Choice, collaboration, continuity of care: the Rural Women's General Practitioner Service—a ten-year review

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Introduction

More women living in rural and remote Australia have the choice of a female general practitioner due to the expansion of the Rural Women's General Practitioner Service (RWGPS) over the last decade. The RWGPS aims to improve access to quality primary health care services in rural and remote areas which currently have little or no access to a female GP. Working in partnership with local GP practices and rural and remote communities, the RWGPS recruits and facilitates the travel of female GP's, either by air or road to eligible communities. Since 1999, the Department of Health and Aging (DoHA) has funded the Royal Flying Doctor Service (RFDS), which has a long history of service provision in remote Australia to coordinate the delivery of the RWGPS across its four operating sections: Central Operations (Northern Territory and South Australia); Queensland Section (Queensland); South Eastern Section (Tasmania, Victoria and New South Wales); and Western Operations (Western Australia). Each RFDS section works in partnership with rural and remote communities and their medical practitioners, within the RWGPS criteria and guidelines, to ensure that the service is appropriately administered and delivered to meet the individual needs of each eligible community. [1]

This paper reviews the expansion of operation of the RWGPS for the period 1999-2008, drawing on program documentation and reflections on ten years of management of the program by the Royal Flying Doctor Service. The paper identifies key themes in program operation which have emerged over the review period and makes recommendations in relation to meeting challenges and further development of the program.

Providing a choice of general practitioner

The RFDS Rural Women's GP service started life modestly, in the early 1990's as a key initiative of the National Evaluation of Cervical Screening. In the Central Highland area of Queensland, a pilot study was established to provide a rural women's cancer screening service.[2] This included a visiting female GP, providing cervical screening services in hospitals and general practice surgeries in ten towns in 1994. The pilot program used existing facilities that the local community were familiar with and found acceptable. Key success factors in the evaluation of the pilot program were the option of attending a female GP and the convenience of having the service available locally.

The following service delivery principles underpinned the pilot program and continue to support the program today almost 15 years later:

- Recognition that access to a female GP is an important predictor for rural / remote women's participation in preventative health services;
- Recognition that access to a female GP is paramount for cultural and social reasons, for indigenous women and women from non-English speaking backgrounds;
- The need for innovative approaches to service delivery to ensure women access screening services;

- The use of existing resources and infrastructure is maximised.

Although the initial pilot project focused primarily on cervical screening, the recognition of the importance of the delivery principles lead to the development of a more broadly-based preventative health service for women which became known as the Rural and Remote Women's Health Service (RRWHS). During the period 1994 to 1998 the funding continued from Queensland Health under the auspices of the Women's Cancer Screening Service, with administration from the Queensland Divisions of General Practice. In 1998 a Commonwealth Government budget initiative provided funding for a national "Fly-in Fly-out Female GP Service". In July 1999, the Rural Women's GP Service started operations administered by the RFDS National Office and coordinated by the RFDS sections. In the period July 1999-June 2000, the project managers and staff were recruited and the initial communities were identified for inclusion into the program nationally with a number of sites becoming operational, and the forty-one existing operational sites in Queensland being transferred into the management of the RFDS. Queensland Health continues to contribute to the funding of the RWGPS, in Queensland locations.[1, 2, 3]

Although clinic numbers were slow to build up over the first contract period of the RWGPS, patient numbers have steadily increased over the years, with an average of over 12,500 per year over the decade and the actual number of patient consultations totalling 127,287 (Table 1). As patient consultations have increased, the number of Aboriginal and Torres Strait Islander patients has also increased. Sixteen Torres Strait Islands were approved as eligible locations in 2005 and this resulted in a significant increase in access to the service by Torres Strait Islanders. Aboriginal and Torres Strait Islander people account for between 10-15% of patients and this has stabilised at an average of 12.5% of the patients over the last three years. The percentage of male patients seen has remained remarkably similar with an average of 4.5% of the patients accessing the RWGPS being male. This may be viewed as an indication that the female GP's provide the population of the clinic locations with an opportunity to see a GP as a gender choice and/or an opportunity to seek a second medical opinion, which otherwise may involve travelling to the nearest community. As new clinic locations have been approved, the number of clinics conducted has also increased. A visit to an eligible clinic location ranges from a half day visit to a two day visit.[3 to 11]

General Practice services have also been broadened to include health promotion activities conducted in collaboration with visiting and local services and the community. These activities are generally provided upon community request and have been conducted on a range of health topics including menopause, puberty, contraception, and vaccination. The age of the audiences vary from school children across the age spectrum. The size of the audience also varies. Health promotion activities commenced in 2003/4; as an additional inclusion in the funding agreement. Over the last six years, an average of over 700 people per year, have participated in health promotion activities. [3 to 11]

In the last ten years over 500 health staff have been transported, primarily on aircraft chartered by the RWGPS, to rural and remote locations. The transported health staff have been able to provide additional health care to the clinic locations, ranging from diabetes education, family planning, HPV vaccination, delivery of medications as well as health equipment servicing engineers. Emergency food supplies have also been delivered by the RWGPS to communities that have been cut off by floods.[3-11]

Table 1 RWGPS Consultations 1999-2008/9

Financial year	Number patient consultations	Number Aboriginal and Torres Strait Islander patient consultations	Number male patient consultations	Health promotion activities attendees	Number clinics conducted
1999/2000	3,112	Not available	Not available	N/A	224
2000/2001	4,546	688	224	N/A	337
2001/2002	8,897	896	434	N/A	612
2002/2003	11,877	1,332	669	N/A	957
2003/2004	14,737	1,504	648	469	1,087
2004/2005	15,817	1,318	522	246	1,178
2005/2006*	16,323	2,206	684	1,303	1,027
2006/2007	16,094	1,933	718	823	1,062
2007/2008	17,174	2,278	704	843	1,043
2008/2009**	18,710	2,270	806	730	1,164
TOTAL	127,287	14,425	5,409	4,414	8,691

* In 2005/6 the data collection method changed for the RWGPS and statistics indicate that there was a reduction in clinical visits; however this reduction is just a reflection of the new methods for counting clinic visits.
** projected figures; based on six monthly report. [11]

Funding arrangements are a feature of the ongoing viability and accessibility of the service. Funding is allocated in four year funding cycles, and has increased from 8.2 million in the initial funding cycle to 11.5 million in the four year period ending in 2011. Medicare Benefits are also claimed and contribute significantly to the funding of the RWGPS. Under subclause 19 (2) of the Health Insurance Act 1973, Medicare benefits are payable for RWGPS consultations provided to eligible clinic locations by a female GP. Upon recruitment of a female GP for the RWGPS, the GP consents to have their Medicare benefits payable under the program directed to RFDS. All patients using the RWGPS are bulk-billed and no fees are changed for any services including pathology costs.[1]

Expansion of services—collaboration in service delivery

Despite challenges in increasing services, the RWGPS has experienced significant growth over the review period. In order for service delivery to be initiated in a location, it has to be assessed on the basis of meeting all the following eligibility criteria: be at least 50km from a practising female GP, whether temporary or permanent; have a population over 1,000 and have reasonable access to primary health care services provided by a male GP. However, delays in the approval process for eligible locations, difficulty in recruiting suitably qualified female GP's and addressing the concerns of the local GP or health provider can make expansion of services challenging and time consuming.

The number of RWGPS clinics can grow by increasing the number of eligible clinic locations; increasing the number of days the female GP attends the eligible clinic location per visit and increasing the frequency of visits to the eligible clinic location up to a maximum of twelve visits per calendar year. The project managers, in consultation with the local health service providers, consider their budgets, availability of GPs, frequency required to maintain continuity of care, and the number of patients attending to determine the number of days that the female GP should provide a RWGPS clinic to an eligible location. It is recognised that the most cost effective model of service provision is when there is the maximum number of patients attending the clinics per the outlay of travel and human resource costs. However, cost efficiency must be considered alongside the need to provide continuity of care which may require shorter, more frequent clinics. [1]

Over the last ten years, the number of eligible clinic locations has increased by an average of fourteen new eligible clinic locations per year. This has been achieved by continual approval of new eligible locations, and the development of innovative methods of service delivery. [3 to 11] Since the commencement of the program, smaller towns or communities (with populations of less than 1,000) have indicated that they would significantly benefit from receiving the RWGPS. Consequently, two alternative models for service delivery have been developed to enable these small towns or communities to group with other small towns or communities (within relative proximity to each other) and aggregate their populations so as to meet the population criteria to receive the RWGPS. The cluster model involves delivering a service to a cluster of smaller locations with an aggregate population of 1,000. The female GP conducts clinics in the community with the largest population to service the whole cluster area. In the hub and spoke model, the visiting female GP rotates through each of the 'hub' and out-posted 'spoke' locations, providing the RWGPS more frequently in the larger hub locations but also in the smaller spoke locations. [1]

Six monthly reviews are conducted to monitor the appropriateness and eligibility of locations for RWGP services. Due to the constant movement of general practitioners in rural and remote Australia, eligible clinic locations may for a period not meet the eligibility criteria of the RWGPS. The main reasons for this occurrence are likely to be: a female GP starts to provide an equivalent long-term general practice service in an eligible location; a male GP starts to provide a long-term general practice service in an eligible location and requests that female GP service be discontinued, or the male GP in a location ceases to provide services. If any of these situations occur, the RFDS; with due regard to the continuity of care, may withdraw the RWGPS from an eligible location until the situation changes. This location would then become non-operational and the clinic would be put 'on-hold'. Clinics may also become non-operational if a change of female GP is required. For the majority of the eligible locations an overnight stay is required. Due to the distance from the regional centres where many of the GPs live, it can take a number of months to recruit a suitably qualified GP. Over the ten year period of this review, there has been an average of sixty-five per cent of the eligible clinic locations in operation. [3 to 11] In some rural and remote areas, there are difficulties in maintaining a GP workforce and there have been requests in these communities to extend the RWGPS to support the workforce shortages. The RWGPS cannot however be used to fill the workforce shortfall. [1]

Providing "continuity of care" in service delivery

The most successful strategy that the RWGPS has achieved in providing continuity of care is the consistency of service in the community by many of the female GP's. Of the eighty-three GP's currently employed, over fifty per cent have been with the RWGPS for more than 5 years and a number will receive their ten-year long service this year. The RWGPS GP's are the longest serving general practitioner in some clinic locations, having been the only consistent GP with the community over the last decade; with up to five changes to the local GP and numerous locums over this period. The provision of the same GP to a community is especially important in indigenous communities where there is a cultural requirement to build-up a relationship with the provider of medical services, before the trust is built to talk about sensitive women's health issues. [3 to 11]

Integration of RWGPS medical records with those of the local GP also facilitates continuity of care. Patient assessment encompasses the use of the patient's regular medical records and records of care provided, diagnostic results and history taken in the visiting RWGPS consultation are recorded also in the regular medical records. The majority of the clinics are conducted in the local GPs practice rooms which allows easy access to patient's regular medical notes. However in Queensland, the majority of the clinics are

conducted in Queensland Health facilities and these medical records are used by the female GPs along with electronic medical records held by the GP's. [3 to 11]

Looking forward to the next 10 years

Considerations for the future challenges of managing the RWGPS include budget constraints and availability of female GPs. The program's capacity in terms of available funds has been reached, for new clinic locations to become operational, a current operational clinic is required to go 'on-hold' prior to new clinics being opened. Charter costs have increased by thirty per cent over the last 12 months; initially due to pilot shortages and then due to high fuel prices, prices have not reduced despite the alleviation of both these factors. There is often no choice in charter operators, out of small locations and the RWGPS has to pay the local market rate.[10,11] Currently female medical graduates are on the increase, in the future this should lead to an increased pool of female GPs, practicing in rural and remote locations across Australia thereby reducing the requirement for the RWGPS.

We would like to acknowledge the dedication and enthusiasm of the female GPs who have worked for the Rural Women's GP Service over the last 10 years and to all the patients, local GPs, practice managers and state health employees who have welcomed them into their communities.

Recommendations

- The RFDS model has been successful in terms of rural and remote residents being able to access services and to recruit and retain health professionals—it is recommended that the model be considered for the provision of other health services to remote communities.
- The RWGPS has integrated well with other GP services offering gender choice and a complimentary service to existing services—it is recommended that gender choice and complimentary services are available in regional and metropolitan centres.
- It is recommended that learnings from the RWGPS inform initiatives to address men's health needs in rural and remote locations, particularly to encourage men to access health services.
- Enhanced collaboration is required between the numerous agencies providing health services to rural and remote communities.
- To expand collaboration with Aboriginal and Torres Strait Islander agencies to increase the engagement with women living in Indigenous communities.

References

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Appendix 1 Service overview

Aim

The RWGPS aims to improve access to primary health care services for women in rural and remote Australia who currently have little or no access to a female GP, by facilitating the travel of female GPs to these communities.

Objectives

- Provide a quality female GP medical service to as many eligible communities as possible in rural and remote Australia, within the available resources.
- Cooperate with and complement existing health service delivery programs.
- Cooperate and not compete with existing doctors and health workers.
- Remain flexible to the changing needs of women in rural communities.
- Provide a broad coverage across the country.
- Where possible work with other agencies as part of the effort to attract and retain doctors to rural general practice. [1]

Operational considerations

States and territories provide different distance, temperatures and transport challenges that have to be overcome. Travel to clinic locations may involve commercial flights, charter flights and private or hire vehicles or a combination of these. Travel time is a considerable part of the GP's day and hence in remote locations overnight stays are required to ensure cost effective service delivery. The number of GPs currently employed by the RFDS is 83. However the actual full time equivalent (FTE) employed is 9.4 GPs, when the travel time is removed the FTE is 5.7 GPs, the travel component takes up 40% of the GPs time, therefore a large consideration in the budgeting for the RWGPS. [3 to 11]

Targeted promotion and advertising of RWGPS clinic is conducted to suit each location: local radio stations, newspapers, and school / community newsletters, posters displayed in shops, community buildings and notice boards. Articles have also been written for magazines aimed at rural readership and RFDS internet sites have up-to-date schedules of clinics available.

The management of waiting lists has been a constant operational consideration for the program managers, as early as 2002/3, annual reports included discussions regarding weighting lists, with 80% of the operational clinics having waiting lists. Waiting lists have been managed in a number of ways from increasing clinic frequency to monthly clinics, to increasing the clinics to two days per visit; up to a maximum of 24 days of service delivery in any one clinic location, to reducing missed appointments, to reducing consultation times, to providing group health promotion information sessions. [3 to 11]

Reporting requirements

The RFDS provides six and twelve monthly progress reports to the Commonwealth Government, these reports are used for the following:

- Review and monitor how the RWGPS is meeting its Service outcomes.
- Financial accountability: how the RWGPS funds are utilised.
- Provide updates on Service data with requests for information.
- Scrutinise the Service data to inform future planning and policy regarding the RWGPS.
- For briefing the Minister for Health and Ageing.
- To provide constructive feedback to the RFDS. [1]

Monitoring and evaluation

Comprehensive evaluations are provided in each funding period when key stakeholders, patients and the female GPs are asked to provide feed back to the Project Managers via detailed questionnaires. Evaluation methods are to be reviewed for the 2009/2010 evaluation, looking at specific requirements for evaluating health service provision in Aboriginal and Torres Strait Islander clinic locations.

Presenter

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