ANNEXURE A

NSW RURAL DOCTORS NETWORK

CELEBRATING 30 YEARS

State of Play of the GP Workforce in Gunnedah Shire

15 February 2021

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NSW Rural Doctors Network activities are financially supported by the Australian and NSW governments

Contents

1. Background

In November 2020, the Gunnedah Shire Council unanimously passed the following Mayoral Minute:

Mayoral Minute
8.1 NSW Rural Doctors Network Engagement

Councillor C Fuller declared an interest, left the Chamber, and took no part in discussion or consideration of this item.

AUTHOR Mayor J Chaffey
MOTION Moved Councillor J CHAFFEY
Seconded Councillor OC HASLER

OFFICER'S RECOMMENDATIONS:

That Council engage NSW Rural Doctors Network, at no cost, to:

1. Collaborate with Gunnedah Shire Council, Hunter New England Health, and other key stakeholders to identify a short, medium and long term approach to address General Practitioner shortages within Gunnedah Shire;

2. Consult with representatives from the Barber Street Medical Practice, Northwest Family Medical Centre, and the community of Gunnedah Shire;

3. Deliver to Council a Strategy which will list actions to address identified issues that will include but is not limited to a General Practitioner attraction and retention strategy for Gunnedah, and which Council can utilise to advocate through local State and Federal members to their respective governments to achieve the identified outcomes.

2.11/20 Council Resolution:

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2. Consult with representatives from the Barber Street Medical Practice, Northwest Family Medical Centre, and the community of Gunnedah Shire;

3. Deliver to Council a Strategy which will list actions to address identified issues that will include but is not limited to a General Practitioner attraction and retention strategy for Gunnedah, and which Council can utilise to advocate through local State and Federal members to their respective governments to achieve the identified outcomes.

4. That Council update the Medical Professionals Support Policy to include the provision of accommodation for doctors via subsidised rental accommodation equivalent to the current value of doctors accommodation support and Council exhibit the revised Policy for 28 days and if no objections are received, the Policy be adopted.

Councillor C Fuller returned to the meeting.

As part of the process of identifying short, medium and long term approaches to addressing the General Practitioner shortages with Gunnedah Shire, NSW Rural Doctors Network (RDN) has undertaken an evaluation of the current primary health care service provision situation, the results of which are contained in this report.

It is noted that while in addition to its town, Gunnedah Shire also includes a scattered rural population and several small population centres – Breeza, Carroll, Curlewis, Mullaley, Tambar Springs, for example – the Shire's medical services are based in town.

2. Executive Summary

This State of Play report provides to Gunnedah Shire Council and its communities, the first step in the process of considering the level of local access the residents of Gunnedah Shire had to General Practice (GP) services at the beginning of 2021. This step is generally taken prior to collecting input from the community and planning collaboratively how strategies to improve service provision might best be shaped using all the resources available for this purpose

The report assembles current data on the population of the Gunnedah Shire and on the GP services based in Gunnedah provided for that population.

Australian Bureau of Statistics data on the shire's population of around 12,600 people indicates that this population is likely to remain stable until 2041, that it will age further in this time, that there is a significant population of Aboriginal and Torres Strait Islander people in the shire, and that there are pockets of socio economic disadvantage in the shire.

The shire communities were in early 2021 serviced by 5 resident GPs, one of whom was a registrar and another working part time, plus a visiting GP anaesthetist who provides one week per month. This number had dropped over the past two years. The resident GP to population ratio then, was around one GP to every 2670 residents, which is well outside a service level of 1 GP per 905 population proposed by the Australian Medical Workforce Advisory Committee in August 2000. This on-paper calculation indicated that 13 – 17 full time equivalent GPs would better meet the primary health care needs of the shire.

The drop in GP numbers has placed such pressure on the two general practices that all doctors' books are closed to new patients, and the overflow of patients seeking appointments is being felt in nearby towns such as Boggabri.

The GP services in Gunnedah are closely linked to Gunnedah Hospital services, since traditionally GPs have admitted and cared for inpatients, staffed the Emergency Department, and provided obstetrics, anaesthetics and GP-level surgical services to the Hospital. The report notes that GP services to the hospital have dropped to a level where about ninety percent of Emergency Department services are now provided by locums employed by the Local Health District for that purpose. In addition, obstetrics and anaesthetic services were under threat because only two GPs with these advanced skills remained in practice when two or three of each would be more appropriate. Finally, the inpatient beds were underutilised because the Emergency Department locums cannot admit patients under their care, the local GPs provide inpatient care only to patients of their own practice, and patients requiring admission are regularly and of necessity transferred to hospitals outside of Gunnedah.

The report offers several recommendations in any efforts to boost GP numbers including a mix of skills and genders and consideration of the fact that at the time of writing, there was no local Aboriginal Community Controlled Health Service providing the range of primary health care services to the sizeable Aboriginal community.

3. Information Relevant to Considering A State of Play

3.1 Benchmarks for General Practitioner Numbers in Rural NSW

In Australia there are no widely accepted benchmarks either for GP to population ratios, or the various allied health professionals to population ratios. However, The Australian Medical Workforce Advisory Committee (AMWAC) in August 2000 suggested a benchmark of 110.4 GPs

per 100,000 population, or 1 GP for every 905 people (AMWAC, 2000. The General Practice Workforce in Australia: Supply and Requirements 1999-2010. AMWAC 2000.2). This is a very rough measure designed to give a ballpark estimate of workforce needs Australia-wide and it therefore cannot factor in local variation such as low socioeconomic status, elevated proportions of high need patients (for example, those of low socioeconomic status, Aboriginal people, frail aged people) or the local variations in GPs and the kind of work they and other health care personnel do (hospital work and procedural work, the number of female GPs, the numbers working part time).

In the same report AMWAC (page 58) indicated that signs of undersupply included:

- Significantly higher doctor to patient ratios and lower access to GPs
- GP waiting times reported for non-urgent consultations in some areas
- Longer hours of work and hours on call for GPs and
- Relatively low bulk-billing rates.

The Rural Doctors Association of Australia (RDAA), in association with Monash University, has recommended that in larger centres where practice is similar to metropolitan general practice, a ratio of a full-time GPs per 1000 Standardised Whole Patient Equivalent (SWPE) be used. In communities where the practitioner is providing inpatient, emergency and after hours services, these services typically take up to 10 hours each week, so that in such communities a full-time practitioner per 750 SWPEs would be appropriate. In areas of high need, such as in small, isolated communities, a full-time practitioner per 500 SWPEs may be required to provide an adequate level of service to meet community needs for healthcare (page 147). This benchmark has not enjoyed widespread support perhaps because it is unclear if this level of service is possible.

However, General Practice: Health of the Nation 2017 showed that the more disadvantaged a patient (in socioeconomic terms), the more frequently they visited their GP. This trend is seen again in the most recent data.

Patient age also affects the frequency of GP visits, with patients visiting more frequently as they get older. (Health of the Nation 2018 Report)

Even though there is no recognised standard for GP to population ratio, in 2018, the Royal Australian College of General Practitioners published that the NSW average ratio was 100.1 full-time service equivalent GPs per 100,000, which equates to 1:1000. (Health of the Nation 2018 Report, page 11.)

One other published estimate of GP to population ratio was provided by RDAA in association with Monash University which proposed a ratio of a full time GP per 1000 Standardised Whole Patient Equivalent (SWPE), and in communities where the practitioner is providing inpatient, emergency and after hours services, that a fulltime practitioner per 750 SWPEs would be appropriate. (Rural Doctors Association of Australia (2003): Sustaining Medical Practice in Rural and Remote Australia, a Summary of the Viable Models of Rural and Remote Practice Project, page 147).

3.2 Viability and Sustainability of General Practice

According to this same report, the three main dimensions having the greatest impact on the viability of rural GP practice are:

- practice organisation and infrastructure
- professional issues including practitioner skills and workforce
- economics including practice income, direct costs, and opportunity costs.

3.3 What Is Considered Desirable in Rural General Practice Services?

a) From a resident's point of view
Residents of rural communities want high-quality health services that are:

- accessible
- affordable
- high quality
- culturally appropriate for Aboriginal and Torres Strait Islander residents

They want services to be provided by:
- skilled practitioners with whom they can readily relate
- practitioners who can provide continuity of care
- both male and female GPs.

For the provision of high-quality health services, it is highly desirable that rural GPs are vocationally qualified with a Fellowship of the Royal Australian College of General Practice (FRACGP) or of the Australian College of Rural and Remote Medicine (FACRRM), or an equivalent, or be in the process of obtaining those qualifications. This training is the equivalent of a specialty in general practice.

Vocational qualification and training is particularly important to patients because it gives them access to Medicare rebates that are higher than those available to them for services provided by a non-vocationally registered practitioner who is not on a vocational training program.

Accessibility includes such considerations as:
- a service being known to the community and present in the community
- affordability
- ability to access a needed service in a timely fashion (such as ability to obtain an appointment in a reasonable time)
- near to transport, community services, parking
- suited to the health needs of the community
- being culturally safe and responsive to Aboriginal and other culturally and linguistically diverse members of the population
- the ability for aged, disabled, frail and ill people to use the health service buildings
- being able to obtain timely treatment in an emergency 24/7
- the ease with which patients can activate referrals from the GP to other services, including allied health services
- the degree of integration among health services (GPs, private and public allied health, community health, and the hospital accident and emergency department) and between general practices
- having a service that continues over time (in turn related to succession planning for health professionals and other strategies to sustain the service into the future).

Integration and proximity of services to one another supports the primary health care approach to health care provision.

Affordability is related to the capacity for patients to pay for their health services, and therefore is in turn closely linked to their doctors' policies on bulk billing. In rural settings, it may also be related to the cost of travelling to the service.

b) From a GP and GP business point of view
It is almost impossible to recruit a GP to a dysfunctional situation. For a town or practice to recruit a GP it is **essential** it has at least:
- accreditation standard practice space
- access to suitable housing for the doctor and his/her family
- access to competent practice staff and locally provided key services such as Information Technology
- good working relations with the hospital and the Local Health District
- and increasingly, as younger doctors come through, a team-based medical and health service or the potential to establish such an arrangement.

In addition, GPs find the following **desirable**:

- accreditable working premises that are conducive to practising high-quality medicine
- reasonable (that is, safe) working hours, including on call and after-hours work
- interesting case loads
- predictable, adequate remuneration
- opportunities to teach and to follow their areas of interest
- practice location in reasonable proximity to the hospital where the doctor is providing accident and emergency service
- timely and immediate access to health records regardless of which health facility the GP is in at the time
- where the GP has advanced skills, sufficient work in their area of expertise to maintain skills.

(NSW Rural Doctors Network 2003. Easy Entry, Gracious Exit. NSW RDN, Newcastle).

While there is no standard definition for reasonable on call hours, in rural NSW this tends to be considered a roster where the doctor is on call one day in four at the most.

For the sustainability of general practice in a location, practices that have the capacity to provide training places for health workers such as undergraduates (students), graduates (registrars) and post graduates (GPs studying for procedural qualifications or advanced skills) are highly desirable, and sometimes leads to trainees choosing to stay after they complete their professional qualifications. They are also a significant drawcard for GPs interested in rural practice.

c) From a potential recruit's point of view

Where a town is working to make general practice circumstances more attractive to incumbent GPs and their potential recruits, it may wish to consider the infrastructure for a modern practice that is available in their town. Consideration might be given to:

- current and future GPs (especially where the population is predicted to grow)
- registrar and medical student placements
- practice nurse(s)
- allied health personnel and possibly allied health trainees
- visiting services (allied health, specialists etc.)
- consolidating existing practices, where that is relevant and desired by the practices
- the location of facilities to help broader integration (hospital, MPS, HealthOne)

In addition, it is important to consider housing for:

- incoming GPs and their families
- where necessary, practice staff (particularly nurses and allied health)
- registrar and students when they are in town (and this may include partners and in some cases children)
- in some cases, locums.

In an environment of shortage, it is critical for towns to maximise their capacity to attract and retain skilled GPs and other health workers.

3.4 Framework for Considering Primary Health Care Services

The framework below is distilled from the research findings on primary health care service provision and workforce. It can be used to consider how well services and the associated workforce meet the needs of the population.

A framework that defines multi-faceted criteria for access, quality and sustainability of the primary health workforce		
ACCESS For the health workforce to be accessible to the community it needs to be:	**QUALITY** For the health workforce to be able to provide the right healthcare at the right time to the community it needs to be:	**SUSTAINABILITY** For the health workforce to be sustainable in the community it needs to be:
Understood/known to consumers and across the healthcare professional network - both the therapeutic benefits **and** presence in the community.	All the criteria for **ACCESSIBLE** (necessary but not sufficient) AND	All the criteria for **ACCESSIBLE** and **QUALITY** (necessary but not sufficient) AND
Present in the community**.**	**Patient-centred**, including shared decision making with patient and family.	**Attractive** to new members of the professions, early career stage and also those migrating from other geographic locations.
Affordable for all patients**.**	**Skilled** to full scope of practice appropriate to professional and community needs**.**	**Viable**: Funding streams are strategically planned for growth.
Timely initial and continued services accessed at optimal therapeutic intervals**.**	**Integrated** with transport and community services**.**	**Embedded** in the social and cultural fabric of the community**.**
Continuous in the management of chronic and/or complex conditions**.**	**Coordinated** across delivery of care to individual patients, groups, and community. Able to provide uninterrupted coordinated care or service across programs, practitioners, organisations and levels over time**.**	**Collaborative** between health care professions to provide optimisation of professional scope of practice within multi-disciplinary teams.
Proximal to transport and community services.	**Efficient:** Achieving desired results with the most cost-effective use of resources. Capacity of the system to sustain workforce and infrastructure, to innovate and respond to emerging needs.	**At critical mass** to manage workload and provide collegial support and development.
Aligned to the range of needs of the population (age group, condition)**.**	**Relevant:** Care, intervention , or action provided is aligned to the client's needs and based on established standards. Care, intervention of action achieves desired outcome.	**Agile**: Incorporating evidence-based innovations in technology and scope of practice within a strategic timeframe.
Culturally safe AND responsive to Aboriginal and other culturally and linguistically diverse members of the population**.**	**Flexible**: Multi-disciplinary team member responsibilities are adaptable to patient/community context**.**	**Visible** to students and trainees at all points on the education spectrum
	Supported professionally and personally (practitioner self-care)	
	Supporting individuals' access to Continuing Professional Development and lifelong learning opportunities, system innovating and evaluating**.**	

4. Local Data Assembly

4.1 Population Trends

ABS data from the 2016 Census indicates that the usual resident population of the Gunnedah Shire Council area was 12,491, and this population had shown both slow growth and slow decline over the previous 13 years.

The 2019 Population Projections published by the NSW Department of Planning indicate that the population of Gunnedah is estimated to remain stable over the next 20 years, changing by 100 people between 2016 and 2041, from 12,500 to 12,600.

In terms of provision of health services, census data and official projections may tell only part of the story. For example, local knowledge might suggest that in the aftermath of the Coronavirus pandemic, more mine workers may choose to live in Gunnedah Shire rather than continue with a fly-in-fly-out arrangement from more populated centres. Also, when considering local industries, there may or may not be an increase in the mining sector and power generation sector.

Within that stable population, however, the predictions of births in the Gunnedah Shire area remain at around 800 over a five year period until 2031, dropping to 750 births over the following two five-year periods. For the next 10 years, this equates to about 160 births per year, and while it is unwise to assume that all those births would occur in the Gunnedah Hospital, it gives an indication that the current rate is likely remain stable over the next decade.

4.2 Change in Age Structure

Subgroups within the predicted stable population of the Gunnedah Shire area will vary in growth characteristics.

- The working age population (aged 15-64) is estimated to decrease from 7,600 in 2016 to 7,200 in 2041 – a decrease of 400.
- The number of children aged 14 and under is estimated to decrease by 500 children, from 2,650 in 2016 to 2,150 in 2041.
- The number of people aged 65 and over is estimated to increase from 2,250 in 2016 to 3,300 by 2041 – a significant increase of 1,050.

It is important when considering health services into the future to note the estimated 30 percent increase in residents aged 65 years and more, with the bulk of these being in the 75+ year age group (750 people). This is because of the association between advancing age and chronic and complex diseases, as well as physical frailty.

The shift from a younger population to an older one can also affect the overall socioeconomic status of the Shire, depending on the provision that retirees have been able to make for their older age. This in turn affects the proportion of the population that holds health care cards of various sorts, which in turn can affect the levels of bulk billing within the community.

4.3 Aboriginality

Gunnedah also has a higher than Australian average proportion of Aboriginal and Torres Strait Islander residents. The 2016 Census indicates that 1562 (12.8 percent) of Gunnedah shire residents identified as Indigenous Australians. This proportion is around five times the national average of 2.8 percent.

In 2021 the Aboriginal population of Gunnedah had a smaller proportion in the working stage of life (15–64 years) than the remainder of the Shire population, with a higher proportion of children under 15 and a smaller proportion of people aged 65 or older.

From a health service point of view, an important characteristic of this population is its relative youth. The median age of this group was 21 years compared to the median age of the whole Shire population of 40 years, and a median age of 38 years for NSW as a whole.

In addition, this high proportion of Aboriginal and Torres Strait Islander people, half of whom are young, is important in the context of medical and health service delivery. Among other factors, the Aboriginal and Torres Strait Islander Health Performance Framework 2020 Summary Report notes that "the burden of disease among Aboriginal and Torres Strait Islander people is 2.3 times that of non-Indigenous Australians. Mental health and chronic diseases such as cancer, cardiovascular disease, respiratory diseases, diabetes and kidney disease are areas of particular concern. A large part of the disparity in health outcomes between Indigenous Australians and non-Indigenous Australians is explained by disparities in social determinants, in particular income, employment and education. In many cases, Indigenous Australians also have lower access to health services than non-Indigenous Australians, for a range of reasons including barriers such as cost and a lack of accessible or culturally appropriate health services." (page 9)

Aboriginal and Torres Strait Islander people as a population group are disadvantaged across a range of socioeconomic factors reported upon in successive censuses. They experience lower incomes than the non-Indigenous population, higher rates of unemployment, poorer educational outcomes, and lower rates of home ownership - all of which can impact upon a person's health and wellbeing.

There is no Aboriginal Community Controlled Health Service based in Gunnedah, nor are outreach services from nearby Aboriginal Community Controlled Health organisations provided on any large scale. While there are some services that target the needs specific to Aboriginal culture and people, this cannot be either as comprehensive or as integrated as those offered by Aboriginal Community Controlled Health Services.

4.4 Socioeconomic Status

In the 2016 Census, the Gunnedah Shire Council area returned a score of 943 on the SEIFA Index, which is below both the state and national average. It places it in the 38th percentile for Australia, and the 36th percentile for NSW. But sub areas in the Shire (Statistical Districts or SA1 areas) ranged in scores from 789 to 1088, meaning that there are pockets of both significant disadvantage and greater advantage in the Shire.

As of January 2021, there are 563 local government areas in Australia, and 128 in NSW (plus far west and Lord Howe). In the 2016 Census for the SEIFA Index above, Gunnedah Shire ranked 46 out of 128 in NSW (with rank 1 being the most advantaged Shire) and 204 out of 563 in Australia.

4.5 The Major Employment Sectors

In 2016 the five major employment industries in the Shire were:

1. mining (739 people, up 319 from 2011)
2. agriculture, forestry, fishing (737, down 199)
3. health care and social assistance (549, up 67)
4. retail (427, down 89)
5. education and training (424, up 24)

These figures not only have implications for the mix of health care services that are required but indicate that the health care sector is among the major employers in the Shire.

4.6 Population Trends in A Nutshell

- The population of the Shire is likely to be stable until 2041
- The population will age further in that time
- The Shire has a significant population of Aboriginal and Torres Strait Islander people
- The Shire also has pockets of disadvantage

All the above impact the provision primary health care services, both the kinds of demands on the service, and the ability for residents to make a co-payment for services.

4.7 GP Service Provision

Data on the provision of medical services in Gunnedah was assembled in a table modelled on that provided in the publication Viable Models of Rural and Remote Practice (Chapter 7). To fully reflect the status of medical services in the Gunnedah Shire area, the table was expanded to include the gender of the doctors, time to obtain an appointment and an indication of whether GPs' books were closed to new patients.

For details of this data, please go to **Appendix 2.**

The data show:

4.7.1 Doctor to Population Ratio

As of January 2021, the population of Gunnedah Shire was being serviced in the two GP clinics by:

- three FTE GPs (10 sessions per week where possible), all three male and two of whom are proceduralists (covering obstetrics, anaesthetics and limited surgery)
- one part-time female GP providing 21 clinic hours per week
- a second part-time female proceduralist from another NSW town providing one week per month
- one GP registrar, male, providing nine sessions per week.

Two GPs - one of them a proceduralist - were on extended leave with uncertain return dates. Both had been working full time.

As of January 2021, this equates to a full-time equivalent of around 4.75 GPs. However, this number does not consider the reduction in clinic services that results when the two GP proceduralists are called away from the clinic to provide obstetrics and anaesthetics services.

As of January 2021, the doctor to patient ratio in the Shire is around 1:2670 (working with 2019 population estimates).

As indicated, this ratio is well removed from the 2018 RACGP-identified state average of 1:1000 and the 2003 RDAA-identified 'desirable' ratio of between 1:1000 and 1:750.

Without considering the additional responsibilities of GPs who practice obstetrics and anaesthetics in Gunnedah, or the possibility that in the future, GPs may provide significant levels of VMO services to the hospital's Emergency Department, for a 1:1000 ratio Gunnedah Shire area would need 13 FTE GPs. To meet the 'desirable' ratio of 1:750, this increases to 17 FTE GPs.

It is important to note that all GPs have work preferences, including what work within their profession they choose to do, and the hours they wish to work. These preferences affect the head count of doctors required in a town. A doctor to population ratio is therefore only a rough indication of the GP numbers required to adequately service a particular population.

4.7.2 GP Work at the Gunnedah Hospital

As of January 2021, all four GPs and the GP registrar had VMO appointments at the Gunnedah District Hospital. In the main, the VMO services provided to the hospital comprised:

- procedural services: obstetrics and anaesthetics including caesarean capability, with limited minor surgery
- each doctor caring for their own patients while in hospital, including those admitted by the ED locum
- there was interest from one GP to be rostered for some shifts at the ED.

At the time of writing, patients presenting to the ED hospital admission, but who were not patients of any of the resident GPs, were transferred to another hospital where admission was possible.

There is one visiting GP anaesthetist who provides anaesthetic services for surgery lists from time to time, and who covers the Emergency Department one weekend per month.

In years gone by, as was typical of rural medical services then, GP VMOs in Gunnedah also provided coverage for the hospital's Emergency Department (ED) on a rostered basis. Where necessary, they admitted patients who had presented at the ED. After admission, the care of these patients either was transferred to their own local GP/VMO, or if the patient did not have their own GP, the admitting GP would care for them for the duration of their hospital stay.

For a variety of reasons, this is no longer the case. This means that approximately 90 percent of presentations to the ED are managed by a locum doctor. The associated challenges with the Gunnedah ED being run primarily on locum services include:

- the very significant cost to the hospital of the locums
- lack of continuity and follow up for patients, since locum appointments are generally short term, and most often are not recurring
- the inability for locums to admit patients to the wards under their own care which means a significant proportion of ED presentations that require admission are transferred to another hospital
- the cost of transfers both financial (to the system) and emotional (to the patient and their family)
- the reduced bed occupancy in the wards with associated underutilisation of staff.

4.7.4 Gender of General Practitioners

It is considered desirable to have female GPs in rural towns. In addition to women often expressing a preference for female GPs, studies have shown that female GPs tend to work differently from their male colleagues. In comparison to males, female GPs on average have longer consultations; manage significantly higher numbers of problems per encounter; see a higher percentage of younger patients and new patients and manage depression more often.

As of January 2021, the number of female GPs in the Gunnedah Shire Council area had dropped from two part-time GPs to one. From time to time, numbers of female GPs are boosted by one or more registrars spending a training term in Gunnedah.

4.7.5 Skills Base of General Practitioners

The advanced GP skills available in Gunnedah include obstetrics, anaesthetics and surgery. Both practices provide services specifically for Aboriginal people in the Shire.

4.7.6 Time to Obtain an Appointment

The time to obtain an appointment is a measure of the adequacy of doctor numbers for the population served.

The average time to obtain a non-urgent appointment varies from doctor to doctor, ranging from two days to two weeks.

4.7.7 Books Closed

All the GPs in Gunnedah have closed their books to new patients. This is because all are working to capacity and cannot take on additional patients.

The medical practice in Boggabri has increased its GP numbers from two FTE to three, partly in response to the overflow of patients travelling from Gunnedah. In February 2021 this practice's books were not closed for any of its GPs, but the time for a routine appointment was blowing out to two weeks despite the extra personnel.

4.7.8 Practice Accreditation

Practice accreditation is important to rural practice for two reasons. The first is it ensures that certain business and practice standards that underpin quality clinical service are met (accreditation is designed to review the systems for managing risks and to improve the quality of patient care). The second is it affords accredited practices access to financial incentives from Medicare (known as PIP and WIP incentives), and these can contribute to the economic viability of individual practices.

Both practices in Gunnedah are accredited.

4.7.9 On Call and After Hours

The Rural Doctors' Association of Australia has indicated that an on call rate of no more than one in four weeknights and one in four weekends is desirable except for brief and infrequent periods. At the moment, the two GP Proceduralists are effectively on call 24/7 for their obstetrics patients. This is not sustainable. These doctors may also be called in to the ED when anaesthetics skills are required.

The two GPs at Northwest Family Medical are on call during business hours for any patients they have in the Gunnedah Hospital. They are not on call for the ED.

4.7.10 On Call Intensity

On call intensity is a measure of how demanding it is to be on call. In some towns, the intensity is low, meaning that the on call doctor is not often required to attend to a case after hours, particularly in the hours that are most difficult and demanding from a performance point of view (between midnight and 6am).

The two GP Proceduralists, when called for obstetrics cases, will routinely attend multiple times, making the intensity high. They may also be called for anaesthetics.

4.7.11 Leave Arrangements

The ability for a GP to readily take leave without unduly disrupting provision of services is one measure of viability and sustainability of that service.

At the time of writing, the doctors practicing in Gunnedah have limited capability to provide alternative cover during periods of leave. On occasion a locum has been secured, however more often the doctors attempt to cover for each other, and in terms of hospital services, the Local Health District must make other arrangements.

4.7.12 Remuneration Sources and Hospital Arrangements

Gunnedah GPs derive remuneration from a mix of Medicare rebates, private fees, and hospital fee for service arrangements.

In both practices decisions about bulk billing are at the individual GP's discretion, with rates varying from almost all patients bulk billed to almost none. Patients who are not bulk billed pay a gap fee.

A fee for service arrangement at the hospital has, over the past decade or so, become less attractive across rural NSW than the years prior. While it can still have a significantly positive impact on GP incomes and engagement in a broader case load, changes to the Medicare rebates over this time, including in the areas of health care plans and practice incentives, have made hospital work less attractive from a financial point of view.

In addition, hospital work, particularly procedural work, tends to carry more risk than work in the clinic, so while it may also be interesting, in a risk-averse environment, it may have lost its attraction.

In this environment, GP coverage for Emergency Departments has also dropped across rural NSW. GPs are increasingly unwilling to disrupt their full clinic loads to attend the hospital emergency department, particularly in locations of GP workforce shortage. This is particularly true of Emergency Department presentations that would normally be managed at the GP clinic.

4.7.13 Incentives Available to Eligible GPs and Practices in Gunnedah

There is a range of incentives that doctors working in Gunnedah, and their practices, can be eligible for.

1. Practice Incentive Payments (PIP)
    - After hours incentives (supporting general practices to provide their patients with appropriate access to after-hours care).
    - eHealth incentive (encourages general practices to keep up to date with digital health).
    - General Practitioner Aged Care Access (to encourage GPs to provide increased and continuing services to Residential Aged Care Facility residents).
    - Indigenous Health Incentive (supports practices and services to provide better health care for Aboriginal and Torres Strait Islander patients).
    - Procedural General Practitioner Payment (encourages GPs in rural and remote areas to maintain local access to surgical, anaesthetic and obstetric services)
    - Quality Improvement Incentive (paid to general practices that participate in quality improvement activities)
    - Rural Loading Incentive (a loading on PIP incentives paid - 40% in Gunnedah as a RRMA 5 location – to assist with the difficulties of providing care in rural and remote areas)
    - Teaching Payment Incentive (to encourage practices to provide teaching sessions to medical students):

2. Workforce Incentives Program (WIP) payments
    a. The Doctor stream (made directly to medical practitioners)

In Gunnedah, a MMM 5 location, eligible doctors providing the required continuous level of service may be paid $0 in their first year up to $23,000 per year after 5 years of service.

b. The Practice stream (made directly to accredited practices) covers nurse practitioners, registered nurses, enrolled nurses, Aboriginal and Torres Strait Islander Health Workers and Health Practitioners, and certain allied health workers. The level of payment is related to the patient load and the hours worked, and may include:
   i. quarterly incentive payments
   ii. Quarterly rural loading payments; and
   iii. Annual Department of Veterans' Affairs loading payments.

3. Relocation grant
   Up to $2000 for an eligible health professional relocating from an MMM 1 - 4 location to Gunnedah, which is a MMM4 location.

4. Site Visit /Observership Grant
   Depending on the length of visit/observership, from $700 to $1500 to eligible health professionals in a MMM4 location such as Gunnedah.

4.7.14 Teaching and Supervising Responsibilities

As previously stated, Gunnedah has traditionally been somewhat dependent on registrars for the provision of GP services in the Shire. Of the five practitioners as at February 2021, one was a registrar, and three were supervisors who may be permitted to supervise up to two registrars each at a given time. It has not been unusual for both practices to have one or more registrars at a time.

The two full time proceduralists, and the full time GP at the second practice, are able to supervise both registrars and students, meaning that both the procedural and supervisory requirements of the town are at the moment supported by a very small number of GPs. It is important to note that although it is preferable for registrars, particularly those who are in their first year of general practice training, to be partially supernumerary in a practice for training reasons, in reality when GP numbers are low, the reliance on registrars for workforce increases.

A reliance on registrars means that medical services in the town depend on an ongoing supply of these trainees, and the willingness/capability of the three supervisors to take on one or two registrars at any given time.

Doctors training to obtain their Fellowship may do so through several training pathways. However, most numerous registrar placements in rural towns come about through the General Practice Education and Training (GPET) program which is implemented by the NSW training provider, GP Synergy, for both the Royal Australia College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM).

To be a supervisor, a fully qualified (fellowed) GP must work from accredited premises and be accredited as a supervisor by either RACGP or ACRRM. To remain an accredited supervisor, they must undertake ongoing training.

Two subsidies are provided to support supervisors and practices that take on the role of training registrars in the general practice environment during their first and second terms. Registrars in these two terms are completing their first year in general practice and are engaged as employees of the practice. The subsidies are designed to help offset the costs to the practice and to the registrar supervisor that are associated with this training period. Registrars in the first term of general practice are required to be away from the practice for nine training days, and their supervisor is required to provide at least one hour face to face teaching per week. Registrars in the second term of general practice are also required to be away from the practice for nine training days, and their supervisor is required to provide at least a half an hour of face-to-face teaching per week. For first-term registrars, practices are subsidised $14,807 and for second-term registrars,

$7403, while the supervisors have an hourly face-to-face teaching rate of $145. Supervisors are also paid this rate while undertaking webinars or face-to-face workshops for supervisors through GP Synergy.

A supervisor may take up to two registrars, but this has consequences in terms of hours of supervision and teaching required of the supervising GP.

Registrars may choose to study and pursue proceduralist skills during their registrar terms, but to do this they must choose and be accepted by a proceduralist supervisor. There are currently two in Gunnedah.

Registrars relocating to live and work in Gunnedah during their training may be entitled to a $3186 subsidy per term through GP Synergy to help cover:

- relocation fees, end of lease cleaning, connection, and disconnection fees
- travel and accommodation for pre-placement interviews or accommodation site visits
- travel to commence the placement.

4.7.15 Procedural Responsibilities

As previously stated, two of the five doctors in Gunnedah are proceduralists, and both are able to perform caesarean sections. A third is able to assist with caesarean sections.

Although a number of Tamworth surgeons visit the Gunnedah Hospital, it is heavily dependent on the proceduralist GPs to retain services in surgery, anaesthetics and obstetrics. While Hunter New England Local Health District is committed to retaining these services at the hospital, unless there is a critical mass of proceduralists in town, it will not be possible to do so.

Proceduralists require caseloads of adequate size to retain their skills. They also require at least one other proceduralist of the same type as themselves in the town to provide backup in an emergency and to cover the population for that procedure should one of the proceduralists wish to be out of town or off duty at any given time.

The number of proceduralists across NSW is falling. This makes it exceedingly difficult to recruit them, especially to inland towns.

At present, Gunnedah, has only just enough proceduralists to continue procedural services. Should one proceduralist leave or decide to cease procedural work, emergency action would need to be taken to maintain procedural services in town.

4.7.16 Services to Aged Care Facilities

Gunnedah Shire has two main residential aged care facilities, Mackellar Apex Road and Alkira Aged Care.

Mackellar Apex Road comprises

- Lundie House (49 bed high care)
- McCauley house (14 hostel-style rooms, low care)
- Inala (16 room dementia-specific)

Alkira Aged Care comprises 41 units.

Residents are under the care of their own GP. Where they are unable to visit their GP, the GP visits them. The doctors generally do regular “rounds” of their patients in these facilities and deal on a case by case basis with any medical issues that arise in between times.

4.8 General Practice Infrastructure

4.8.1 Practice Premises

For a general practice to be accredited, a surgery building must meet certain standards. Both practices are accredited and meet these standards.

Both practice buildings are privately owned, one of them leased to the practice, the other owned by the practice principal.

A major drawback for both premises - one more so than the other - is their limited capacity. This means that when the available consulting rooms are occupied by GPs, registrars or practice nurses, there is no room left for any additional practitioners, be they permanent GPs, registrars or visiting specialists providing services to the town.

The practice building owned by the practice principal has capacity to be extended.

In January 2021, one practice had six consulting rooms available for GPs and registrars (plus two procedure rooms), the other had four consulting rooms for GPs and registrars and two stations for practice nurses. Without additional premises or an extension on one practice building, this limits capacity to 10 GPs.

At the end of January 2021, the period for interested individuals to lodge an Expression of Interest for seven consulting rooms in the Gunnedah Rural Health Centre closed. The results are yet to be announced.

4.8.2 Housing

In rural areas housing for incoming students, GPs, GP registrars as well as GP and allied health locums, is an important viability component of general practice. This is especially true of GP registrars who have training terms of six months and toward the end of their training pathway, may carry a full GP load. If these registrars relocate to Gunnedah for one or more terms, sometimes with their family, suitable accommodation is a critical factor in their choosing to train in Gunnedah as opposed to another rural town.

The issue of housing for registrars is important because they may help alleviate GP shortages in rural towns, although their presence may also place additional responsibilities on their supervising GP.

While in comparison to some other rural NSW towns Gunnedah is relatively well placed in terms of housing for incoming health professionals, it is not in an ideal accommodation situation. Two Council units each of two to three bedrooms are kept for incoming health workers, while some registrars are supported by the training body in private rental arrangements. However, the rental market in Gunnedah for quality accommodation as of early 2021 was very limited, making it difficult for doctors and other health workers to choose Gunnedah.

4.8.3 IT Systems

Computerisation is required for practice accreditation, and it also confers considerable benefits by making patient records readily accessible on any networked surgery computer. In addition, computerisation when combined with internet access permits the efficient and timely relay of test results such as pathology and radiology.

Both practices are fully computerised.

An arrangement has been in place at the hospital for more than 10 years whereby electronic patient records held at the respective practices are accessible to the GP VMOs while at the hospital. This makes GPs' patient records, including medication lists, available to the treating doctor at the hospital.

There is commercial IT support available in the town.

At the hospital, while initial ED records are iPM (the Patient Administration System) further records for ED and inpatient records are paper based. An electronic medication management system is in the process of being implemented.

Community health records are fully electronic, using CHIME (Community Health Information Management Enterprise).

However, the software programs used by the hospital system are not compatible with those commonly used by GPs in rural NSW.

While a GP service was offered out of the Gunnedah Rural Health building, those services included networked computer systems that used software commonly used by GPs in rural NSW.

The ongoing challenge for treating patients across the public and private sectors, is that the various software programs being employed in the different settings to manage patient records are not compatible with each other, sometimes even within the same organisation.

4.9 Specialist Medical Service Provision in Gunnedah

Five specialists from Tamworth provide services at Gunnedah Hospital. An orthopaedic surgeon visits one of the GP clinics twice a month.

4.10 Local Health District Services

4.10.1 Community Health Service

Community health services are provided between 8:00am to 4:30pm, Monday to Friday, with a limited visiting nursing service on weekends.

The Community Health Service delivers the community-based and inpatient services below (expressed as availability in days per week).

- Aboriginal health education (5)
- Aboriginal antenatal clinic (1)
- Aged care (5)
- Aged Care Assessment Team - New England ACAT (Ph: 1300 789 077); My Aged Care (Ph: 1800 200 422) This service visits from Tamworth, as required
- Aboriginal maternal infant health service midwife (1)
- Audiometry (1)
- Cardiac rehabilitation (2)
- Community nursing (5)
- Diabetic care (1)
- Dietetics (2)
- Discharge planning (5)
- Drug and alcohol services (4)
- Early childhood services (5)

- Immunisation clinic, including the school-based immunisation program (1)
- Child and adult mental health - adult (3) child and adolescent (5)
- Occupational therapy (includes home modifications) - adult (2-3)
- Paediatrics (2)
- Palliative care (5)
- Physiotherapy (5) (providing both inpatient and outpatient care)
- Pulmonary rehabilitation (1)
- Social work including sexual assault counselling (5)
- Speech pathology (5)
- Women's health (3)
- Wound care (5)

In 2019-2020, the Gunnedah Community Health Service provided 14,565 occasions of service.

The service also provides outreach to the villages of Mullaley, Curlewis, Carrol and Breeza.

During December 2020, the majority of community health services relocated from a cramped building on the grounds of the Gunnedah District Health Service to the adjacent Gunnedah Rural Health Centre. Physiotherapy and oral health remained in the old building, and allied health continue to use an area in the old space for play therapy.

Gunnedah Mental Health Services are provided through Peel Sector Community Mental Health Services, based in Tamworth. The services below are provided.

- One adult mental health clinician who is based at Gunnedah two days a week and Tamworth three days a week.
- The adult service looks after older people with mental health concerns. There are some specialists in this area available for Gunnedah residents.
- The Child and Adolescent Mental Health Service (CAHMS) position: a 1 FTE position based in Gunnedah.

The Healthy for Life program is managed by HealthWISE.

4.10.2 Hospital Services

One District Group 2 (C2) district hospital, Gunnedah Health Service, provides acute care services for residents of the Gunnedah Shire Council area.

The Ministry of Health in 2016 defined a District Group 2 (C2) hospital as one that has 4,000 or less acute weighted separations but greater than 2,000 acute separations (a formal separation is a discharge from, transfer from or death in a hospital).

Gunnedah Hospital is a 48-bed acute facility with services in general medicine, obstetrics, day only surgery (10 beds) and dental. The Hospital has a dental clinic and physiotherapy unit. It has a helipad and can access Westpac services to Tamworth and other higher-level facilities and Childflight services to Newcastle. Rehabilitation services in the hospital are provided in conjunction with allied health clinicians based in the Community Health Service.

Tamworth Rural Referral Hospital is located 75 kilometres (about one hour’s drive) from Gunnedah and is the referral hospital for Gunnedah Shire. A number of specialties are available there.

The bulk of surgery at Gunnedah is provided by four surgeons from Tamworth, with specialties covering gastroenterology and general surgery. In addition, some surgery and obstetrics is provided by local GPs, while oral surgery is provided through HNE Oral Health Service and a private dentist. A visiting nephrologist also provides a community-based consultation service from the community health building.

While the three full-time GPs and one part-time GP in private practice are Visiting Medical Officers who admit and provide inpatient care for their own patients, they provide very limited emergency department coverage and no inpatient care for patients who are not on their GP clinic books. The registrar also has VMO rights at the hospital and may commence some sessions at the ED.

GP VMOs are remunerated for work completed in the hospital through a fee for service arrangement.

Because there are only two GP obstetrician anaesthetists in Gunnedah, obstetrics and surgical services are reliant on their availability. These GPs are currently on call for their patients.

While local GPs provide a portion of the medical services in the hospital as noted above, as of December 2020 the emergency department is operated primarily through locum services. The Registrar in Gunnedah now has VMO rights to the hospital and will work some shifts in ED, and one of the resident GPs does the occasional shift in ED. In addition, a Tamworth-based GP anaesthetist provides ED cover one weekend per month which usually coincides with him providing anaesthetic cover to the theatre session on the Friday of that weekend.

4.10.1.2 Visiting Specialist Services

There are currently three general surgeons, one gastroenterologist and one nephrologist providing visiting services through the hospital. However, there is no visiting orthopaedic, urology or psychiatric services.

4.10.1.3 Career Medical Officer Services

Segens Medical Dictionary defines Career Medical Officer as “an Australian term for a registered medical practitioner employed by a hospital or health service, who doesn’t practice at specialist or consultant level.”

Traditionally, the arrangements in NSW C2 rural hospitals and smaller has been that acute and emergency care has been provided by resident GP VMOs. Hence, a Career Medical Officer model in this setting has been neither desirable nor necessary.

However in recent years, for a variety of reasons including rural GP shortages, there has been a downsizing in the proportion of GP VMOs willing to undertake these roles, putting Local Health Districts in the position of considering other ways to provide 24/7 medical services in their smaller hospitals.

While there is no Career Medical Officer (CMO) model in place for Gunnedah, the locums employed for the ED are classified as CMOs.

4.10.1.4 Inpatient Services

Gunnedah’s inpatients are predominately public patients, although those who require admission and have private health insurance are encouraged to be admitted under their private health insurance so that the hospital can receive the local revenue associated with this.

Currently Gunnedah’s GP VMOs generally admit only their own patients or those who belong to their practice. At a time when there are too few GPs in Gunnedah, many patients are without a local GP VMO so that when they require admission, they must be transferred to Tamworth, a bigger hospital where there are doctors on duty who can admit them.

Obstetrics Patients: If one of the GP Obstetricians is away then the other will manage their patients.

If a woman in labour presents to the hospital but there is no GP Obstetrician available at the time, the hospital's midwife will assess the woman in consultation with an obstetrician based at a networked hospital, to determine whether she can safely give birth at Gunnedah Hospital or if transfer to higher level hospital is required.

To further support local services, the hospital has rostered an on-call midwife to assist the midwife on duty to safely support women to birth at Gunnedah, in consultation with obstetricians from the District's networked hospitals.

Each woman's care depends on a range of factors including her medical history, any pregnancy complications and stage of labour.

4.10.1.5 Pharmacy Services

Pharmaceuticals are supplied to Gunnedah Hospital by Tamworth Hospital, and a Tamworth-based Regional Pharmacist provides advice and support.

4.10.1.6 Pathology Services

HNE Health is in the process of transitioning Gunnedah Hospital's pathology service provider from Laverty to NSW Health Pathology (NSWHP). This is because NSWHP has the ongoing resources, expertise, and technology to provide Gunnedah Hospital with consistent, reliable pathology cover, both during the day and on weekends, whereas Laverty no longer has this capacity. The LHD is working with both NSWHP and Laverty to make this a seamless transfer in April this year.

4.10.1.7 X-ray and Imaging Services

HNE Imaging based at the hospital provides a 24/7 X-ray service to the hospital itself and an outpatient service Monday to Friday during business hours.

A private x-ray service in Gunnedah provides ultrasound and CT during business hours to inpatients and patients from the ED. Outside these hours patients must be transferred to Tamworth for ultrasound and CT services.

4.10.1.8 Inflows for Services

The hospital is utilised mostly by residents of Gunnedah Shire, although some patients come from Tamworth and Quirindi for surgery.

In addition, some mothers come from Baradine as well as Coonabarabran (which has not been serviced locally in obstetrics for some years), to birth in Gunnedah Hospital. High risk obstetrics cases usually birth in Tamworth Hospital, but may be transferred directly to John Hunter Hospital.

4.10.1.9 Activity Level

Bureau of Health Information figures indicate Gunnedah District Hospital provided 5207 inpatient bed days during 2019-020.

Recently, ward occupancy has been low as a result of the restricted admission capability combined with improved access to the Aged Care Facilities in Gunnedah. There continues to be periods when patients are admitted awaiting Nursing Home placement.

The falling occupancy rate is reflected in the following average occupied bed days figures

2018/19	15.99
2019/20	14.05
2020/21	11.64

There were 153 births in 2019-20, which was one less than the previous year.

The emergency department continues to be busy with 9571 presentations for the 2019-20 year (an average of around 26 presentations per day) and 2358 presentations for the following July to September quarter. This number has been trending upward for the past three years. For the 2019-20 year, more than half of the presentations at the Emergency Department were triaged as 4 and 5 and might reasonably be considered as suitable for management through a GP clinic.

4.10.3 Health Service Medical Records

While initial ED records are iPM, further records for ED and inpatient records are paper based. An electronic medication management system is in the process of being implemented.

Community Health records are fully electronic, using CHIME.

GP VMOs can access the patient records that are held at their clinics via a compatible computer and software in the doctors' room in the hospital.

However, the software programs utilised by the hospital system are not compatible with those commonly used by GPs in rural NSW.

While there was a GP service offered out of the Gunnedah Rural Health building, there were networked computer systems that utilised software commonly used by GPs in rural NSW.

4.10.4 Hospital Buildings

A Clinical Services Plan has been completed for Gunnedah Health Service and is currently with the Ministry of Health for endorsement. At this stage, the timeframe for building of the new facility is yet to be determined.

The Health Service campus also accommodates the Ambulance Service, Alkira Aged hostel, and the Gunnedah Rural Health Centre.

4.11 HealthWISE Services

HealthWise is a not for profit organisation based in the New England region that delivers Federally funded primary health and social services, including in Gunnedah, where it has one of its four offices.

Services provided in Gunnedah through HealthWISE include:

- Mental health services
- Allied health services – physiotherapy, speech pathology, podiatry, exercise physiology, dietetics, occupational therapy.
- Diabetes Clinic
- Indigenous Primary Health Care

- Healthy Ageing Group Class
- Integrated Team Care

HealthWISE also administers the bulk of the Federally funded outreach services in Gunnedah which comprises each year from that program's Indigenous Outreach streams:

- Dietitian/Nutritionist, 10 x 1 day, 2 x 0.5 days, plus 4 x 1 day
- Diabetes Educator 10 x 1 day
- Aboriginal Health Worker 14 x 1 day; 2 x 0.5 days
- Exercise Physiologist 10 x 1 day
- Podiatrist 10 x 1 day

In addition, the Brian Holden Vision Institute Foundation provides an outreach service in Optometry 6 x 2 days per year.

5. Summary

This State of Play report examines and attempts to quantify the size and scope of the challenges the Gunnedah Shire community faces in having their primary health care needs met by a GP workforce that is lacking in both numbers, skills mix and gender mix. In addition, it notes how the lack of GPs presents significant difficulties for the Gunnedah Hospital services that have traditionally been provided by GPs – specifically inpatient, procedural (obstetrics and anaesthetics in particular) and Emergency Department services.

Calculating a GP shortage can, at best, be seen as an academic exercise given there is no widely accepted GP to population ratio in use in Australia, let alone in NSW. However, the Gunnedah Shire level of 1 GP for about every 2670 residents is clearly well short of the 1:905 AMWAC figure of 2000 mentioned in the Benchmarks section, and the 1:1000 that is commonly used as a rough indicator. This shortage is compounded by the additional and specialty workload that comes with the procedural services offered in Gunnedah – particularly obstetrics and anaesthetics – as well as that associated with the significant high needs groups in the Shire such as Aboriginal and Torres Strait Islander people and people of advancing age.

There is a significant gap in culturally appropriate and safe services for the 1562 (2016 Census) Aboriginal and Torres Strait Islander residents of the Shire given there is no Aboriginal Community Controlled Health service either in Gunnedah or providing outreach services in to Gunnedah, this being a service that might reasonably be expected for a population of this size.

Putting aside those complexities mentioned, it would be reasonable to calculate that 13 full time GPs for a population the size of Gunnedah Shire would be a starting point to meet community need and this would then require adjusting upwards to account for the procedural workload, the proportion of the population comprised of high needs individuals, and for Emergency Department and inpatient loads if these were areas of work that incoming GPs decided to pursue.

Any consideration of attracting additional GPs to Gunnedah would best be framed in the context of the following needs in the mix:

- Two to three additional GP obstetricians and the same number of GP anaesthetists to support the obstetrics service in particular, but also surgical services
- A balance of male and female clinicians
- GPs with skills and experience providing culturally appropriate and culturally safe services for the shire's Aboriginal and Torres Strait Islander population
- Ideally, GPs with an interest in emergency services willing to participate in the Emergency Department roster
- GPs with the capacity and willingness to supervise students and registrars
- GPs wishing to admit and care for patients in the Gunnedah Hospital

For the moment, there is enough clinic infrastructure to reasonably provide for about five more incoming GPs, after that, thought will need to be given to more clinical space, depending on the outcome of the Expressions of Interest for the clinical rooms on offer in the Gunnedah Rural Health Centre.

Housing availability is a challenge when considering attracting additional GPs to Gunnedah. While the two units kept for this purpose are invaluable, they are insufficient for the numbers of GPs that the Gunnedah Shire may look to attract. The housing subsidy offered by Gunnedah Shire Council is significant but cannot ensure there is sufficient housing for incoming GPs and registrars.

The current arrangement where the hospital Emergency Department is of necessity mostly run by locums is not tenable long term. It has both clinical drawbacks in terms of continuity of care and capability to care for admitted patients, as well as being a drain on economic resources that cannot

be sustained. On the other hand, the traditional model of GPs providing all the GP-level medical services to Gunnedah Hospital has generally become unattractive to rural GPs and Local Health District examination of alternatives has to date found no viable avenues to pursue.

This State of Play report provides much of the data required to inform planning for short, medium, and long term GP workforce. It would best be used in conjunction with both health professional and community input on their priorities for developing the primary health care service in the Shire and include allied health and nursing in the primary health care context.

6. Appendices

Appendix 1: Explanation of Terms Used in This Report

Appendix 1.1 After Hours

The Rural Doctors Asssociation (NSW) Settlement Package, under which GP Visiting Medical Officers are paid for their attendance at their local hospital, defines in hours as those that fall between 7am and 6pm Monday to Friday as well as between 7am and 12noon on Saturday, while after hours is defined as any hours outside that. Nevertheless, for the purposes of reimbursement, these after hours are further divided into:

- the periods that fall between 6pm and 10pm Monday to Friday as well as between 12 noon and 10pm on Saturday
- those hours between 10pm and midnight on any day ("late night")
- the hours between midnight and 7am on any day ("antisocial").

In 2018, the Australian Department of Health (DoH), for the purposes of Medicare item numbers for emergency GP attendances at a patient's home or at the GP clinic, defined after hours as times outside of 8am to 8pm Monday to Friday, and Saturday 8am to 12pm. This was further broken down into sociable and unsociable after hours, specifically:

- **sociable after hours**: 7am to 8am Monday to Saturday, plus 6 pm to 11 pm Monday to Friday, plus 12 noon to 11pm Saturday, plus 7am-11pm Sunday
- **unsociable after hours**: 11pm to 7am every day.

(Australian Department of Health (2018): Improving Quality in After Hours GP Services)

Appendix 1.2 Allied Health

The term allied health is relatively new and there is still no universally accepted definition of allied health professions. Instead different governments and government departments, health service providers, health insurers and education providers include different professions under the heading 'allied health'.

However, there is general agreement on some basic principles. Allied health professionals:

- are health professionals that are not part of the medical, dental, or nursing professions
- are university qualified practitioners with specialised expertise in preventing, diagnosing, and treating a range of conditions and illnesses
- often work within a multidisciplinary health team to provide specialised support for different patient needs.

(*AHPA What is allied health?)*

In the context of the Gunnedah Shire, this is taken to include (but is not limited to):

audiology
chiropractic
dietetics
diabetes education
exercise physiology
occupational therapy
pharmacy
physiotherapy
podiatry

psychology
social work and
speech pathology

Appendix 1.3 Bed Days

The total number of bed days of all inpatients accommodated in a hospital during the year. It is the count of the number of inpatients accommodated in the hospital at around midnight each day.

Appendix 1.4 General Practitioner

In this report, General Practitioner is as defined by the Commonwealth Department of Health and Ageing as a medically qualified person working in a medical practice that offers primary, continuing, comprehensive whole-person care for individuals, families, and communities.

The Australian College of Rural and Remote Medicine defines the General Practitioner as the doctor with core responsibility for providing comprehensive and continuing medical care to individuals, families, and the broader community. Competent to provide the greater part of medical care, the General Practitioner can deliver services in the primary care setting, the secondary care setting, the home, long-term residential care facilities, or be electronic means – wherever and however servers are needed by the patient within their safe scope of practice.

Appendix 1.5 HealthOne

HealthOne NSW is an integrated primary and community health initiative that brings together GPs with community health and other health professionals in multidisciplinary teams. Bringing together these health professionals in a flexible manner is the strength of the model. While there is no fixed model for HealthOne NSW services, they are characterised by a motivation to bring health care professionals together to reduce the increasing burden of chronic disease and to focus on those people in the community who need a greater level of coordinated care.

(NSW Health definition of HealthOne)

Appendix 1.6 Locum

The Merriam Webster dictionary defines ‘locum’ (short for locum tenens) as a person filling an office for a time or temporarily taking the place of someone else. The terms is generally applied to doctors or clergymen.
(Definition locum)

Appendix 1.7 Outreach Services

This is an Australian Government program aimed to increase access to health services for rural communities and Aboriginal people by providing visiting health and telehealth services according to need and local priorities. Outreach services also provide urban and regionally based health practitioners with the opportunity to experience working in a rural, remote, or Aboriginal community, and supports students and registrars to participate in Outreach clinics.

Appendix 1.8 Modified Monash Model (MMM)

The Modified Monash Model (MMM) is a measure of rural remoteness and is the means by which the Federal Government defines whether a location is a city, rural, remote, or very remote. A scale of 1 (major city) to 7 (very remote) is used. This scale is use for programs designed to better distribute health workforce in rural and remote areas.

On the MMM, Gunnedah is categorised as 4, medium rural town with a population of between 5000 and 15,000.

Appendix 1.9 Multi-Purpose Service (MPS)

The MPS is a joint initiative of the Commonwealth and NSW governments that brings together a range of health and aged care services in a single location and under a single management structure. A Multi-Purpose Service (MPS) is not solely a hospital, nursing home, hostel, or community health service, but a combination of services. Accident and emergency services are still provided. Other services such as ambulance and Home and Community Care (HACC) can choose to be part of the MPS.

In the vicinity of Gunnedah Shire, Boggabri has a Multi-Purpose Service.

Appendix 1.10 On Call

The Rural Doctors Association of Australia (RDAA) defines on call as any period when the doctor is available to attend a patient in a timely fashion in order to render a medical service.

Note: when on call, a doctor generally needs to be within a short travelling distance from the hospital and be prepared to work at any time.

Appendix 1.11 Poverty Lines

A poverty line is the minimum level of income deemed necessary to achieve an adequate standard of living. In Australia it is commonly based on a benchmark income of $62.70 per week established by the Henderson Poverty Inquiry for the September quarter of 1973 as the disposable income required to support the basic needs of a family of two adults and two dependent children. Poverty lines for other types of family are derived from the benchmark using a set of equivalence scales. (Melbourne Institute of Applied Economic and Social Research, March 2007. *Poverty Lines: Australia: March Quarter 2007)*

The report 2020 Poverty in Australia Overview shows that the single rate of Youth Allowance (plus rent assistance and energy supplement) is $168 per week below the poverty line, while Newstart is $117 per week below the poverty line. The Aged Care Pension is $10 per week below the poverty line. The report found that 13.6% of Australians live below the poverty line.

The poverty line is an important consideration in primary health care because it gives a measure of what proportion of the population has a low income, and in turn the level of bulk billing that health professionals are likely to be called on to adopt. The flow on effect is the bottom line of health professionals' businesses, and on occasion, the difficulty low income earners experience in accessing health services.

Appendix 1.12 Primary Health Care

Primary Health Care is generally the first contact a person has with Australia's health system. It relates to the treatment of patients who are not admitted to hospital.

Many people associate primary health care with their local General Practitioner (GP). While general practice is the cornerstone of primary care in Australia, primary care can also include care provided through nurses (such as general practice nurses, community nurses and nurse practitioners), allied health professionals, midwives, pharmacists, dentists, and Aboriginal health workers.

Primary health care can be provided in the home or in community-based settings such as general practices, other private medical practices, community health centres, local government, and non-government service settings, such as Aboriginal Community Controlled Health Services. It is not provided in hospitals where the type of care is known as acute care.

Appendix 1.13 Proceduralist

This refers to a General Practitioner who has post graduate qualifications and advanced skills in surgery, and/or obstetrics and/or anaesthetics.

Appendix 1.14 Registrar

A GP registrar is a fully registered medical practitioner who is undertaking additional training in a recognised GP training program with general practice as their specialty. This training includes hospital and general practice experience and may include advanced training in a number of areas including rural procedural practice, for example, anaesthetics, obstetrics, gynaecology, mental health, paediatrics and surgery.

Appendix 1.15 Rural Generalist

A Rural Generalist (RG) is a medical practitioner who is trained to meet the specific current and future health care needs of Australian rural and remote communities, in a sustainable and cost-effective way. An RG provides both comprehensive general practice and emergency care, and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team.

Appendix 1.16 The Socioeconomic Indexes for Areas (SEIFA)

The SEIFA is a measure of socioeconomic advantage/disadvantage most recently calculated using the 2016 Census. The indexes use education, income, and occupation as well as indicators of wealth, living conditions, access to services, and disadvantage to score locations according to their advantage/disadvantage. The SEIFA reflect the socioeconomic wellbeing of an area rather than that of individuals. Areas for which the indexes are calculated range from Statistical Areas 1 (SA1) which have a population of between 200 and 800, with an average of around 400 people, through to local government areas, states/territories and for Australia as a whole. There are 57,523 SA1s in Australia.

The ABS broadly defines relative socioeconomic advantage and disadvantage in terms of people's access to material and social resources, and their ability to participate in society.

This report uses the SEIFA Index of Relative Socioeconomic Advantage and Disadvantage (IRSAD) for its capability to summarise information about the economic and social conditions of people and households within the Shire through including both relative advantage and disadvantage measures.

As measures of socioeconomic conditions, the index is best interpreted as an ordinal measure, that is, what rank in Australia, in the state or among local government areas does its score give it. The scores are also useful for understanding the distribution of socioeconomic conditions across the Shire. However, it is important to note that the scores do not represent some quantity of advantage or disadvantage.

The ABS use a number of statistical processes to arrive at the scores and ranks produced by this index. An important one is the employment of standardisation so that a score of 1000 is about the Australian average, and like all normal distributions, the middle two thirds of the scores will fall

between approximately 900 and 1100. Scores above this are outliers in terms of advantage, and below this are outliers in terms of disadvantage.

Specifically, a **low** score indicates relatively greater disadvantage and a lack of advantage in general. For example, an area could have a low score if there are:

- many households with low incomes, or many people in unskilled occupations, AND
- few households with high incomes, or few people in skilled occupations.

A **high** score indicates a relative lack of disadvantage and greater advantage in general. For example, an area may have a high score if there are:

- many households with high incomes, or many people in skilled occupations, AND
- few households with low incomes, or few people in unskilled occupations.

In the 2016 NSW census, the lowest score for this index for local government areas was 818, and the highest was 1168.

Appendix 1.17 Separations

A formal separation is a discharge from, transfer from or death in a hospital.

Appendix 1.18 Session

A session refers to a period, normally between three and four hours, during which a GP provides medical services for patients. Often the session (usually a morning or an afternoon session) is provided in the GP's surgery.

Appendix 1.19 Triage Categories

Triaging refers to the process of assigning degrees of urgency to wounds or illnesses to decide the order of treatment of a large number of patients or casualties. In hospital emergency departments, a specialised nurse triages a patient as soon as possible after they present. Patients are allocated a triage category based on the time in which they need medical attention.

The five triage categories are:

Triage category 1: People who need to have treatment **immediately or within two minutes** are categorised as having an immediately life-threatening condition. People in this category are critically ill and require immediate attention. Most would have arrived in emergency department by ambulance. They would probably be suffering from a critical injury or cardiac arrest.

Triage category 2: People who need to have treatment **within 10 minutes** are categorised as having an **imminently life-threatening condition**. People in this category are suffering from a critical illness or are in very severe pain. People with serious chest pains, difficulty in breathing or severe fractures are included in this category.

Triage category 3: People who need to have treatment **within 30 minutes** are categorised as having a **potentially life-threatening condition**. People in this category are suffering from severe illness, bleeding heavily from cuts, have major fractures or are severely dehydrated.

Triage category 4: People who are categorised as having a **potentially serious condition**. People in this category have less severe symptoms or injuries, such as a foreign body in the eye, sprained ankle, migraine, or earache.

Triage category 5: People who are categorised as having a **less urgent condition**. People in this category have minor illnesses or symptoms that may have been present for more than a week, such as rashes or minor aches and pains.

The proportion of presentations that are triaged 1, 2 and 3 in a hospital ED compared to those triaged as 4 and 5, is used as an indication of the level of access populations have to GP services. Although this is an imprecise indication, patients categorised as triage 4 and 5 could generally be treated in a GP clinic in preference to an emergency department.

Appendix 2: Rural Doctors Association Viable Models Table for Gunnedah 2021

Characteristics	Details	Summary observations
Community characteristics Location	MMM 4	Inland. medium rural town with a population of between 5000 and 15,000
Description	Medium town and surrounding agricultural area, tourism, mining	Population steady, gradually ageing
Population base	12,215 (2016 Census), estimate 2019 = 12,681	Predicted steady population until 2041
SEIFA (for an explanation of SEIFA, please see explanation of terms)	Score of 943 in 2016 census in lowest 40% in both NSW and Australia	Collection districts (SA1) range from 789 (very disadvantaged) to 1088 (quite advantaged).
Special health needs	Growing older population, pockets of disadvantage, significant proportion Aboriginal Australians	
GPs in community	5, one of whom is a registrar.	2 full time procedural GPs, a third one week per month
Gender of GPs	4 males working full time, one female working 21 clinic hours per week. One visiting proceduralist is female.	
Practices in community	2	One with two GPs and one registrar, one with two GPs and a 0.25FTE
Hospital role delineation	District hospital C2	Procedural (obstetrics, anaesthetics, surgery) with visiting specialists
Time to obtain appointment	Surgery 1 = 3 weeks for specific doctor, for emergencies, can see the doctor available for that day's emergencies. Surgery 2 = within 24 hours, can make appointments up to a week in advance	However, books are closed in both clinics
Books closed?	Closed to new patients at both surgeries	
Practice structures and organization Strategic planning	Yes	Both practices accredited
Infrastructure ownership	One owned by GP, other rented from private owner	
Management responsibility	With the respective practice principals	
Systems documentation	Both practices accredited	
Doctors	Surgery 1: 2 full time, 2 on extended sick leave plus 0.25FTE (one week in four) Surgery 2: 2 full time, 1 providing 21 clinic hours per week. One FT is a registrar.	All fellowed 2 fellowed, third is in training.
Nurse	Surgery 1: 3 at any given time Surgery 2: 2 with three on duty two days a week	
Practice manager	Surgery 1: 1 Surgery 2: 1	

Characteristics	Details	Summary observations
Professional Workforce requirement	Dr to population ratio around 1: 2670	
Professional support	4 permanent GPs and four visiting specialists to the hospital. An additional specialist provides services from one of the practices.	
Hospital access	48 beds Full rights for public and private patients	4 GPs and one registrar have VMO rights but currently are admitting and caring only for patients who are on their clinic books
On call requirement	GP proceduralists largely on call 24/7 Other GP VMOs on call during clinic hours for inpatients under their care.	
On call after hours work intensity level	When the proceduralists are called in for a birth, the on call is intense, may be called in several times in the one day	
Leave arrangements	Depends on cover from other Doctors in the practices, on locums when they can be secured, and is particularly difficult for the proceduralists.	
Professional isolation	Evacuations are to Tamworth and to Newcastle	
Economic Remuneration source	Mixed Medicare/fees/hospital	Bulk billing policy is at the discretion of the individual GPs and ranges from practically no bulk billing to practically all patients bulk billed.
Core remuneration	Medicare	
Grants and incentives	A range of incentives outlined in the State of Play document	
Hospital	State VMO package (RDA NSW package)	
Practice premises and facilities Premises	One is owned by the practice principal The second is privately owned and leased to the practice	The building owned by the practice principal has potential for additions
IT systems	Fully computerised both practices	
Medical equipment	In good condition	

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