re commissioning of community services during first 17 months, than acute care HA management support to Primary Care Groups regarded as variable Focus on establishment of information technology infrastructure at practice level upgrading, standardisation, internet	Increasing focus on service development, a major driver being health improvement, despite obstacles Areas include coronary health disease & mental health associated with two National Service Framework areas, diabetes, sexual health.			

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
connections Board member contribution variable, with GP dominance Need to engage other professions acknowledged as future priority, including practice nurses Beginning to implement strategies for user involvement				
(Wilkin, Dowswell et al. 2001); Study date: 2000; Evidence and Quality Criteria: 4 B1				
By late 2000 collaboration and sharing of resources by practices in Primary Care Groups/Primary Care Trusts ranged from 25% minor surgery to counsellors 65% and 67% out-of-hours centre, with shared resources to enhance workforce capacity including employing NPs and salaried GPs 28% for both, extending the role of pharmacists 26%,	By late 2000 the most common strategies to improve access to primary care included targeting poorly served areas or groups 32% and reducing waiting times 23%			
(Wilkin, Bojke et al. 2003); Study date:2000; Evidence and Quality Criteria: 4 B1				
There was no evidence that larger Primary Care Group/Trusts were performing any better or worse than smaller ones in				

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
key areas of activity such as primary care development and quality improvement.				
(Charles-Jones, Latimer et al. 2003); Study date:2000/01; Evidence and Quality Criteria: 4 C				
Perceptions of GPs re changes brought about by Primary Care Trusts: increasingly practices are allocating patients and patient problems according to a hierarchy of appropriateness based on the expertise needed to manage them. GPs are moving from a patient centred approach to a more biomedical role as the consultant in primary care in order to achieve improved accessibility and better manage resources.	Many practices are introducing nurse triage to manage patients' requests for same day appointments.			
(Wilkin, Coleman et al. 2002); Study date:2002; Evidence and Quality Criteria: 4 B1				
Almost all Primary Care Groups were commissioning Community Health Services Non congruent boundaries remain a problem in Primary Care Trusts establishing partnerships with other agencies. Most have focussed on aged care and social	Over half Primary Care Trusts had nurse led services to improve access to primary care, 54% had reduced waiting times for appointments and 53% had extended the role of pharmacists. Substantial increase in range of services available in primary care including counselling 74%, specialist nurses 67% and specialist			

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
services. However many social service still reporting collaboration difficulties with Primary Care Trusts, but changes over time from focus on clinical issues as problems to more structural issues. Increasing use of data by Primary Care Trusts from practices & sharing information on quality between practices	GPs 62%. 82% had Personal Medical Services schemes in operation many to target underserved groups			
(Audit Commission 2004); Study date:2003; Evidence and Quality Criteria: 4 B1				
Primary Care Trusts felt little capacity to implement new General Medical Services contract Five out of nine Primary Care Trusts were developing new and expanded roles for nurses and pharmacists in order to take on some of the work traditionally done by doctors Many Primary Care Trusts were aiming to shape general practice using growth moneys, Personal Medical Services				

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
contracts, Practitioners with Special Interests and quality frameworks. However some felt powerless to effect real change at the practice level Ability of Primary Care Trust to shape general practice relates to history of Primary Care Trust & relationship with general practice at the local level				
Local Health Care Cooperatives				
(Craig, McGregor et al. 2002); Study date: 1998/99; Evidence and Quality Criteria: 4 B2				
Shifts from secondary to primary care, small, non strategic piecemeal, not underpinned by resource shifts & primary care commissioning not seen by HA & Trusts as a major driver of change				
(Goldie and Sheffield 2001); Study date: 1999; Evidence and Quality Criteria: 4 C				
Role tensions re engagement of Local Health Care Co-operative in Primary Care Trust & Health Board planning & disagreements in how shift in balance between primary & secondary care was to be achieved				

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
Early implementation issues included budget devolution, retaining savings who and level of retained, engagement of Local Health Care Co-operatives in strategy and planning, approaches for shifting to primary health care, and need for capacity building, culture change re management style				
(Audit Scotland 2001); Study date: 2000; Evidence and Quality Criteria: 4 B1				
Local Health Care Co-operative boards generally represent a number of disciplines and perspectives, especially GPs, nurses and more public participation found compared with Primary Care Groups in England although still limited. Lack of congruent boundaries with Local Authority, with some Local Authority needing to establish relationships with up to 11 Local Health Care Co-operatives. Larger Local Health Care Co-operatives have more structures & relationships for working in partnership	More than 50% of Local Health Care Co-operatives engaged in some work on reducing inequalities in access More than 70% of Local Health Care Co-operatives directly manage at least one service, mainly allied health, with top three being physiotherapy, podiatry and occupational therapy. Very few managing community mental health services			

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
than do smaller Local Health Care Co-operatives				
(Simoens and Scott 2003); Study date: 2000; Evidence and Quality Criteria: 4 B1				
Major finding is of heterogeneity of organisational structures, modes of operation & decision-making , relationships among participating structures, and management costs Marginal representation in Boards of for eg mental health, local councils, voluntary services, lay representatives that was foreshadowed in the policy. Dominant style of partnership that governed the relationship between participating practices was coordination ie working together to deliver common objectives, followed by co-evolution ie working together in the presence of less clearly defined common objectives and uncertain ways to achieve those objectives. Good Local Health Care Co-operative leadership, good working relationships between participating				

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practices and enthusiastic GPs were the major facilitating factors				
(Simoens and Scott 2005); Study date:2000; Evidence & Quality Criteria: 4 B1				
General practices from disadvantaged areas over represented in Local Health Care Co-operatives				
Personal Medical Services				
(Chapple, Macdonald et al. 1999); Study date:1998; Evidence and Quality Criteria: 3 B2 & 4 B2				
		Service provides point of access, continuity and stability in a deprived area	Patient satisfaction high, and they value excellent communication with staff	
(Campbell, Steiner et al. 2005); Study date:1998-2001 paper from Nat Personal Medical Services evaluation; Evidence and Quality Criteria: 4 B1				
Catalysts for quality improvement in Personal Medical Services sites – teamwork, shared culture, clear objectives and leadership	Improvement in quality of care in Personal Medical Services sites in all areas of care only angina, and elderly care was statistically significant. There were greater improvements in Personal Medical Services sites that had a specific objective to improve certain aspects of care e.g. mental health			
(Steiner A, Campbell S et al. 2002); Study date:1998-2001 Personal Medical Services national evaluation report; Evidence and Quality Criteria: 4 B1 & 3 B1				
Mental health: Personal Medical Services improved significantly in developing protocols & procedures & becoming more patient	Quality of care improvements for aged clients Personal Medical Services		While mental health scores improved slowly but steadily, remain well below that set by National Service Frameworks	Average annual increase of 5% in funding to Personal Medical Services over and above what General Medical Services

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focussed. In all areas of clinical effectiveness, Personal Medical Services embraced teamwork models & protocol development went together with team approaches usually featuring nurses in key roles & supported by protocols	made fewer improvements to practice access than General Medical Services practices, eg telephone contact/scheduling appointments No difference between General Medical Services & Personal Medical Services re patient assessment of their quality of primary care, except for continuity of care with particular GP which declined at a faster rate for Personal Medical Services practices			receive mainly due to staff costs
(Carter Y, Curtis S et al. 2002); Study date: 1998-2001; Evidence and Quality Criteria: 4 B1				
Achieved recruitment of GPs to deprived areas, but still remains a challenge Nurse role enhancement achieved. NPs fundamental to development of some Personal Medical Services schemes, by taking a lead, providing support for GPs and partnering with them. Key to NPs success with vulnerably clients was their flexibility & ability to work holistically	Half Personal Medical Services sites in sample reported improved access to health care through a variety of ways ranging from open access appointments to outreach to community development work Sites targeting minority ethnic groups found progress, but very slow - may have underestimated the complexities of the task	Improved access & enhanced availability of services for vulnerable client groups		

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Emergence of new inter professional relationships and partnerships, providing the basis for intersectoral collaboration				
(Riley, Harding et al. 2003); Study date: 1998-2001 sub set of Carter; Evidence and Quality Criteria: 4 B1				
Personal Medical Services enabled a change of cultural values in primary care especially regarding GPs relationships with nurses and practice staff. However Personal Medical Services has not necessarily led to equal partnerships within primary care teams. Rather new inter-professional relationships emerged, which form the basis for further improved intersectoral collaboration	In Personal Medical Services pilots with explicit focus on vulnerable populations, the GP based medical model has made way for a community oriented/public health models with emphasis on health maintenance for the vulnerable			
(Sibbald B, Petchey R et al. 2002); Study date:1998-2001; Evidence and Quality Criteria: 4 B1				
Salaried GP job satisfaction was comparable to other GPs eg in General Medical Services Salaried GPs reported more problems with professional isolation & working conditions Salaried contracts successfully addressed		Modest improvement in access to primary health care but not stat significant		

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
some factors limiting GP commitment to work in deprived areas				
(Walsh N, Andre C et al. 2002); Study date:1998-2001; Evidence and Quality Criteria: 4 B1				
Range of organisational models established: new organisational structures, modifying existing organisations eg mergers, loose arrangements to work together. Establishment took considerable time, with building trust, building teams, changes in personal power and influence, input into decision-making all big issues they faced/experienced Support for establishment from community trusts/Primary Care Groups/Primary Care Trusts was critical Clinical competence was an issue in all pilots for both nurses & GPs, with a variety of mechanisms being employed to address Marked changes in new roles for nurses. Most successful in sites where doctors, nurses &		Some sites are providing access to groups previously un serviced		

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managers have negotiated changes with one another & nurses have received training and support. Restrictions re prescribing & ambiguities re referring to secondary care have been barriers to nurse role development. Changes in nature as well as volume of work with nurses taking on straightforward problems & GPs seeing increasing numbers of patients with complex needs, and appointments have been reviewed and lengthened to accommodate this type of work.				
(Chapple 2001); Study date: 2001; Evidence and Quality Criteria: 3 C				
			Some evidence that patients support nurse led Personal Medical Services	
(Leese and Petchey 2003); Study date: 2001; Evidence and Quality Criteria: 4 B1				
Major obstacles included recruitment & retention & high staff turnover creating uncertainty HA considered nurse led/nurse enhanced pilots, those employing salaried GPs & those where there had been changes to staff roles & responsibilities to be most successful re achieving the original				

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objectives HA identified problems with lack of funding and staffing as key barriers to providing additional services Lack of additional funds to provide additional services & problems with setting budgets also major obstacles				
(Shaw, de Lusignificantnan et al. 2005); Study date: not stated; Evidence and Quality Criteria: 4 C				
Some Personal Medical Services used to stimulate development of primary care team, but with others the lack of agreed goals, recruitment difficulties inadequate communication and hierarchical structures prevented these developments				
(Sheaff and Lloyd-Kendall 2000); Study date: not stated; Evidence and Quality Criteria: 2 A2				
Few contracts mentioned integrated working between district nurses, health visitors or Practice Nurses. None specified any division of clinical labour even where a NP was to be introduced. Contract incentives rarely linked to contract				

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objectives and rarely stipulated services to be provided when and by whom				
(Walsh, Roe et al. 2003); Study date: not stated; Evidence and Quality Criteria: 4 C				
Personal Medical Services Nurses saw their roles as being different to Practice Nurses who did not diagnose or prescribe treatment & saw only part of the patient's journey and district nurses ie did no wound management. The diagnosis, treatment & review of undifferentiated conditions are what make these nurses different, in many instances their roles overlapped with GPs - acceptable to both parties when negotiated through regular dialogue less evidence in Trust based pilots- where senior trust managers keen to manage Personal Medical Services pilots as any other Current structures do not support nurse held Personal Medical Services contracts to develop a different model of primary care, eg little support at either national/local level to	Nurse led/multidisciplinary led pilots delivering more community oriented services			

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assist with contract negotiations. Also regulatory obstacles eg prescribing roles, signing sick certificates. Liability & negligence issues need attention as nurses take on roles previously carried out by GPs Extending nurse roles happening to varying degrees, extended clinical role to include diagnosis, treatment & management of chronic disease, referrals to specialists - but took time to establish and get accepted. Clinical competence was an issue in all pilots for both nurses & GPs, with a variety of mechanisms being employed to address eg consultations with medical advisers, attending courses, clinical governance approaches eg reviewing clinical decisions with more senior clinicians				
General Medical Service contract				
(Sutton and McLean 2006); Study date:2004/05; Evidence & Quality Criteria: 2 A2				
Quality scores increased with the size of the clinical team, although team				

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composition was not a factor				
(Doran, Fullwood et al. 2006); Study date:2004/05; Evidence & Quality criteria: 2 A2				
Socio-economic and demographic factors had little effect on practices' achievement re quality. Smaller practices performed marginally better than larger ones.				
Primary Care Mental Health Workers				
(Crosland, Harrington et al. 2003); Study date:2002/03; Evidence and Quality Criteria: 4 B2				
Practice team work and community work roles highly valued by managers and colleagues in theory, but many Primary Care Mental Health Workers had only recently started in their positions. Few graduates were having any contact with other primary health care workers, including GPs, and there was a sense that other workers were unaware of their roles Early days, lack of career alternatives and low level of remuneration were identified by new Primary			Too early to tell whether work clinically effective	

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
Care Mental Health Workers as potentially affecting motivation and retention. The competencies of supervisors are considered a priority need to be addressed.				
(Lester, Freemantle et al. 2006); Study date:2003/04; Evidence and Quality Criteria: 3 B1 &4 B1				
Practices & workers who seemed to work most effectively ie mutual satisfaction with role appear to share a number of characteristics: - regular feedback between practice and Primary Care Trust, - clear lines of communication with a senior staff member and - protected time to discuss issues with the practice			No significant difference in mental health symptom scores, associated with a Primary Care Mental Health Workers Higher levels of patient satisfaction in practices with Primary Care Mental Health Workers	No difference in use of voluntary sector or health service costs associated with a Primary Care Mental Health Workers
(Harkness 2005); Study date:2004/05; Evidence and Quality Criteria: 4 B1				
Lack of a career path affecting motivation Slow implementation: only 500 half target by 2005 A third not integrated into primary care as was the aim 66% managing patients,	Often not first point of contact 50% were specialist mental health referrals 72,000 new patients expected to be seen based on estimates from postal survey of GPCMHW c/f 300,000 policy expectation	Low rates of access for children, people 65+, and ethnic backgrounds		Less than 20% of patients referred on for further mental health treatment

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
99% team working, 96% networking so less patient contact role than expected	The majority seen for common mental health problems			
(Bower, Jerrim et al. 2004); Study date: undated; Evidence and Quality Criteria: 4 C				
Differences in role expectations and in practice, with the latter almost exclusively related to client work; with little broader role as per guidelines – disagreements and ambiguity also re nature of new Primary Care Mental Health Workers role in client work and relationships with other mental health staff & hence potential for role conflict				
NEW ZEALAND				
Primary Health Organisation **Aim: Improve health and reduce health inequalities**				
(Perera, McDonald et al. 2003); Study date: 2003; Evidence & Quality criteria: 4 C				
There is strong support for the Strategy and its goals Anticipated changes re collaboration & team approaches associated with implementation of the Primary Health Care Strategy & development of Primary Health		Patient co-payments had decreased in all 'Access' funded practices. Opinions varied with regard to whether reduced fees had made a difference to patient access and utilisation rates		

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
Organisations District Health Boards were noted to be generally supportive of the Primary Health Organisation establishment process, & overall the ongoing relationship of Primary Health Organisations with individual District Health Boards was described as being good Processes for enrolment & payment noted to be cumbersome Enrolment funding tied to practices who are members of Primary Health Organisations – so powerful position of practices verses other non-revenue generating providers whose clients are not recognised unless registered with a practice Overall funding levels were seen to be limited. In particular the funding streams for health promotion and management costs were felt to be inadequate				

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
(Hefford, Crampton et al. 2004); Study date: July 2002-Sept 2003; Evidence & Quality criteria: 2 A1				
		Evidence of more people from Maori & PI groups getting improved access to low cost care with the implementation of the Primary Health Care Strategy		
(CBG Health Research Limited 2004); Study date: March 2004; Evidence & Quality criteria: 4 C				
There is potential for greater utilisation of the nursing role in Care Plus, & while evaluations have found that Care Plus allows full utilisation of nursing skills & increases nursing profiles, input from GPs and nurses varies, & can be constrained by funding, time & practices' support of autonomous nursing practice			Some patients expressing a negative attitude towards nursing consultations	
(Wyllie 2004); Study date: March-May 2004; Evidence & Quality criteria: 3 B1				
44% were aware of Primary Health Organisations, and just over half of these knew or thought their usual GP belonged to a Primary Health Organisation. There was widespread support for the three components of the Primary Health Care Strategy, ie a focus on keeping people well, use of		People paying less fees in Access Primary Health Organisations. Excluding reasons for fee decreases not related to the Primary Health Care Strategy, 8% of the 78% who had visited a GP in the last twelve months reported paying less than usual on their most recent visit, while 11% reported paying more		

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
a greater range of health professionals and community consultation.				
(Cumming, Raymont et al. 2005); Study date: April 2004- March 2005; Evidence & Quality criteria: 4 C				
Planning in Primary Health Organisations around new services still in early stages Population health issues beginning to be addressed, with innovative programmes related to changing health determinants and identifying populations with low use of services. Improved enrolment data were seen to allow better estimation of population health need and to facilitate targeting of services on the basis of need Governance arrangements varies & community members well represented on boards General agreement that Primary Health Organisation management required a large input of time & money. Small Primary Health Organisations were	The Strategy was seen to be providing opportunities to improve patient care through more flexible service delivery with a focus on prevention Freedom from fee-for-service funding was reported to allow some practitioners in 'Access'-funded practices to spend longer with patients, allowing a greater focus on education and prevention In general, informants suggested new service developments would depend on the resources available. 4 types of new services were identified: those offering greater accessibility and acceptability; secondary care liaison; condition/disease specific clinics; and extra-practice services	3.9million enrolled by 2004 By Oct 2004 it was generally agreed fee reductions had improved access to care. Felt by some respondents that the delivery of low-cost care, a key goal of the Strategy, has yet to be achieved for all patients.		

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
struggling with inadequate management resources while large ones were trying to establish and maintain adequate communication with practices. New programmes require an expansion of managerial capacity, & it was easy to take on too much There are many opportunities under the Strategy for enhancement of nursing practice, although individual general practices vary enormously in nursing development. There is also concern that the medical and nursing workforce may be inadequate to the tasks required by the Strategy Individual practices varied enormously in the degree of nursing development, depending mainly on the preferences of the GPs as employers. May key informants saw workforce capacity GPs and nurses as a major issue for the immediate future				

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
Time & effort & money spent in establishing/upgrading systems and infrastructure, including patient enrolment data and information technology systems There is strong support for the Primary Health Care Strategy and its goals However, some GPs were concerned that their role had been inadequately recognised in the Strategy and were worried about the long-term financial implications for themselves and their practices [arising from the move to capitation and government policies relating to user charges] and about perceived moves towards greater control of general practice by government. Some practitioners have come to believe that the prospects are positive in a financial sense and expressed an optimistic view of the Strategy				
Primary Care Organisation: Not-For-Profit community-governed				
(Crampton, Dowell et al. 2000b); Study date: 1996/97; Evidence & Quality criteria: 2 A2				

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
		Utilisation rates in not for profit Primary Care Organisations for doctor, nurse and midwife combined were higher amongst the young, elderly and community service card holders. For males they were higher amongst those living in the most socio-economically deprived areas, but not for females. However, overall utilisation rates appear to be somewhat lower than utilisation rates of fee-for-service practices 53.9% compared with about 80% of the general population		
(Crampton, Dowell et al. 2000a); Study date: 1997/98; Evidence & Quality criteria: 4C & 2 A2				
Variety of legal structures in community governed non-for-profits, with most being incorporated societies. Patients and community members represented on the board of management in most and staff in 2/3rds, almost all employ staff on salaries, except one in which the doctors were self employed Community governed				

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NFPs had high patient:doctor ratios generally over 2000 c/f NZ wide variation of 1070-1916, which could be accounted for by expanded role of nurses, service patterns and incentive structures inherent in capitation				
(Crampton, Dowell et al. 2001); Study date: 1997/98; Evidence & Quality criteria: 4C & 2A2				
Location of services governed by needs of communities served and located in poor urban areas or remote predominant Maori areas				
(Crampton, Davis et al. 2004); Study date: 2001/02; Evidence & Quality criteria: 4 B1				
		not for profit serve a younger, largely non-European population, with over ¾ holding a means tested benefit card, over 10.5% were not fluent in English, and who lived in areas ranked as most deprived, as measured by encounter data		
(Crampton, Davis et al. 2005a); Study Date:2001/02; Evidence & Quality criteria: 4 B1				
Variability in primary care team composition between community governed not for profit, Independent Practitioners Associations,				

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independent practices: with independent practices more likely to be solo GP, and less likely to employ a nurse or other practice management staff. Community governed not for profit more likely to employ community workers, midwives and other professionals and practice management staff. Irrespective of ownership and governance arrangements, capitation-funded practices as a group employed more nurses and community workers and more Maori staff than fee-for-service practices				
(Crampton P, Davis P et al. 2005b); Study date: 2001/02; Evidence & Quality criteria: 4 B1				
Community governed not for profit's employed on average more doctors, Maori & PI staff, nurses, community workers, midwives than for-profit practices There were no significant difference between non-profit and for-profit practices in the use of computer age-sex register, computerized patient	Significant differences in availability of services between not for profit ie community governed and for profit Primary Care Organisations, with non profits providing more group health promotion, community worker services, dental health, mental health, ante and postnatal care, complementary/ alternative services. For profit			

Impact on infrastructure	Impact on service delivery	Impact on access/utilisation	Impact on health outcomes/ patient satisfaction	Impact on the rest of the health system
records, or computer-based recall systems, but non-profits were more likely to have computerized disease registers In terms of service planning, non-profits were more likely to carry out community needs assessment, locality service planning, All significant P values Non-profits were more likely to have a range of written policies related to quality management than for profits	Primary Care Organisations provided more sports medicine, emergency/accident call out services and specific services for older people Non-profits were more likely to carry out intersectoral case management. All significant P values Not for profit practices had statistically significant lower patient charges for all age groups & waived fees for a higher proportion of patients than for-profit practices			
Primary Care Organisation Primary Care Organisations: Independent Practitioner Associations				
(Malcolm and Powell 1996); Study date: 1994-96; Evidence & quality criteria: 4 B1				
Independent Practitioner Associations characterised by variation in size and the numbers of GP members in the local area GP members rated achieving better health outcomes, making better use of primary care resources, improving and protecting GP status as the most important				

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Independent Practitioners Associations goals Barriers to achieving these goals included lack of time and government policies. A significant proportion of Independent Practitioner Associations members also were in favour of a move to registration/ enrolment and capitation payment, and some had experienced these changes				
(Malcolm, Wright et al. 2000); Study date: Sep – Dec 1998; Evidence & Quality criteria: 4 B1				
By the end of 1998, Independent Practitioner Associations had made progress in applying a new model of clinical governance, with commitment to managing both clinical activity and health resources Moderate success in establishing collaborative external relationships with other providers, including an effective partnership with Maori & good working relationship with the funding authority.	A number of Independent Practitioner Associations reported moderate success in establishing new services and development of integrated care initiatives			

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A number of Independent Practitioner Associations had community reps on their boards and had established other community engagement mechanisms				
(Barnett 2003); Study date: 1999; Evidence & Quality criteria: 4 B1				
Generally high satisfaction with Independent Practitioner Associations leadership, associated with GP involvement in Independent Practitioners Associations activities				
(Houston, Coster et al. 2001); Study date: 1999; Evidence & Quality criteria: 4 B1				
Quality improvement activities included education of staff 96% and GP members 92%; guideline development 92% and implementation 84%; rational prescribing initiatives 84%; peer review 84%; patient satisfaction surveys 64%; clinical audit 64%; and developing quality standards 64%. All Independent Practitioner Associations believed that their roles included improving the quality of care for patients.				

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A number of supports for this role provided by Independent Practitioner Associations included education, guideline development, peer review, clinical audits, patient satisfaction surveys				
(Kriechbaum, Crampton et al. 2002); Study date: 1999; Evidence & Quality criteria: 4 C & 4 B2				
Each of the 4 Independent Practitioner Associations contained 2 tiers of governance structure, a policy tier and a committee tier. Each utilised a peer group review process to provide input to some administrative functions. They were all GP run and led, with little official consumer/community involvement. GP members generally satisfied 82.3% Over 80% of IPA members had no dissatisfaction with their Independent Practitioner Associations and that 25% said they had benefited financially from their membership				