# THE ROYAL WOMEN'S GENERAL PRACTITONER SERVICE

Alternatively titled: The Best Man for the Job is a Woman.

# THE UNDERLYING PRINCIPLES.

- Access to a female GP is an important predictor for rural / remote women's participation in preventative health services.
- 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.


CORRYONG
MEDICAL

# WHERE DID WE COME FROM?

- 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. This included a visiting female GP, providing cervical screening services in hospitals and general practice surgeries in ten towns in 1994.

- Since 1999 DoHA has funded the RFDS to co-ordinate the delivery of the RWGPS across it four operating sections: Central Operations (NT & SA); Queensland; South Eastern Section (Tas, Vic & NSW); and Western Operations (WA)

# THE FACTS AND FIGURES

| FINANCIAL YEAR | NO. PT. CONSULTS | NO. ATSI PATIENT CONSULTS | NO. MALE PATIENT CONSULTS | HEALTH PROMOTION ACTIVITIES ATTENDEES | NO. CLINICS CONDUCTED |
|---|---|---|---|---|---|
| 1999/2000 | 3112 | Not Available | Not Available | N/A | 224 |
| 2000/2001 | 4546 | 688 | 224 | N/A | 337 |
| 2001/2002 | 8897 | 896 | 434 | N/A | 612 |
| 2002/2003 | 11877 | 1332 | 669 | N/A | 957 |
| 2003/2004 | 14737 | 1504 | 648 | 469 | 1087 |
| 2004/2005 | 15817 | 1318 | 522 | 246 | 1178 |
| 2005/2006 | 16323 | 2206 | 684 | 1303 | 1027 |
| 2006/2007 | 16094 | 1933 | 718 | 823 | 1062 |
| 2007/2008 | 17174 | 2278 | 704 | 843 | 1043 |
| 2008/2009 | 18710 | 2270 | 806 | 730 | 1164 |
| TOTAL | 127287 | 14425 | 5409 | 4414 | 8691 |

# HOW IS IT FUNDED?

- 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. Medicare benefits are payable for RWGPS consultations provided to eligible clinic locations by a female GP.
- All patients using the RWGPS are bulk-billed.
- No fees are charged for any services including pathology costs.

# WHAT ARE THE 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.
- 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.

# HOW DO WE GROW?

- Increasing the number of eligible clinic locations.
- Increasing the number of days the female GP attends the eligible clinic location per visit.
- Increasing the frequency of visits to the eligible clinic location up to a maximum of twelve visits per calendar year.
- The project managers determine the number of days that the female GP should provide a RWGPS clinic to an eligible location.
- 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.

# WHAT ABOUT THE SMALLER TOWNS?

- Over the last ten years, the number of eligible clinic locations has increased by an average of fourteen new eligible clinic locations per year.
- For the smaller towns or communities (with populations of less than 1,000) two alternative models for service delivery have been developed.
- Small towns or communities 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 the GP conducting 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.

# WHEN DO WE STOP PROVIDING THE SERVICE?

- If 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.
- If the male GP in a location ceases to provide services.
- 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.

# CONTINUITY OF CARE

- 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.
- Integration of RWGPS medical records with those of the local GP also facilitates continuity of care.

# CONTINUITY OF CARE

- 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.

# CHALLENGES & OPPORTUNITIES

- Budget constraints.
- Availability of female GPs.
- Attitudes of local 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.
- 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.

# THE END OF THE MARATHON PRESENTATION