Northern
Eyre
Peninsula
Health
Alliance

# Needs Assessment Report

June 2021

Northern Eyre Peninsula Health Alliance

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# Table of Acronyms

| Acronym | Name |
|---|---|
| ABS | Australian Bureau of Statistics |
| ACCHO | Aboriginal Community Controlled Health Organisation |
| AHPRA | Australian Health Practitioner Regulation Agency |
| ASGS | Australian Statistical Geography Standard |
| CSAPHN | Country SA Primary Health Network |
| DC | District Council |
| EFNLHN | Eyre and Far North Local Health Network |
| FTE | Full-time equivalent |
| FUNLHN | Flinders and Upper North Local Health Network |
| GP | General Practitioner |
| LGA | Local Government Area |
| LHN | Local Health Network |
| MPS | Multi-Purpose Services Program |
| NEP | Northern Eyre Peninsula |
| NEPHA | Northern Eyre Peninsula Health Alliance |
| NHWFDS | National Health Workforce Dataset |
| PGY | Post Graduate Year |
| PHIDU | Public Health Information Development Unit |
| RDWA | Rural Doctor's Workforce Agency |
| RGPSA | Rural Generalist Program South Australia |
| RHWS | Rural Health Workforce Strategy |
| SAVES | South Australian Virtual Emergency Service |

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# Introduction

Access to health care is a human right recognised nationally and internationally. Access to 'healthcare services and treatment that meets my needs' is the first Right listed in the Australian Charter of Healthcare Rights (Australian Commission on Safety and Quality in Health Care, 2020). There is international recognition of 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (The United Nations, 1966, p. Article 12.1). To achieve this, nations have agreed to take steps which are necessary for 'The creation of conditions which would assure to all medical service and medical attention in the event of sickness' (The United Nations, 1966, p. Article 12.2(d)), which includes:

> 'the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care' (Committee on Economic, Social and Cultural Rights, 2000).

Access to healthcare is dependent on effective service coverage, which relies on the existence of a strong health workforce. However,

> 'Mere availability of health workers is not sufficient: only when they are equitably distributed and accessible by the population, when they possess the required competency, and are motivated and empowered to deliver quality care that is appropriate and acceptable to the sociocultural expectations of the population, and when they are adequately supported by the health system, can theoretical coverage translate into effective service coverage' (The World Health Organisation, 2016, p. 10).

It requires the recruitment and retention of competent, motivated health professionals and the existence of a health system that supports and empowers them to deliver quality care.

The Northern Eyre Peninsula (NEP) has a critical shortage of medical services and other health services are available at a much lower level than like communities across Australia. With the example of General Practitioners (GPs), some towns have no General Practitioners located in their communities and rely solely or predominantly on locums, and other towns have services that are difficult to sustain and are at risk of having insufficient general practitioner coverage in the near future.

Although the impact of COVID-19 on urban to rural migration is yet to be realised, early movement from local knowledge suggests that more people are migrating from metropolitan areas to the Northern Eyre Peninsula. Often these groups are people looking for a place to retire. Further, Regional Development Australia Eyre Peninsula (2021) estimates an additional workforce increase for new operational jobs of 248 across the NEP region in the immediate future. With an average household size of 2.3 persons, the population increase from that would be 570 persons.

There are currently 150 construction jobs in the NEPHA region with further construction jobs projected to be created in the immediate future (Regional Development Australia Eyre Peninsula, 2021) Further construction jobs are projected to be created by infrastructure projects on the NEP, such as the National Radioactive Waste Management Facility, the Wilcherry Project by Alliance Resources, Iron Road's Central Eyre Iron Project, and ElectraNet's Eyre Peninsula Link Project. Such migration and population growth will put further pressure onto the issue at hand. If NEP communities cannot support their population with adequate fundamental primary health and emergency care services, they could fail.

The Northern Eyre Peninsula Health Alliance (NEPHA) is a cross jurisdictional alliance formed in 2019, seeking to redress the critical shortage of medical and health professional services in the Northern Eyre Peninsula region.

There is shared frustration amongst NEPHA Members and other regional stakeholders about the ongoing challenge to provide their communities with local health services, despite the demand for GP services supporting the viability of a minimum of one GP in each of the communities.

Local and State Government have contributed considerable time and resources to attracting GPs to the NEP Region. For example, the District Council of Streaky Bay have taken on the operation and funding of the Streaky Bay and Districts Medical Practice and the funding of locum services. The District Council of Kimba have provided a rent free fully equipped medical centre and a doctors house free of charge, are investing almost $1 million into an upgrade and extension of the existing medical practice, paid the accreditation costs for the previous GP and have participated in extensive advocacy to attract a GP to Kimba, including significant media engagement, the Mayor's participation as the presiding member of Eastern Eyre Health Advisory Committee for several years, representing Local Government on the Rural Health Workforce Strategy Steering Committee, and presentations to State and Federal Ministers. Eyre and Far North Local Health Network have undertaken the ownership, operation, and funding of the Mid-Eyre Medical Clinic, covering primary health care services in Kimba, Cowell, Cleve and Elliston. Despite these considerable efforts, the NEP region as a whole has not seen progress towards the creation of a long-term and sustainable GP workforce that is commensurate to the cumulative efforts of various Stakeholders.

Each stakeholder provides necessary components for reform; however, initiatives are not cohesively understood or actioned. This results in the absence of an actionable robust regional health plan addressing systemic issues and sustainability. The purpose of the NEPHA Project is to find an alternative, more sustainable, integrated, and multidisciplinary model for the provision of general practitioner services on the Eyre Peninsula, thereby enabling improved access to health care for Northern Eyre Peninsula communities.

The purpose of this Needs Assessment Report is to identify and articulate the Northern Eyre Peninsula's needs in relation to the recruitment and retention of GPs on the NEP.

# Context

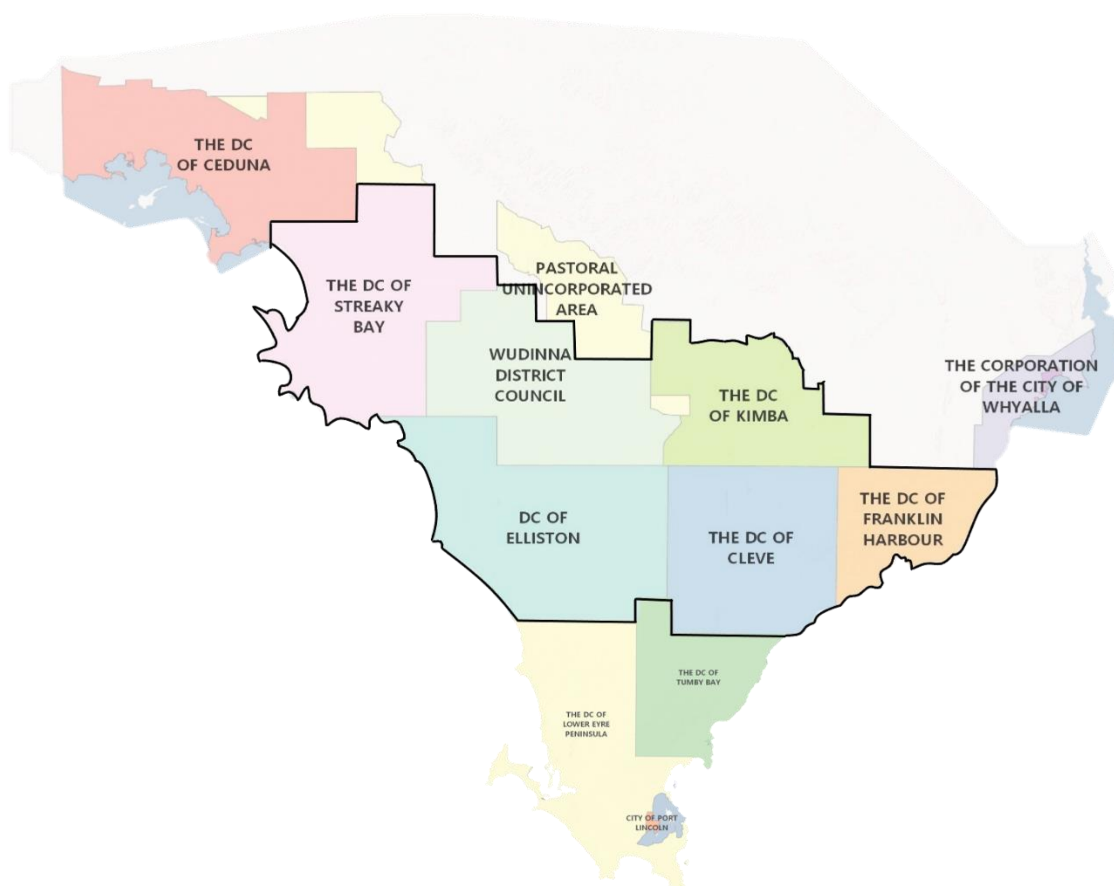
## Local Government Areas

For the purpose of the NEPHA Project, the NEP region consists of the following Local Government Areas (LGAs):

- The District Council (DC) of Elliston
- The District Council of Streaky Bay
- The District Council of Franklin Harbour
- The District Council of Cleve
- The District Council of Kimba
- Wudinna District Council

The following map shows the Eyre Peninsula divided into Local Government Areas (South Australian Country Fire Service, 2021) overlayed by an outline of the Northern Eyre Peninsula catchment.

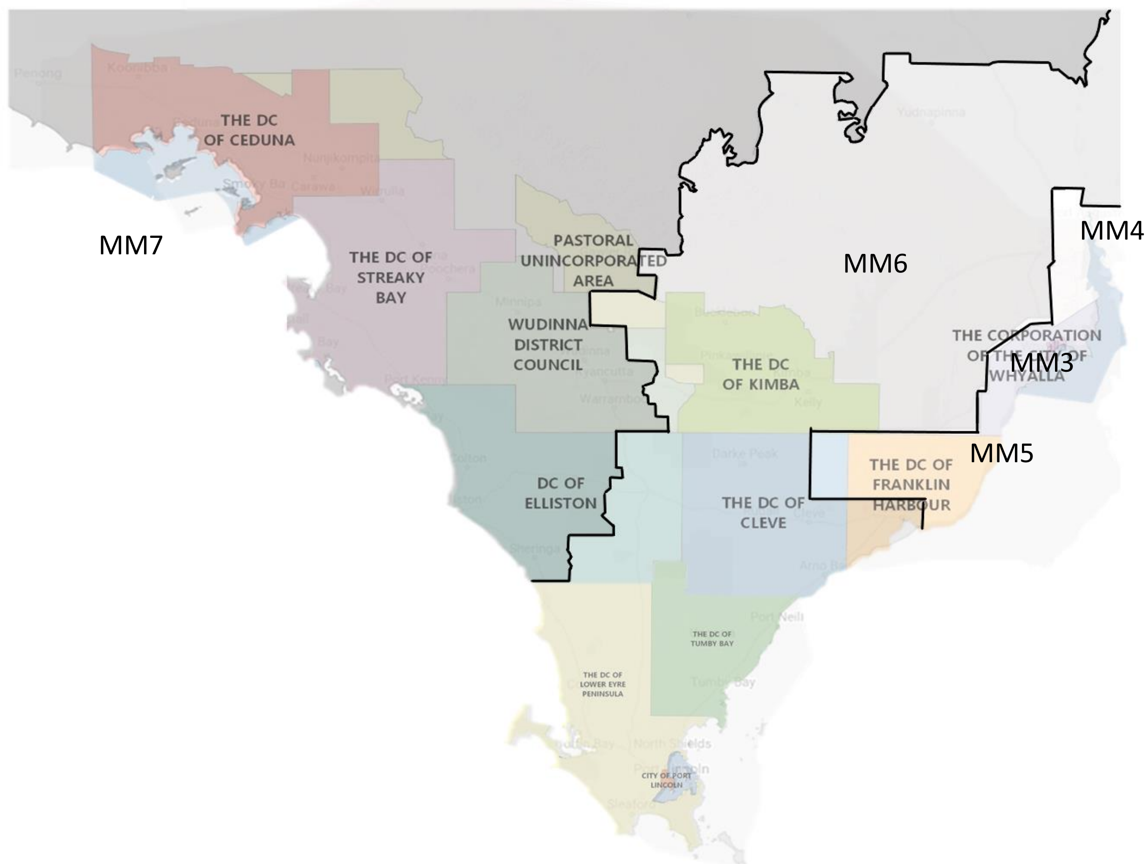
*Figure 1: Map of the Eyre Peninsula divided into Local Government Areas overlayed by an outline of the Northern Eyre Peninsula catchment.*



## Remoteness Categories

The map below shows the Eyre Peninsula divided into Local Government areas (South Australian Country Fire Service, 2021), overlayed by the Remoteness Category of each Eyre Peninsula town according to the Modified Monash Model Classifications (Australian Government Department of Health, 2021). Cleve, Cowell, Kimba, Port Lincoln, Tumby Bay and Cummins are classified as MM6: Remote Communities, while Ceduna, Streaky Bay, Elliston and Wudinna are classified as MM7: Very Remote Communities (Australian Government Department of Health, 2021). The Whyalla City Council is classified as MM3: Large Rural Towns and Port Augusta City Council is classified as MM4: Medium Rural Towns.

*Figure 2: Map of Eyre Peninsula divided into Local Government Areas overlayed by a Map of the Eyre Peninsula divided into Remoteness Categories*



## Medical Practices in and Surrounding the NEP Region

The NEP Region is situated within the Eyre and Far North Local Health Network (EFNLHN). The medical practices in Cleve, Cowell, Kimba and Elliston form the Mid-Eyre Medical Practice owned and operated by Eyre and Far North Local Health Network. The medical practice in Wudinna is privately owned and the medical practice in Streaky Bay is a non-for-profit organisation. Lock Community Health and Welfare centre is not a medical practice, although a visiting private GP consults there one day per week.

Table 1: Medical Practices in and surrounding the NEP Region (shaded = NEP Region)

| Location | Name | Ownership | Local Health Network (LHN) |
|---|---|---|---|
| Cleve<br>Cowell<br>Kimba<br>Elliston | Mid Eyre Medical | Eyre and Far North Local Health Network | EFNLHN |
| Lock | Lock Community Health and Welfare Centre | Building owned by Eyre and Far North Local Health Network.<br><br>Visiting private General Practitioner consults one day per week. | EFNLHN |
| Streaky Bay | Streaky Bay and Districts Medical Clinic | Community Owned Not-For Profit | EFNLHN |
| Wudinna | Wudinna Medical Practice | Private Practice | EFNLHN |
| Ceduna | Yadu Health | Aboriginal Community Controlled Health Organisation (ACCHO) | EFNLHN |
| Ceduna | Ceduna Family Medical Practice | Eyre and Far North Local Health Network | EFNLHN |
| Cummins | Lower Eyre Medical Practice | Private Practice | EFNLHN |
| Coffin Bay | Lower Eyre Family Practice | Private Practice | EFNLHN |
| Tumby Bay | Bayview Medical Practice | Private Practice | EFNLHN |
| Port Lincoln | Port Lincoln Aboriginal Health Service | Aboriginal Community Controlled Health Organisation (ACCHO) | EFNLHN |
| Port Lincoln | Lincoln Medical Centre | Private Practice | EFNLHN |
| Port Lincoln | Boston Bay Family Health Practice | Private Practice | EFNLHN |
| Port Lincoln | The Investigator Clinic | Private Practice | EFNLHN |
| Whyalla | Doctors at Westlands | Private Practice | Flinders and Upper North Local Health Network (FUNLHN) |
| Whyalla | Bunyarra Medical Clinic | Private Practice | FUNLHN |

| Whyalla | McRitchie Crescent Surgery | Private Practice | FUNLHN |
|---|---|---|---|
| Whyalla | Doctors on Playford | Private Practice | FUNLHN |
| Whyalla | Nunyara Aboriginal Health Service | Aboriginal Community Controlled Health Organisation (ACCHO) | FUNLHN |
| Whyalla | ABC Surgery | Private Practice | FUNLHN |

## Hospitals in and surrounding the NEP Region

There are six hospitals in the NEP region. All hospitals in the NEP region are smaller hospitals, funded by grants 'to ensure they can meet minimum staffing and service provision requirements' (SA Health, 2019, p. 12). All hospitals in the NEP region have an emergency and outpatient service operating 24 hours per day, acute beds and low care aged care beds. Some hospitals have high care aged care beds and Elliston Hospital has a specialised dementia unit. Port Lincoln Hospital is the only case-mix funded hospital in the Eyre and Far North Local Health Network. It is case-mix funded because it has 'adequate volume and complexity of activity to be funded under national activity-based funding rules' (SA Health, 2019, p. 12).

Table 2: Hospitals in and Surrounding the NEP Region — = NEP Region

| Hospital | Funding* | LHN | Beds | Services |
|---|---|---|---|---|
| Elliston Hospital & Pines Hostel | Grant-funded | EFNLHN | Acute: 6<br>Dementia Unit (Pines Hostel): 15 | • Residential Aged Care (Commonwealth Multi-Purpose Services (MPS) Program funded)<br>• 24 Hour Emergency and Outpatient<br>• General Practice Medicine Inpatient Services<br>• Specialised Dementia Unit |
| Streaky Bay Hospital & Elmhaven Hostel | Grant-funded | EFNLHN | Acute: 10<br>High care Aged: 9<br>Low Care Aged: (Elmhaven Hostel): 15 | • Residential Aged Care (Commonwealth MPS Program funded)<br>• 24 Hour Emergency and Outpatient<br>• Low risk General Practice Medicine Inpatient Services |
| Cleve District Hospital and Aged Care | Grant-funded | EFNLHN | Acute: 12<br>Long Stay Nursing Home: 8<br>Low Care Aged: 20<br>Independent Living Cottages: 15 | • Residential Aged Care (Commonwealth MPS Program funded)<br>• 24 Hour Emergency and Outpatient<br>• Low risk General Practice Medicine Inpatient Services |
| Cowell District Hospital and Aged Care | Grant-funded | EFNLHN | Acute: 12<br>Long Stay Nursing Home: 8<br>Low Care Aged: 10 | • Residential Aged Care (Commonwealth MPS Program funded)<br>• 24 Hour Emergency and Outpatient<br>• Low risk General Practice Medicine Inpatient Services |
| Kimba District Hospital and Aged Care | Grant-funded | EFNLHN | Acute: 12<br>Long Stay Nursing Home: 8<br>Low Care Aged: 11 | • Residential Aged Care (Commonwealth MPS Program funded)<br>• 24 Hour Emergency and Outpatient |

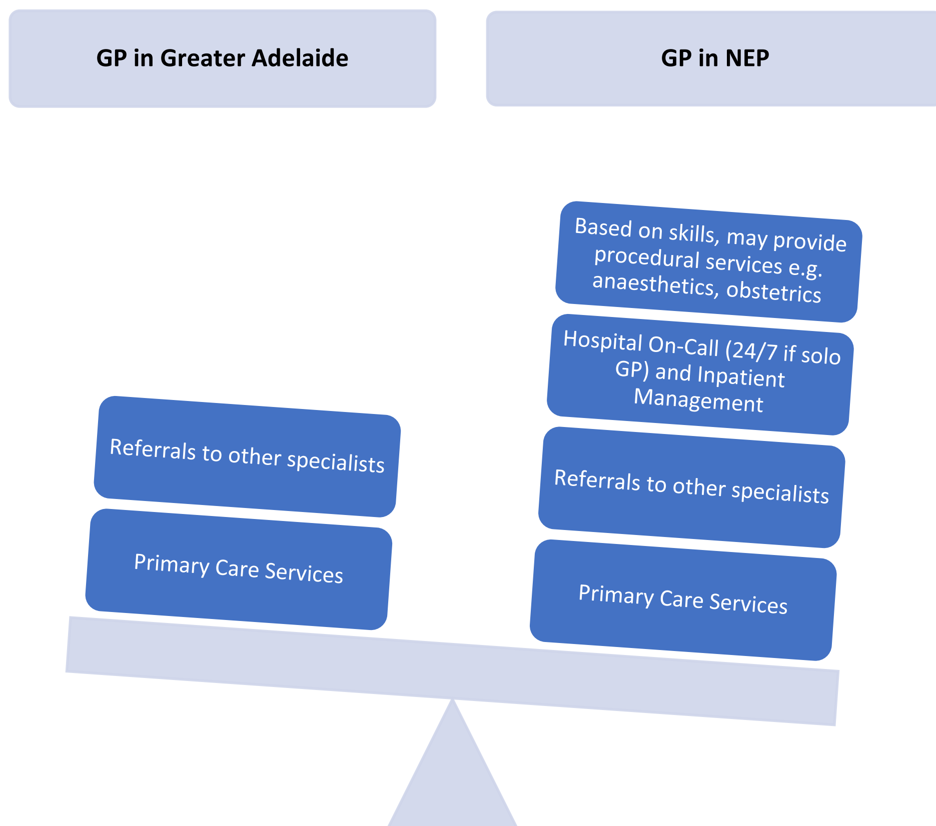
| | | | Independent Living Cottages: 8 | • Low risk General Practice Medicine Inpatient Services |
|---|---|---|---|---|
| Wudinna Hospital & Trudinger Residence | Grant-funded | EFNLHN | Acute: 13<br>Low and High care Aged: 10 | • Residential Aged Care (Commonwealth MPS Program funded)<br>• 24 Hour Emergency and Outpatient<br>• Low risk General Practice Medicine Inpatient Services |
| Tumby Bay Hospital & Uringa Hostel | Grant-funded | EFNLHN | Acute: 16<br>Low and High care Aged: 22 | • Residential Aged Care (Commonwealth MPS Program funded)<br>• 24 Hour Emergency and Outpatient<br>• General Practice Medicine Inpatient Services |
| Cummins District Memorial Hospital & Miroma Place Hostel | Grant-funded | EFNLHN | Acute: 11<br>Low and High care Aged: 22 | • Residential Aged Care (Commonwealth MPS Program funded)<br>• 24 Hour Emergency and Outpatient<br>• General Practice Medicine Inpatient Services |
| Ceduna District Health | Grant-funded | EFNLHN | Acute: 15<br>Low and High Care Aged: 38<br>Day Procedure/Chemotherapy: 4 chairs<br>Dialysis: 2 chairs<br>Step-Down Unit: 10 beds<br>Independent Living Units: 34 | • Residential Aged Care (Commonwealth MPS Program funded)<br>• 24 Hour Emergency and Outpatient<br>• Acute Inpatient<br>• Emergency and elective surgery<br>• Maternal and birthing<br>• Palliative Care Suite<br>• Community Health |
| Port Lincoln Hospital and Health Service | Casemix -funded | EFNLHN | Mix of medical, special care, surgical, obstetric, palliative care, paediatric: 50 beds | • Special Care unit<br>• Renal Dialysis<br>• 24 Hour Emergency and Outpatient<br>• Medical and Surgical<br>• Maternity and Obstetrics<br>• Mental Health Services<br>• Community Health<br>• Palliative Care<br>• Paediatrics<br>• Visiting Medical Specialists and Surgeons |
| Whyalla | Casemix -funded | FUNLHN | 48 single patient rooms | • 24-hour accident and emergency services<br>• General medical and specialist surgical care<br>• Anaesthetic, cardiac, obstetric and neonatal services |

| | | | | |
|---|---|---|---|---|
| | | | | • Chemotherapy and renal dialysis services<br>• Regional cancer resource centre<br>• Rehabilitation services<br>• Telerehabilitation service<br>• Integrated mental health services<br>• Stroke services |

## The Role of GPs in the NEP Region

In metropolitan South Australia, a general practitioner’s role is to provide primary care and referrals to other specialists, while hospital medical services are provided by doctors who are employed on-site at hospitals. In the NEP region, general practitioners provide primary care, referrals to other specialists and general practice medicine services to the hospital. Depending on skills, the GP may provide procedural services such as anaesthetics or obstetrics. The GP is contracted by the hospital under a fee-for service-arrangement and works on an on-call basis. The solo GPs in Wudinna and Streaky Bay are on call for the hospital twenty-four hours per day and seven days per week unless they are relieved by locums. GPs who work in Mid Eyre Medical rotate on an on-call roster, but currently cover four hospitals at one time.

*Figure 3: Responsibility and Scope of a NEP GP compared to a GP in Greater Adelaide*



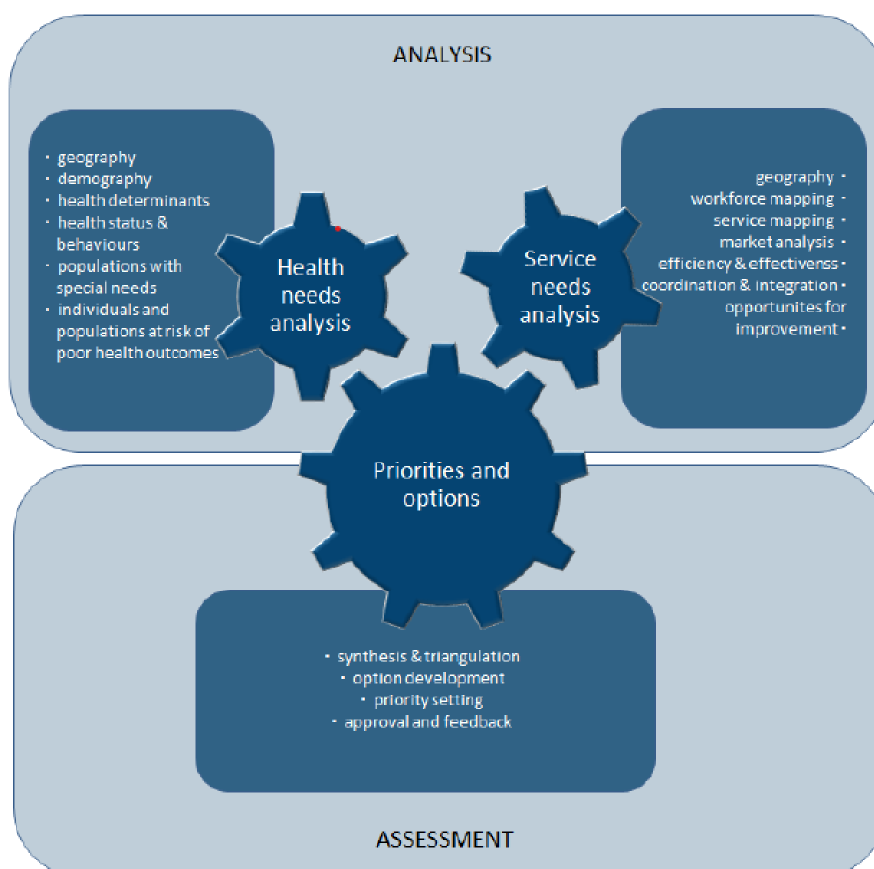
# Method

## Needs Assessment Process

This Needs Assessment used the methodology described in the PHN Needs Assessment Guide (Australian Government Department of Health, 2015). Figure 4 demonstrates this method (ibid, p. 6).

1. Part 1: Analysis of Health Needs and Service Needs (Australian Government Department of Health, 2015, pp. 5-6)
2. Part 2: Assessment of "Opportunities, Priorities and Options" (Australian Government Department of Health, 2015, p. 5)

*Figure 4: The Needs Assessment Framework*




Country SA Primary Health Network (CSAPHN) already analyses the health needs and service needs of the Country SA PHN region as a whole (Country SA PHN, 2018).

This Needs Assessment identifies needs in relation to a particular service issue in a particular geographic region, namely, the recruitment and retention of the medical workforce in the NEP region. Thus, only needs in relation to the issue of focus are analysed.

The assessment of Opportunities, Priorities and Options which will occur separately to this Needs Assessment will consider opportunities to work with groups outside of the NEP region.

## Data used for Needs Assessment:

### Quantitative Data – ABS, PHIDU and NHWFDS

Quantitative data from the Australian Bureau of Statistics (ABS) (2021) Torrens University's Public Health Information Development Unit (PHIDU) (2021) and the National Health Workforce Dataset (2019) (NHWFDS) were used to determine the full time equivalent (FTE) GPs in the NEP region. The PHIDU data was also used for other social health information about the NEP region.

#### *Limitations to quantitative data*

Although health workforce and community health needs can be somewhat demonstrated through quantitative data, the quality of available quantitative data to specifically measure the need for GPs in the Northern Eyre Peninsula Region is limited.

Data on GPs per 100,000 population was not available from PHIDU for most of the NEPHA LGAs due to the small numbers of full-time equivalent GPs in each LGA and privacy constraints.

Data on the Full Time Equivalent Total Medical Practitioners with General Practice Specialty Employed in Australia working in their registered profession in 2019 was sourced from the NHWFDS (hereinafter referred to as 'the NHWFDS data'), although local knowledge from the consultation indicated that the figures from this data set do not accurately represent the situational reality on the Eyre Peninsula. For example, the NHWFDS data showed that the District Council of Wudinna had zero full time equivalent GPs in 2019, while local knowledge from the consultation indicated that there was a local GP providing full time services there in 2019. Further, the NHWFDS data showed that the District Council of Elliston had the FTE of three GPs and The District Council of Lower Eyre Peninsula had FTE of over seven GPs, however local knowledge from the consultation indicated that there were far less FTE GP services being provided in these LGAs in 2019. The NHWFDS uses data from the annual Australian Health Practitioner Regulation Agency (AHPRA) registration process and a workforce survey completed at the time of registration (Australian Government Department of Health, 2019). The exact method used in to reach these figures is unknown. However, it is presumed that there is higher possibility for inaccurate representation of the actual GP supply in the NEPHA LGAs due to the self-reporting method by which the data was collected and the possibility that the data could include GPs who have undertaken work in the NEP region of a temporary nature.

To gain data that is more representative of the current situational reality on the Eyre Peninsula, consultation data on the FTE GPs servicing the NEP region in 2021 was used with population data from 2020 (Australian Bureau of Statistics, 2021) to manually calculate the FTE GPs per 100,000 people in the NEP region. These rates were compared with the rate of General Medical Practitioners per 100,000 people for total South Australia, Greater Adelaide and the Rest of South Australia in 2018, sourced from the PHIDU Social Health Atlas (Public Health Information Development Unit, 2021). Although comparing 2021 figures with 2018 figures somewhat limits the comparability of the data, it still provides an indication of the vast disparity in volume of GPs in the NEP compared to the whole of South Australia, Greater Adelaide, and the rest of South Australia. The Area of each LGA and Total South Australia was sourced from the ABS (Australian Bureau of Statistics, 2021).

### Qualitative Data - Stakeholder Consultation and Thematic Analysis

To supplement the quantitative data, a stakeholder consultation was conducted. A further reason for stakeholder consultation is to understand factors which affect the choice to live and work as a GP in the NEP towns. These factors informed the assessment of need in the NEP region in relation to the recruitment and retention of GPs and other health professionals. This was an opportunity to empower the community to contribute their views, and to recognise the needs of those whose views 'may not be represented in routine statistical collections' (Australian Government Department of Health, 2015). The stakeholder consultation was also an opportunity to gain the most current data on the issue, as it was conducted in 2021.

A series of semi structured interviews were conducted with local stakeholders to identify the needs of the NEP region in relation to the recruitment and retention of GPs. A theoretical thematic analysis method, as described by Braun and Clarke (2006) was adopted to analyse the key semantic themes arising from the interviews. The theoretical position of this analysis was that of 'realism,' 'which reports experiences, meanings and the reality of participants' (Braun & Clarke, 2006).

### Qualitative Data – Literature review

A small selection of literature was analysed to gain a broad view of the issue and to provide further evidence of the needs identified in the data analysis and stakeholder consultation.

## Outcomes of the Needs Analysis

Although this section summarises the key needs of the Northern Eyre Peninsula region, the prevalence and relevance of these needs vary between NEP towns. While the below is generally representative and effort has been made to highlight contextual differences, context and local conditions should always be considered in addition to the below.

Table 3: Outcomes of the Needs Analysis[1]

| Identified Need | | Key Issue | Description of Evidence |
|---|---|---|---|
| 1 | Increase Critical Mass of GPs | There are not enough General Practitioners to service the population in the Northern Eyre Peninsula Region.<br><br>All of the NEP region and its surrounding area is considered to be a Distribution Priority Area for GPs.<br><br>GPs are retiring and not being replaced by the new generation of GPs.<br><br>The number of GPs in metropolitan South Australia per 100,000 population is disproportionally higher than the number of GPs on the NEP.<br><br>There is stress placed on health professionals and support staff in the health system due to the limited number of GPs on the NEP.<br><br>The limited number of GPs on NEP limits access to primary healthcare for the NEP population and results in poorer health outcomes.<br><br>There is a need for more female GPs with skills in women's health to work on NEP. | PHIDU Data (Public Health Information Development Unit, 2021)<br><br>ABS Data (Australian Bureau of Statistics, 2021)<br><br>Distribution Priority Area mapped via Health Workforce Locator (Australian Government Department of Health, 2021)<br><br>Country SA PHN Needs Assessment (Country SA PHN, 2018)<br><br>Consultation (2021) |
| 2 | Restructure of on-call model | The current on call models on NEP do not allow GPs to have an adequate work and life balance and lead to burn out of GPs.<br><br>The remote on call model on NEP is perceived as potentially unsafe by doctors unfamiliar with or new to this model and by nurses working in the system. | Consultation (2021) |
| 3 | Doctor Remuneration, Benefits Package & Working Conditions | The locum circuit is more competitive in the employment market than rural GP practices.<br><br>There is a perception that the responsibility and workload of a rural GP is not currently | Consultation (2021) |

[1]This table has been used with the permission of the Commonwealth Department of Health. The opinions expressed in this paper are those of the author and do not reflect those of the Australian Government or Department of Health.

|  |  |  |  |
|---|---|---|---|
|  |  | commensurate to their remuneration and benefits package.<br><br>GPs need to have a say in their working conditions. Their needs should be reviewed and addressed regularly.<br><br>Communities do not want to compete on the package they are offering to doctors. |  |
| 4 | Onus of Responsibility to Provide Primary Care Services and the Ancillary Support for the Workforce Needs Clarification. | Onus of responsibility for providing primary care services is fragmented and not clear. Each agency that has picked up the onus denies that the responsibility to provide such services is within their ambit. | Consultation (2021) |
| 5 | Local Capacity Building to be Able to Undertake Workforce Planning | GP practices on NEP need support to undertake succession planning.<br><br>The expertise of existing GPs on the Eyre Peninsula should be consulted on what is best practice in succession planning on NEP.<br><br>Succession planning should focus on identifying candidates with personal values and characteristics that suit the rural context. | (Eley, et al., 2015)<br><br>Consultation (2021) |
| 6 | Collegial Support for Doctors to Reduce Feelings of Professional Isolation | For solo GPs on the NEP, there is a lack of collegial and professional support. | Consultation (2021) |
| 7 | Resources for Backfilling | Due to the limited number of GPs on NEP, there is a lack of support to backfill GPs when they get sick, need time off or are undertaking professional development.<br><br>Due to the limited number of GPs on NEP, there is not enough support to supplement for the extra workload during holiday periods. | Consultation (2021) |
| 8 | Liveability | There is a need to reduce feelings of remoteness and isolation for GPs.<br><br>GP tend to leave NEP towns for their children to attend high school.<br><br>There is a need to support partners of GPs to find work.<br><br>Accommodation is deteriorating in some areas.<br><br>The lack of childcare services in some communities is a barrier for nurses and doctors to work in those towns. | Consultation (2021)<br><br>University of Adelaide and GPEx Medical Specialty Decision Making Study (Laurence, et al., 2020) |
| 9 | Support for Nurses | Some nurses are stressed and scared without the access to physical support of a doctor. | Consultation (2021) |

| | | | |
|---|---|---|---|
| | | Nurses have limited opportunity to practice their skills in preparation for Accident and Emergency presentations.<br><br>Some nurses need to be supported to build their capacity and confidence to best assist the GP. | |
| 10 | Creating High Quality Training Environments in NEP Medical Practices | GPs need to train in rural locations to be more likely to work in rural locations.<br><br>The limited number of GPs in the NEP region and the lack of maturity in the development of some NEP medical practices precludes the ability to host GP Registrars in the NEP region. | University of Adelaide and GPEx Medical Specialty Decision Making Study (Laurence, et al., 2020)<br><br>The University of Adelaide, WAGPET and GPEx Graduate Tracking Study (Laurence, et al., 2016)<br><br>Consultation (2021) |
| 11 | Longer term Doctors instead of Temporary Locums | There is a lack of continuity of care where locums are used.<br><br>Locums sometimes lack understanding of the context within which they are working.<br><br>There is a lack of trust between some nurses and some locums. | Consultation (2021) |
| 12 | Support for Doctors and Nurses to Complete Professional Development | Doctors and nurses are expected to source their own professional development opportunities; however, it is expensive and time consuming to undertake professional development in the city due to the distance.<br><br>It is difficult to get support to backfill doctors and nurses while they are completing their professional development. | Consultation (2021) |
| 13 | Health System Co-Ordination | Communication and co-ordination between agencies to plan the health workforce on the NEP is needed.<br><br>Smaller hospitals need the support from larger hospitals.<br><br>Solutions should be developed with the potential to address Oral Health workforce needs.<br><br>Solutions should be developed with the potential to address Allied Health workforce needs. | Country SA PHN Needs Assessment (Country SA PHN, 2018)<br><br>Consultation (2021) |

# Discussion of Needs

All quotations in this section are from participants of the community consultation referred to in the Method unless another source is referenced.

## Need 1: Increase Critical Mass of GPs

There are not enough General Practitioners to service the population in the Northern Eyre Peninsula Region. All of the NEP region and its surrounding area is classified as a Distribution Priority Area for GPs, which 'identifies areas where people don't have enough access to doctors, based on the needs of the community' (Australian Government Department of Health, 2019).

Table 4 shows that the rate of GPs to population in Greater Adelaide is 110.9 FTE GPs per 100,000 people, or 1 FTE GP per 902 people. The rate in the NEP region is significantly lower, at 49.64 FTE GPs per 100,000 population, or 1 FTE GP per 2014 people. In Greater Adelaide, 1 FTE GP covers 2.2$km^2$, whereas with the current numbers of GPs in the NEP Region, 1 FTE GP covers 7328.3$km^2$.

Table 4 also shows that the rate of GPs to population in the rest of South Australia (all areas apart from Greater Adelaide) is 92.7 FTE GPs per 100,000 population, which is also significantly higher than the NEP region. In the rest of South Australia there is 1 GP covering 2709$km^2$.

Table 4: Ratio of GPs to Population and Area

| NEP Local Government Area (LGA) | Area $km^2$[2] | FTE GPs[3] | Estimated Resident Population[4] | FTE resident GPs per 100,000 population | Ratio of GPs to Population | Ratio of GPs to Area |
|---|---|---|---|---|---|---|
| DC Cleve | 5018.8 | 2.1 full time equivalent GPs, supported by locums<br><br>0.2 FTE visiting GP at Lock (external to Mid Eyre Medical)[5] | 5151 | 44.65 | 1: 2239 | 1: 8,788 $km^2$ |
| DC Franklin Harbour | 2755.6 | | | | | |
| DC Kimba | 5697.1 | | | | | |
| DC Elliston | 6741.9 | | | | | |
| Total Mid-Eyre Medical | 20,213.4 | | | | | |
| DC Streaky Bay | 6222.9 | 1 full time, occasionally backfilled by a locum or a retired GP | 2204 | 45.4 | 1:2192 | 1: 6222.9 $km^2$ |
| DC Wudinna | 5075.3 | 1 full time | 1307 | 76.5 | 1:1300 | 1: 5075.3 $km^2$ |
| **Total NEP region** | 31,511.6 | 4.3 FTE resident GPs, supported by locums | 8662 | 49.64 | 1:2014 | 1: 7328.3 $km^2$ |
| **Total South Australia** | 984,274.9 | 1,854.5 | 1,736,422 | 106.8 | 1:936 | 1: 530.7 $km^2$ |
| **Greater Adelaide** | 3,240 | 1,492.5 | 1,345,777 | 110.9 | 1:902 | 1: 2.2 $km^2$ |
| **Rest of South Australia** | 981,034.9 | 362.13 | 390,645 | 92.7 | 1:1079 | 1: 2709 $km^2$ |

[2] The Area of each NEP LGA and Total South Australia was sourced from the Australian Bureau of Statistics (2021). The area of Greater Adelaide was sourced from The Australian Government Department of Agriculture, Water and the Environment (2021).

[3] The FTE GPs in the NEP LGAs was sourced from the Consultation (2021). The FTE GPs for South Australia, Greater Adelaide and the Rest of South Australia was sourced from PHIDU (2021).

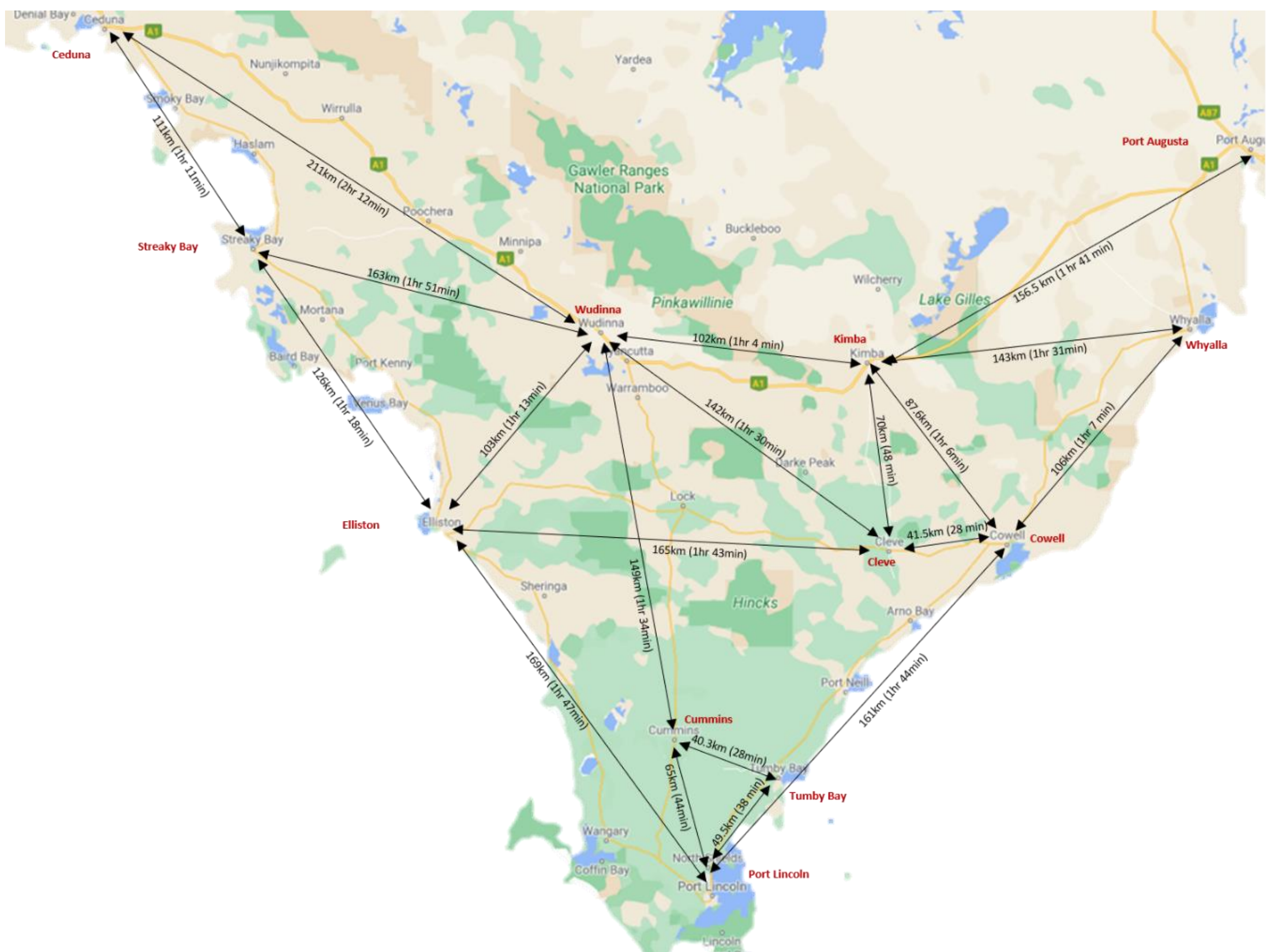
[4] The Estimated Resident Population of the NEP LGAs was sourced from the ABS (2021). The Estimated Resident Population of South Australia, Greater Adelaide and the Rest of South Australia was sourced from PHIDU (2021).

[5] This doctor does not provide services to the Elliston Hospital.

GPs in the NEP region service significantly more people and cover significantly more geographic area than GPs in metropolitan South Australia. Further, GPs in the NEP region take on the additional obligations under the fee-for-service arrangement with the hospitals that metropolitan GPs do not. Figure 5 shows the distances and travel time by car between towns with hospitals (Google, 2021). Most of the NEP towns are at least one hour's drive apart. In addition to the fatigue caused by driving long distances, hazards such as kangaroos, extreme weather, bushfires, and lack of phone signal on stretches of road pose danger to travellers. Road traffic, especially during holiday periods may slow travellers down and make the roads more dangerous. Currently, with 4.3 resident doctors in the NEP, citizens are likely to have to drive on these roads to seek medical services from a doctor. If a doctor is on call remotely for multiple hospitals, these road hazards may prevent the doctor from being able to drive to physically see a patient in another town in the event of an emergency. Alternatively, the doctor will bear these risks to their own safety and drive to the other town in favour of the safety of the patient to whom they have a professional duty of care.

## Distances and Travel Time Between NEP Towns

*Figure 5: Map of distances and travel time between NEP Towns*



There is particularly a need for more female GPs with skills in women's health to work on NEP: 'We need to be accessing solid, quality female doctors with staying power' (Anon., 2021). The consultation indicated that there is one resident female GP servicing the NEP region. Consultation participants expressed that most females feel more comfortable speaking about women's health issues, such as menopause, gynaecological conditions and testing for cervical and breast cancer, with a female doctor. Consultation participants were worried that an important women's health issue might be missed if females cannot access a female doctor and are not willing to be consulted by a male doctor on these issues.

### Why is the NEP Below the Critical Mass of GPs?

Currently, GPs are retiring and not being replaced by the new generation of GPs. One medical practice in Port Lincoln has had five out of ten doctors retire and not be replaced. Consultation participants in every NEP town expressed that almost every NEP town is 1 doctor's retirement away from losing their medical service: 'We are always a few years off disaster;' 'If there is no doctor, there is no hospital and there is no town;' 'In the future we are going to lose Dr [name]. Then we are back to square one'.

### Effects of NEP being Below the Critical Mass of GPs:

There is stress placed on health professionals and support staff in the health system due to the limited number of GPs on the NEP. Doctors, nurses and medical practice staff are burnt out:

- 'We skate along. Tensions are very high.'
- 'Having less doctors in the system "ups the ante." On a good day, medical practice staff just do their job. On a bad day, the medical practice staff are triaging patients just for a doctor's appointment.'
- 'There are only two doctors left in the Mid-Eyre Medical model. They are burning out. They won't last long. They are both becoming unwell more frequently. The days when they have a locum is good, but not the days without locums.'
- 'We are worried that [doctor] is going to give up out of frustration.'
- 'There is a great lifestyle, but there is no time to live it for the doctors here.'
- '[Prospective] doctors are afraid of being overworked and out of their depth.'
- Travelling long distances by car is a burden on GPs if they are servicing multiple communities.

The limited number of GPs on NEP limits access to primary healthcare for the NEP population and results in poorer health outcomes:

- 'Because there aren't enough doctors, we are not getting to the patients with chronic disease. There is a backlog of patients with management plans which means their chronic illness is not managed.'
- 'People who should have been assessed sooner by a doctor deteriorate if they don't get seen.'
- 'There is a backlog of doctor tasks at the hospital because of the lack of rounds.'
- 'When there is no GP, health benchmarks of the community do not get measured, for example, the proportion of diabetics who have had the HbA1c test, whether the practice has identified all of the diabetics who attend the practice, whether a diabetic's blood pressure is to target, or whether someone with ischemic heart disease has the target level of cholesterol.'
- 'The lack of doctors and nurses means that things get left and then they escalate.'

## Need 2: Restructure of On-Call Model

The current on call models on NEP do not allow GPs to have an adequate work and life balance and lead to burn out of GPs.

For NEP towns with a solo GP, there is an obligation to be on-call for twenty-four hours per day and seven days per week, unless they have locum support which is expensive. This obligation is no longer attractive for the new generations of GPs: 'No one wants to be on call 24/7. No one will take that contract;' 'Being on call 24/7 and the lack of work/life balance is what tips the balance and makes GPs leave. They know they can get a better deal elsewhere.'

In other NEP towns, there are multiple doctors rotating through an on-call roster, but due to the limited number of doctors in the system, they are on call for four hospitals at one time. For three hospitals, they are on call remotely. The remote on call model on NEP is perceived as potentially unsafe by doctors unfamiliar with or new to this model and by nurses working in the system:

- 'Being on call for four hospitals is way too much.'
- 'Being on call for four hospitals from one location is not ideal'
- 'Other centres have used hub and spoke models, but the Eyre Peninsula's towns are too far apart.'
- 'If you are a Nurse here, the doctor could be two hundred kilometres away. You're it.'

Consultation participants expressed that there are communication difficulties when the doctor is remotely on call. One doctor expressed that it is hard for nurses to understand the doctor's instructions and for the doctors to express what they want the nurses to do. Different hospitals have different cultures they are used to communicating a certain way (aside from the standard hospital protocols by which they are bound): 'The doctor has to know the intricacies to be able to be on call remotely in an effective way.'

Some nurses expressed that it is more difficult to trigger what they want from the doctor by communicating over the phone, for example, when they would like the doctor to physically see the patient. Nurses occasionally feel as though if the doctor could see the signs and symptoms of the patient rather than go by the information given to them by the nurse, the doctor might make a different decision.

Nurses expressed that communication with the on-call doctor via the fax machine is a problem. When documents such as medication charts are faxed, information cannot be clarified easily. To make changes to the medication chart, the document must be faxed again. This process is time consuming and prone to error.

Some nurses expressed that the capacity or willingness of some doctors to use video-conferencing technology rather than the telephone is limited. They need support in using the Information Technology so they can view the patient and not only act on the nurse's descriptions. Poor quality or non-existent internet and mobile communications throughout districts add to these difficulties.

## Need 3: Doctor Remuneration, Benefits Package & Working Conditions

Consultation participants expressed that the locum circuit is more competitive in the employment market than rural GP practices in terms of remuneration, benefits and working conditions: ‘Big city practices or the locum circuit is more attractive. They have the monopoly of the workforce.’ This is because doctors on the locum circuit are perceived to have less commitment to the role and less ongoing workload than that of a rural GP, but they are remunerated more: ‘The locum market is more competitive…How can GP practices compete?’ The consultation indicated that the market price for locums per day is much higher than the money per day a resident GP would make. The price of a locum can also be more during holiday periods such as Easter and Christmas time.

The responsibility and workload of a rural GP is not currently commensurate to their remuneration and benefits package. In the consultation, doctors expressed that the level of responsibility being either a solo doctor or one of a limited number of doctors and the additional obligation to be on call for the hospital were not commensurate to their remuneration and benefits: ‘Rural GPs feel undervalued and underpaid.’

One doctor in the remote on call model expressed that if they are treating a patient remotely while they are on call, but they do not attend the hospital, they are only paid the on-call rate. If they are consulting over the phone or video, they still undertake the duty of care to the patient and professional liability as though they were consulting in person, but they aren't being paid accordingly as though they were attending the hospital.

Another doctor expressed that originally, their contract was to work in Cleve and Elliston. After the GPs in Cowell and Kimba left, then these two towns came into the jurisdiction of this doctor’s work, but there were no incentives or remuneration to account for the on-call obligations for the two extra towns.

Consultation participants expressed that GPs need to have a say in their working conditions:

- ‘The doctor needs to have a say. The model of practice needs to suit the doctor that you want to engage. It has to be flexible enough for them.’
- ‘There is poor recognition of rural GPs from the system more broadly. Their needs are not considered.’
- ‘There isn't a huge pool of doctors to pick from who are willing to come out to the country, so you need to take whoever is the captive audience and then ask what they need and how they want to work.’
- Being flexible in what benefits and working conditions the candidate wanted was what attracted another GP to the NEP region.

A GP in the Mid-Eyre Medical model expressed that their employment contract had not been renewed yearly and so there was no opportunity to negotiate their employment conditions. This indicates that GPs needs should be reviewed and addressed regularly.

## Need 4: Onus of Responsibility to Provide Primary Care Services and the Ancillary Support for the Workforce Needs Clarification.

The onus of responsibility for providing primary care services in the NEP region is fragmented and not clear. The NEP region was previously reliant on private practitioners to provide primary care services, and now various agencies have picked up the onus out of absolute necessity, such as the District Council of Streaky Bay and Eyre and Far North Local Health Network. There has been no determination of whose responsibility it is to provide such services.

- 'It shouldn't be up to the community to get a GP.'
- 'The question then is who will run the business if GPs don't want to run it.'
- 'The provision of primary care (i.e. GP practices) is not their [Eyre and Far North Local Health Network's] core business. They stepped into it many years ago as a reasonable and economic solution to staffing small hospitals in these remote areas – which are traditionally serviced by the local GP.'
- 'If this was a mining company, the problem would have already been solved. There is no will from the State Government to solve this. State Government does not want to fund it.'
- 'Councils will do what they can, but they cannot do it all.'
- 'GP and hospital health services are the responsibility of State and Federal governments. As, (predominately), small rural councils are forced to step up providing support, infrastructure and substantial funding, their residents and ratepayers are effectively taxed twice as their rates are used to shore-up these essential services.'

Once the onus is clear, then a co-ordinated approach can occur.

Further, the onus to provide accommodation for doctors, nurses and nursing students is not clear. Some NEP towns have doctors' houses owned by the Council and others have doctors' houses owned by the hospital:

- 'Currently, Elliston hospital pays for students' accommodation when they do placement, but the hospital shouldn't have to do this.'
- 'It is not clear on whose responsibility it is to maintain, update, furnish and fix things in the doctors' houses. These little things build up for a doctor. They compound the issue.'

## Need 5: Local Capacity Building to be able to Undertake Workforce Planning

GP practices on NEP need support and resources to undertake succession planning. Consultation participants have expressed that succession planning should focus on identifying candidates with personal values and characteristics that suit the rural context:

- 'Whether you work rurally as a GP depends where you are in life and what you value.'
- 'There is a certain character who stays rural long term - they have interests that keep them there.'
- 'You need to identify the right person early, while they are training and make contact. Keep in touch with them and provide the incentives to work back in the town.'

One study has found that the combination of levels of individual traits such as low harm avoidance, high self-directedness and persistence, which correlate with high levels of resilience 'may be indicative of individuals best suited to rural and remote medicine' (Eley, et al., 2015). This correlates with the following statements from the consultation, which indicate that the 'right' person for rural general practice has high resilience and self-directedness:

- 'We need to attract people with experience and a good head on their shoulders who are not easily spooked and can cope with different situations.'

- ‘Someone with a frontier, pioneer mindset’

The expertise of existing GPs on the Eyre Peninsula should be consulted on what is best practice in succession planning on NEP:

- ‘Existing GPs on EP have the instinct to identify the right personality and character early’
- ‘It is crucial to use the experience of the GPs that currently exist on the Eyre Peninsula before they retire…Perhaps engage them in a consultancy role to design the model or be mentors to registrars.’

The consultation showed that medical practices in the NEP region are currently focussing their limited resources on the day to day operation of the practices given the scarcity of the GP workforce. Therefore, support for succession planning can only happen when there is a greater mass of GPs working in these practices and when resources and time can be directed to succession planning.

## Need 6: Collegial Support for Doctors to Reduce Feelings of Professional Isolation

For solo GPs on the NEP, there is a lack of collegial and professional support:

- ‘The doctor has no reference point - no professional support.’
- ‘There is no collegial structure between practices.’
- ‘Doctors are used to having the tertiary support. This is why nurturing is important, so that they don't give up and decide to return to the city where there is the tertiary support.’
- ‘GPs need other peers to refer to when problem solving.’
- ‘To make it attractive for doctors, the system needs to be supported by existing good hospital staff and there needs to be a strong hospital reputation. Doctors need to be able to embrace the strength of the existing hospital staff.’
- ‘It takes a special person to go out there without support.
- Doctors need to work in a group so they can get support from each other. Backup is crucial.
- Doctors should know that they are coming into a place that they’ll have well trained nurses.
- ‘A good thing about mid-Eyre medical is that all doctors are in one system and they can share medical information with each other.’
- ‘Once in town, doctors need a support network, someone to "download" to… If there was a second doctor, they could offload to each other and talk on hand over of shift.’

Further, medical students perceive that rural general practice does not necessarily offer a supportive work environment (Laurence, et al., 2020, p. 90). This may be an obstacle to recruiting GP registrars and early career GPs.

## Need 7: Resources for Backfilling

Due to the limited number of GPs on NEP, there is a lack of support to backfill GPs when they get sick, need time off or are undertaking professional development:

- ‘No one has treated supporting existing GPs as a priority. The priority has been on getting GPs into places where there is no GP. This might be a misplaced priority.’
- ‘There needs to be the support of locum backup for when doctors need holidays.’
- ‘There is Commonwealth money to support rural GP’s to take leave however the locum support provided is patchy and unreliable and has to be booked many months/years in advance.’
- ‘RDWA [Rural Doctors Workforce Agency] used to provide locum assistance - they were on the ground and asked how it was going. For some reason this has stopped.’

Consultation participants expressed praise for the South Australian Virtual Emergency Service (SAVES), which provides after hours face-to face consults with a doctor via telehealth for emergency department presentations that are triage categories 2-5 (Rural Doctors Workforce Agency, 2021):

- 'SAVES is excellent. They are efficient at ordering medication and it is a simple process over the video conferencing unit. [Our hospital] has just started using it more.'
- 'SAVES is helpful. If the doctor isn't feeling well and they are on call, they can ask to call SAVES after a certain time.'
- 'SAVES is very helpful. It should be advertised when recruiting nurses.'

Consultation participants expressed that due to the limited number of GPs on NEP, there is not enough support to supplement for the extra workload during holiday periods:

- 'On Easter long weekend in Cowell there are 300 boats launched off the marina, but there is no doctor in Cowell over that time. Then emergencies come to Cleve.'
- 'People present at the hospital if they can't get an appointment at the medical practice, especially on long weekends and holidays. Then, the doctor has to come to the hospital to see the patient if the nurses can't attend to the patient. There are many accident and emergency presentations which are minor. If there was an outpatient clinic for a few hours on long weekends it would cut down on walk ins to the hospital.'
- 'Population of Streaky Bay can swell to 5000 in summer during the tourist season. This puts extra pressure on the doctor.'

## Need 8: Liveability

'Unless the money is outrageous, money is not the driving incentive or deterrent. The reason to be there is family, hobbies and ties.'

The consultation showed that socially, every NEP town is highly liveable. Consultation participants from all NEP towns commented on the strong sense of community they experienced living there: 'It is about the heart and soul [of the town]'. A nurse expressed that the recognition of their work from the community and their neighbours when they walk down the street is rewarding. All of the permanent doctors in the NEP region expressed that they like their town and their community. They find their community supportive and respectful. One of the doctors expressed that if it weren't for the efforts of their local Council to accommodate their needs, they might not have decided to take the job as the local GP. Another doctor expressed that their social ties to the community was the only reason they have stayed so long in the job as the local GP. The PHIDU data shows that all the NEP towns are ranked highly in Australia for the percentage of the population who undertake voluntary work for an organisation or group (Public Health Information Development Unit, 2021) This demonstrates a high level of community contribution by the population of the NEP region:

Table 5: Volunteers in NEP LGAs

| Local Government Area | People aged 15 years and over who participated in voluntary work | Population aged 15 years and over | % volunteers | Australian Rank |
|---|---|---|---|---|
| Kimba (DC) | 420 | 810 | 51.9 | 1 |
| Cleve (DC) | 690 | 1,411 | 48.9 | 4 |
| Wudinna (DC) | 452 | 971 | 46.5 | 6 |
| Elliston (DC) | 363 | 842 | 43.1 | 11 |
| Streaky Bay (DC) | 677 | 1,660 | 40.8 | 18 |
| Franklin Harbour (DC) | 410 | 1,072 | 38.2 | 35 |

Source: (Public Health Information Development Unit, 2021)

Despite the social liveability of the NEP region, other liveability factors are obstacles to the recruitment and retention of GPs and other health professionals.

Remoteness from home and family was mentioned by most consultation participants as an obstacle to recruitment and retention of GPs on NEP. All NEP towns are multiple hours' drive from Adelaide are at least 1 hour's drive away from public airports in Whyalla, Ceduna and Port Lincoln. Further, isolation from 'family and friends, cultural and social opportunities and professional isolation' was the most common disadvantage of rural general practice by medical students in a Medical Specialty Decision Making Study (Laurence, et al., 2020).

Multiple consultation participants expressed that doctors are likely to leave NEP towns when their children become high-school aged to send their children to school in Adelaide. Many also expressed the need to support the GP's spouse or partner to find work in the town, or to recruit GPs who are single or whose spouse's or partner's work is not bound by a city location.

Many consultation participants mentioned that accommodation for doctors is deteriorating in some areas and not being upgraded. Further, the rental market in many towns is scarce, leaving few attractive places for a doctor to live. Regional Development South Australia has also identified the scarce rental market as a barrier to workforce recruitment in regional South Australia, stating that there has been a 26.3% decrease of available rental properties in regional South Australia between January 2019 and January 2021 (Regional Development South Australia, 2021).

The lack of childcare services in many communities is a major barrier for nurses and doctors to work in those towns. The lack of childcare services means GPs with a working partner have no one to care for small children during work hours. Where there are childcare services available, the opening and closing times of such services is not suitable for shift workers who need care for their children in the early hours of the morning or later at night.

## Need 9: Support for Nurses

In the absence of a doctor providing physical services 24 hours per day and 7 days per week, nurses working at the hospital need support.

The consultation showed that some nurses are stressed and scared without access to the physical support of a doctor when the doctor is on call remotely. When the doctor is on call remotely, nurses cover inpatients, outpatients, long stay patients and any incidents that happen in the aged care hostel with no doctor physically present to provide assistance. It is frightening for some nurses not having a doctor physically present in emergency situations because the doctor is another set of hands as well as skills. Some nurses have been in a position where the retrieval service cannot land due to weather conditions and the doctor is not on site, so they were stuck with an acutely unwell patient by themselves. They are afraid that this could happen to them again. On the weekend there are two nurses on shift in the hospital, and this might be one nurse if the other nurse were to be giving insulin or attending to a fall in the aged care, for example. Without a doctor this potentially leaves one nurse to deal with an emergency department presentation. Additional stress is put on nurses in emergency situations when there is only one nurse with particular skills, for example, canulation: '[The level of difficulty to deal with an emergency] also depends on which staff you're on shift with - how much experience is on the floor.' The communication issues of the remote on call model discussed in Need 2 also compound the lack of access to support for nurses. Some nurses are worried that if something went wrong, the scrutiniser such as a coroner, might not give concessions for the situation that the nurse is in.

When the doctor is on call remotely, the nurses sometimes do the administration and communication roles that a doctor would ordinarily do if they were on site. For example, one nurse called a larger hospital to transfer a patient when the on-call doctor was not free. The nurse found it hard to talk to the person on the other end at the larger hospital because 'they don't want to hear from a nurse.'

Nurses have limited opportunity to practice their skills in preparation for Accident and Emergency presentations, which compounds the issue above: ‘A barrier is that a GP or nurses might not see an emergency for a few years or might get a case of a particular condition that they haven't seen in 6 years.’

Nurses need to be supported to build their capacity and confidence to best assist the GP. Some nurses’ confidence needs to be built through building trust between the nursing staff and the doctors: ‘Teamwork, collaboration, trust and knowing your scope is very important. [Town] is lucky because they have the support for doctor and nurse collaboration;’ ‘When there is training, the doctor isn't here to train with the nurses. There is no team training together.’

Nurses’ confidence and capability also needs to be built through upskilling in areas such as plastering, suturing, X Ray skills, and canulation:

> ‘SAVES is good, but our towns need nurses with more training, including practice nurses. Currently, nurses are "band aid nurses". They need to be upskilled. As they are the second check on doctors, they need the skills to be able to ask the right questions of the doctor. This will add support to the doctor.’

There is a perception of some consultation participants that nurses are de-skilled when they work rurally and that it would be more attractive for nurses to work in rural areas if they have the sense that working rurally and upskilling will make them more employable. Consultation participants have expressed that any upskilling needs to be contextualised and in person, rather than online:

- ‘Their training needs to be contextualised. Not a city emergency department specialist coming to provide them training. Training provided by someone who can apply it to context;’
- ‘Online training is tokenistic. Training should be done on site to be contextual.’

## Need 10: Creating High Quality Training Environments in NEP Medical Practices

The Medical Specialty Decision Making Study undertaken by GPEx and the University of Adelaide indicates that ‘rural exposure is important [for medical students] in deciding to choose a career in rural general practice (Laurence, et al., 2020, p. 51).’ Further, a Graduate Tracking Study demonstrates that experience of rural general practice at the vocational training level positively influences the likelihood of graduates choosing to work in rural general practice (Laurence, et al., 2020, p. 32).

The Rural Generalist Program South Australia (RGPSA) launched in 2021 is an initiative of the South Australian Rural health Workforce Strategy, aiming to ‘develop and implement a continuous and integrated Rural Training Pathway’ (SA Health, 2021). In 2022, RGPSA anticipates to have 2 general practice intern positions, 2 Post Graduate Year 2 and above (PGY2+) general practice/emergency training positions, and one PGY2+ general practice/anaesthetics training position on the Eyre Peninsula. None of these positions are located at medical practices or hospitals in the NEP region, although they are in the nearby towns of Port Lincoln, Cummins, and Ceduna (ibid).

Although there is opportunity for Eyre Peninsula towns to host GP Registrars, consultation participants reported that the limited number of GPs in the NEP region and the lack of maturity in the development of some NEP medical practices precludes the ability to host GP Registrars in the NEP region:

- ‘To facilitate training, you need an experienced principal in the practice - but we are running out of those.’
- ‘It is a “Chicken and the egg” situation. We need GP registrars to train in the region, but we need the Principal GP to supervise them.’
- ‘Previous supervisors of Registrars have retired.’

Therefore, there is a need to focus on creating high quality training environments within medical practices in the NEP region. In the consultation, GPEx outlined some key conditions for a high-quality registrar training environment:

- ‘A clinically high functioning practice;
- A supervisor and lead clinician with a commitment to teaching. They need to be clinically strong, available with time and willingness to teach, and affable;
- A quality the team in and around the medical practice, for example practice managers and nursing staff at the hospital;
- A place that can nurture registrars;
- A place where there will be a job for the registrar; and
- A region that will engage well with the GPs when they get there.'

To encourage a GP registrar training in the NEP to continue to work there after graduation, the model of care in which they are training needs to ‘allow for the flexibility required to engage the next generation of rural GPs who wish to work in a more structured environment with a greater degree of certainty and who have no intention of becoming business owners or of remaining in one location for an indefinite period of time’ (Rural Doctors Workforce Agency, 2011, p. 9).

## Need 11: Longer term Doctors instead of temporary locums

There is a lack of continuity of care where locums are used:

- ‘Acute and Palliative care patients have no continuity of care as a result of seeing different doctors due to the locum coverage.’
- ‘People get sick of telling the whole story to locums repeatedly. They won't say something to the locum until it gets really bad - especially males.’
- ‘There is a disconnect between patients and locums - the patients have to tell the locums the story from the beginning. Some people won't go to see a locum because they do not feel comfortable speaking to them about their issues.’
- ‘There is rarely a handover process between locums.’
- ‘Splintering of medical care due to different locums cycling through.’
- ‘When the GP has a relationship with the patients and the kids from the beginning, it adds a personal touch and the patient is more likely to discuss their personal problems too. If there is a new locum, the patient will only talk about the acute problem and hide the rest - they won't open up. This means that psychological and chronic illnesses are not managed well. A patient needs to be seen many times to manage a chronic illness, otherwise it becomes an acute situation. GP is also the source of information for the defined population. If this information is not gathered, then the ability to measure the health outcomes of the community is limited.’
- ‘When locums are used, anyone with an ongoing issue does not get treated well. They tell their story multiple times to different doctors. Sometimes different doctors have differing opinions.’

Locums working across multiple towns sometimes do not understand the context within which they are working:

- ‘You [the doctor] have to get to know the people who are going to ring you [the nurses]. Over time you get a sense of their understanding.’
- ‘Many have never been to the region before…New locums have to learn how to use Medical Director and they have to get used to being on call remotely for four towns.’
- ‘The locums that come out are usually from hospitals and have no GP experience and no rural experience.’

- ‘Locums only know what they have been told by nurses - they are reliant on the nurses' information.’

There is a lack of trust between some nurses and some locums:

- ‘Treatment is suboptimal if there is no trust between the nurses and doctors. Locums get cranky with nurses or talk to them like they are mentally incompetent. There is little trust from some nurses of some locums.’
- ‘In [the previous place that I worked in], nurses were quite respected -here the nurses not respected by the locums.’
- ‘There isn't a team environment between the nurses and doctors. It sometimes feels like "nurses versus doctors"’
- Some nurses believe that the locums are not updating patient information in the medical recording software such as medication charts, and this information is rarely correct. They perceive that no one is following up when doctors are not doing this. They believe this could be ‘mopped up’ if there was a doctor round at the hospital every day.

Therefore, it is more ideal to have longer term doctors who can build familiarity with the context and rapport and trust with patients and staff of the medical practices and hospitals.

## Need 12: Support for Doctors and Nurses to Complete Professional Development

Doctors and nurses are expected to source their own professional development opportunities; however, it is expensive and time consuming to undertake professional development in the city due to the distance. The consultation showed that supporting GPs to undertake professional development with backfilling for the days they are out of town and co-ordinating opportunities to practice various skills in other hospitals would be attractive for prospective GPs.

## Need 13: Health System Co-Ordination

Country SA Primary Health Network (CSAPHN) identified that there is a ‘Lack of connection and communication between various health providers both within and between rural communities’ (Country SA PHN, 2018). Consultation participants also expressed the importance of health providers and other institutions working together:

- ‘Communication and systems are crucial’
- ‘EFN and FUN have to work together to find solutions’
- ‘If the logistics, co-ordination, and the skills of the rural generalists are good enough, then there will be less retrievals.’
- ‘Larger hospitals have to be on board with the idea of letting Eyre Peninsula GPs come in and do the professional development that they want to do and then fill the gaps with the visiting doctors. Not the other way around where the GPs fill the gaps.’
- ‘If the GP knows that the bigger centres will be open and accepting to referrals, then it will be more predictable for them and therefore less scary.’

Communication and co-ordination between agencies to plan the GP workforce on the NEP is needed. Such agencies include but are not limited to the Royal Flying Doctors Service, Rural Doctors Workforce Agency, Universities, Eyre and Far North Local Health Network, Flinders and Upper North Local Health Network, GPEx, and the Rural Generalist Program South Australia. Efforts to redress the critical shortage of GPs in the NEP region should complement and not duplicate the initiatives arising from the South Australian Rural Medical Workforce Plan 2019-2024.

Further, solutions should be developed with the potential to address Oral Health Workforce needs and Allied Health Workforce needs, given there is also a shortage of these health workforces on the Eyre Peninsula.

## Important Considerations:

There are minor themes identified in the consultation which are important to mention. Although they are not primary needs, they are important considerations to note.

### Recognition of Rural Generalism

Some consultation participants expressed that there is little recognition of the broad scope of practice and the increased responsibility of a rural GP compared to a GP working in a metropolitan area. In 2018, the title 'Rural Generalist' was defined to describe and formally recognise the nature of a rural GP's work and skill base. A Rural Generalist 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, by providing 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' (Royal Australian College of General Practitioners; Australian College of Rural and Remote Medicine, 2018). The National Rural Generalist Pathway has since been developed to create a pathway for doctors to train to become rural generalists. It is important for NEPHA to assist in raising the profile of Rural Generalism as a medical specialty:

> 'For clinicians, it provides clear and public recognition as to their scope of practice. For the next generation, it will be an important factor in encouraging them to become a Rural Generalist. For rural communities, it provides transparent and rigorous public accountability for the skills of their providers relative to different scopes of practice' (National Rural Generalist Taskforce, 2018, p. 37).

### Communication from EFNLHN to Mid-Eyre Communities

Another minor theme identified from the consultation was the frustration from consultation participants in the lack of communication they had from EFNLHN about its efforts to recruit and retain GPs in the Mid-Eyre Medical Practice: 'Don't keep me out of the loop, because it won't pacify me;' 'Communication from EFNLHN would be good. There is angst between towns…No one knows what happened. Even if it is filtered communication to the community. Put it out there what the common goal is to all communities. The community is very engaged in the fight [to get doctors].' There is a need for Eyre and Far North Local Health Network to undertake community engagement strategies with the communities serviced by Mid-Eyre Medical to build trust with the community in the efforts being made to recruit and retain GPs in the Mid-Eyre Medical Practice.

### Protect Newly Arrived GPs

It was also identified from the consultation that there may be a need to protect GPs in the early stages of their arrival to the region from potentially becoming overwhelmed by the weight and pressure of the crisis. There is potential that a new doctor could feel a sense of pressure and obligation to the community based on the community's (justified) strong concern about the lack of GP services, and the backlog of health concerns which have not been addressed due to the lack of GP services:

- 'Don't frame the new doctor coming in as "this person will be our saviour" - otherwise you have the weight of the community and the crisis on the doctor's shoulders;'
- 'There will be pressure when a new doctor comes into a community that hasn't had a doctor for a long time - there will be the pressure of the backlog of patients and expectations of the community that the doctor has come in to save them.'

# Conclusion

This Needs Assessment Report has identified and articulated the Northern Eyre Peninsula's needs in relation to the recruitment and retention of GPs on the Northern Eyre Peninsula. The most and critical need is to increase the mass of GPs on the Northern Eyre Peninsula and this is the fundamental purpose of the NEPHA Project. Needs 2 – 13 relate to conditions, structures and resources that are needed to best assist in the recruitment and retention of GPs to the Northern Eyre Peninsula. The addressing of these needs should be integrated into any solutions which are developed, including the development of new models for GP services. With these needs addressed, the Northern Eyre Peninsula will be in a strong position to recruit and retain GPs, and in turn, achieve better and more sustainable health service coverage for the region.

Georgia Brazenall

NEPHA Project Officer

11 June 2021

# Appendices

## Appendix A: List of Consultation Participants

| Group | Number of Consultation Participants within NEP | Number of Consultation Participants not within NEP |
|---|---|---|
| Hospital Nurses and Nursing Management | Nursing Management: 7<br><br>Hospital Nurses (mix of Registered and Enrolled nurses): 12 | - |
| Doctors | 4 | 4 |
| Dentists | 1 | 1 |
| Medical Practice Staff (including Practice Nurses), Board Members (where applicable), and Management | Practice Nurses: 3<br>Practice Management: 2<br>Board Members: 7 | 2 |
| Staff and Elected Members of Local Government | 12 | - |
| Eyre and Far North Local Health Network Executive | - | 3 |
| Other Stakeholders | - | • Royal Flying Doctors Service<br>• GPEx<br>• Academics from the University of Adelaide<br>• Project Manager at SA Dental Service<br>• Rural Support Service, SA Health<br>• Country SA PHN |

## Appendix B: Consultation Questions for Each Consultation Group

### General Practitioners

**<u>Looking at the overall problem:</u> Dearth of Medical and Health Professionals in the Northern Eyre Peninsula region.**

For you, what are the drawbacks of working in your profession in a small rural town?

What do you think are the obstacles for people in your profession to work in a small rural town?

What do you think are the effects of not having enough GPs and health professionals on the Northern Eyre Peninsula?

- Community Health outcomes
- Effect on current medical and health professionals

Can you think of threats which might worsen this problem in the future?

**<u>Looking at the overall objective</u>: Recruiting and retaining medical and health professionals in the Northern Eyre Peninsula region.**

What do you personally enjoy about working in your profession in a small rural town?

What current strengths does the Eyre Peninsula/Your community/your workplace have which attracts staff in your profession and keeps them in the region?

What future opportunities do you think exist for the Eyre Peninsula/your community/your workplace which could help attract staff in your profession and keep them in the region?

Do you have any suggestions on what a new model needs to function effectively? How can we make it work?

**Hours**

- What is your opinion on the hours and days per week that a rural GP currently works?
- To you, what is an ideal number of hours for a rural GP to work?
- What is your opinion of a rural GP's obligation to be on call?
- To you, what is a reasonable number of days per month to be on call?

**Employment conditions**

- Would you personally prefer to be on a salary or own your own practice? Why?

- Would you personally prefer to service one community only or multiple communities? Why?
- What is your opinion on GPs living in the community in which they work versus living in a neighbouring community?
    - Neighbouring = approx. 1 hour away

**Professional + Personal Support**

- What do you think of SAVES- how helpful/unhelpful is it for you?
- What professional and day to day support do you currently have from other GPs? Is this sufficient?
- What professional and day to day support do you currently have from nursing and allied health professionals? Is this sufficient?
- What Professional Development is available for GPs working on the Eyre Peninsula? Is this sufficient?
- What opportunities exist to improve accessibility to meaningful professional development for GPs working on the EP?
- What support for families and spouses of GPs is available for working in your town/on the EP? Is this sufficient?
    - Social activities
    - Schooling
    - Work for Spouse
    - Housing

**Anything else you would like to add?**

Nursing Management, Nurses, Oral Health Professionals

**Intro:** Tell me about yourself and your job

**<u>Looking at the overall problem:</u> Dearth of Medical and Health Professionals in the Northern Eyre Peninsula region.**

For you, what are the drawbacks of working in your profession in a small rural town?

What do you think are the obstacles for people in your profession to work in a small rural town?

What do you think are the effects of not having enough medical and health professionals on the Northern Eyre Peninsula?

- Community Health outcomes
- Effect on current medical and health professionals

Can you think of threats which might worsen this problem in the future?

**<u>Looking at the overall objective</u>: Recruiting and retaining medical and health professionals in the Northern Eyre Peninsula region.**

What do you personally enjoy about working in your profession in a small rural town?

| What current strengths does the Eyre Peninsula/Your community/your workplace have which attracts staff in your profession and keeps them in the region?<br><br>What future opportunities do you think exist for the Eyre Peninsula/your community/your workplace which could help attract staff in your profession and keep them in the region?<br><br>Do you have any suggestions on what a new model (mid Eyre) needs to function effectively? How can we make it work? |
| --- |
| • What clinical support do you currently have from GPs in the region? Is this sufficient?<br>• To do your job effectively, what clinical support do you need from a General Practitioner?<br>• What support do you currently have from other health professionals in the region? Is this sufficient?<br>• To do your job effectively, what support do you need from other health professionals?<br>• To be able to work at the top of your scope, what support and professional development do you need? |
| Anything else you would like to add? |

| Academics |
| --- |
| **Intro: Tell me a bit about your research and background** |
| **<u>Looking at the overall problem:</u> Dearth of Medical and Health Professionals in the Northern Eyre Peninsula region.**<br><br>What are the major contributing factors to this issue?<br><br>Can you think of threats which might worsen this problem in the future?<br><br>Looking at the current models of health service provision on the Eyre Peninsula, what doesn't work about them? |
| **<u>Looking at the overall objective</u>: Recruiting and retaining medical and health professionals in the Northern Eyre Peninsula region.**<br><br>What are the major factors to enable/facilitate recruitment and retention of medical and health professionals on the Eyre Peninsula?<br><br>Can you think of opportunities for change to improve the recruitment and retention of medical and health professionals on the Eyre Peninsula?<br>- Policy opportunities<br>- Social opportunities<br>- Economic Opportunities<br><br>Do you have any suggestions on what a new model on the Eyre Peninsula needs to function effectively? How can we make it work? What are the key ingredients in a successful model? |
| What do you think are the barriers which prevent medical student graduates from following a career path in rural general practice, particularly in areas as remote as Eyre Peninsula towns?<br><br>What strengths exist in tertiary medical education which encourage medical student graduates to follow a career path in rural general practice, particularly in areas as remote as Eyre Peninsula towns?<br><br>What future opportunities do you think exist for tertiary medical education which could encourage medical student graduates to follow a career path in rural general practice, particularly in areas as remote as Eyre Peninsula towns? |
| Would you be able to help me identify the most relevant articles of yours for my literature review? |
| **Anything else you would like to add?** |

Medical Practice Staff, Local Government, Eyre and Far North Local Health Network Executive

**<u>Looking at the overall problem:</u> Dearth of Medical and Health Professionals in the Northern Eyre Peninsula region.**

What do you think are the obstacles for GPs and other health professionals to work in a small rural town?

What do you think are the effects of not having enough GPs and health professionals on the Northern Eyre Peninsula?

- Community Health outcomes
- Effect on current medical and health professionals
- Effects on broader community + other industries

Can you think of threats which might worsen this problem in the future?

**<u>Looking at the overall objective</u>: Recruiting and retaining medical and health professionals in the Northern Eyre Peninsula region.**

What current strengths does the Eyre Peninsula/Your community have which attracts medical and health professionals and keeps them in the region?

What future opportunities do you think exist for the Eyre Peninsula/your community which could help attract medical and health professionals and keep them in the region?

What are positive flow on effects of having enough health professionals and GPs in your community?

**Professional + Personal Support for GPs**

- What support for families and spouses of GPs is available for working in your community? Do you think this is sufficient?
    - Social activities
    - Schooling
    - Work for Spouse
    - Housing
- What opportunities are there for your community to improve the support offered to GPs and their families?
    - Social activities
    - Schooling
    - Work for Spouse
    - Housing

**Anything else you would like to add?**

| GP training |
| --- |
| **Intro: Tell me a bit about your organisation** |
| **<u>Looking at the overall problem:</u> Dearth of Medical and Health Professionals in the Northern Eyre Peninsula region.**<br><br>What do you think are the barriers in GP training pathways which prevent GPs in training from following a career path in rural practice, particularly on the Eyre Peninsula?<br><br>Can you think of threats which might worsen this problem in the future? |
| **<u>Looking at the overall objective</u>: Recruiting and retaining medical and health professionals in the Northern Eyre Peninsula region.**<br><br>What strengths do current GP training pathways have which encourage GPs in training to follow a career in rural practice, particularly in areas as remote as Eyre Peninsula towns?<br><br>What future opportunities do you think exist for current GP training pathways which could encourage GPs in training to follow a career in rural practice, particularly in areas as remote as Eyre Peninsula towns? |
| **Anything else you would like to add?** |

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Northern
Eyre
Peninsula
Health
Alliance

Addressing the Failure of Medical Services
on Northern Eyre Peninsula, South Australia

# OUTLINE OF MODEL

The Northern Eyre Peninsula (NEP) region is suffering a prolonged health crisis, threatening the well-being of rural Australians and the survival of small towns. The situation has worsened over time, with the ratio of GPs to population less than half of the ratio in the Greater Adelaide region and areas of South Australia outside of the Greater Adelaide Region. Without intervention, the remaining GPs in the region continue to operate under an unsustainable workload and are at immediate risk of departing the region and further damaging its reputation, making recruitment nearly impossible.
The NEP's workforce crisis is caused by our region offering inadequate remuneration, stressful working conditions, old and inadequate housing, and inadequate and outdated medical practice infrastructure.

NEPHA proposes a workable service delivery model to address the shortage of GPs in the NEP Region.

## The Vision

To improve hospital and primary medical service provision to the NEP Region, in the next five years the NEP aims to achieve a total of 12 FTE GPs consulting in NEP medical practices and participating in an on-call roster to provide 24-hour services for medical emergencies.

Within five years, 12 FTE Vocationally Registered (VR) GPs will be providing services in NEP. Additionally, the region will host 4 Non-Vocationally Registered (Non-VR) General Practice positions through either the More Doctors for Rural Australia Program, the Rural Generalist Program SA or the Remote Vocational Training Scheme (RVTS) or Australian General Practice Training Program (AGPT) to create a pipeline of trainee doctors.

The NEP's medical services will be comprised of six high quality medical practices and six hospitals, grouped into three clusters. GPs will be remunerated well for hospital and on-call work in accordance with South Australia's Fee-For-Service Agreement, have reasonable consulting and on-call workloads and receive paid time off. They will work in collegial groups, being able to seek support from one another across the NEP. They will be supported to access professional upskilling on the Eyre Peninsula and have paid time off to undertake professional development. GPs and their families will be satisfied with their work life and community life and will remain on the NEP for multiple years. If they decide to leave, they will be easily replaced by new VR GP recruits who want to work in the region.

Non-VR doctors will train within each cluster, supervised by a VR GP in the cluster who has enough time to dedicate to providing high quality training and support to the Non-VR doctor(s). Non-VR doctors will have positive experiences training on the NEP and they will be likely to return to the NEP as a VR doctor or share their experiences and promote training and working on the NEP to other doctors.

Having enough GPs distributed across the region will increase access to primary healthcare and emergency care for the NEP Population. NEP residents will have shorter waiting times to see their GP

in their closest town and chronic disease in the NEP region will be identified early and managed appropriately. The NEP population will have certainty of access to an on-call GP who is able to physically attend their local hospital where necessary. With increased numbers of GPs in the NEP, hospital nurses will have better access to support from GPs in treating hospital inpatients and Aged Care residents. This will in turn decrease the professional and personal burden on nursing staff in the region and likely make the NEP a more attractive place to work as a nurse. Overall health outcomes will improve, reducing the burden on all health professionals in the region and lessening the need for tertiary hospital transfers.

## Workable Service Delivery Model

To sustain the GP workforce, a new service delivery model is required.

It is recommended that within five years, 12 FTE VR GPs will be working across the NEP. Assuming existing NEP GPs remain in the region, an additional 9 GPs will be engaged over an implementation period of five years to reach 12 FTE GPs.

To support a pipeline for the future workforce it is essential that medical practices in the NEP region become teaching and training practices. In addition to the 12 FTE VR GPs, the region aims to host 4 Non-VR General Practice positions through either the More Doctors for Rural Australia Program, the Rural Generalist Program SA, the Remote Vocational Training Scheme (RVTS), or the Australian General Practice Training Program, to create a pipeline of trainee doctors.

### *Configuration of Medical Practices*

NEPHA recommends the development of a service delivery model comprised of six medical practices operating within three clusters which are based on geographically proximate groups of towns. Cluster One includes Streaky Bay and would engage three GPs and one registrar. Cluster Two includes Wudinna and Elliston and would engage three GPs and one registrar. Cluster Three includes Cleve, Kimba and Cowell, and would engage six GPs and two registrars.

## Diagram

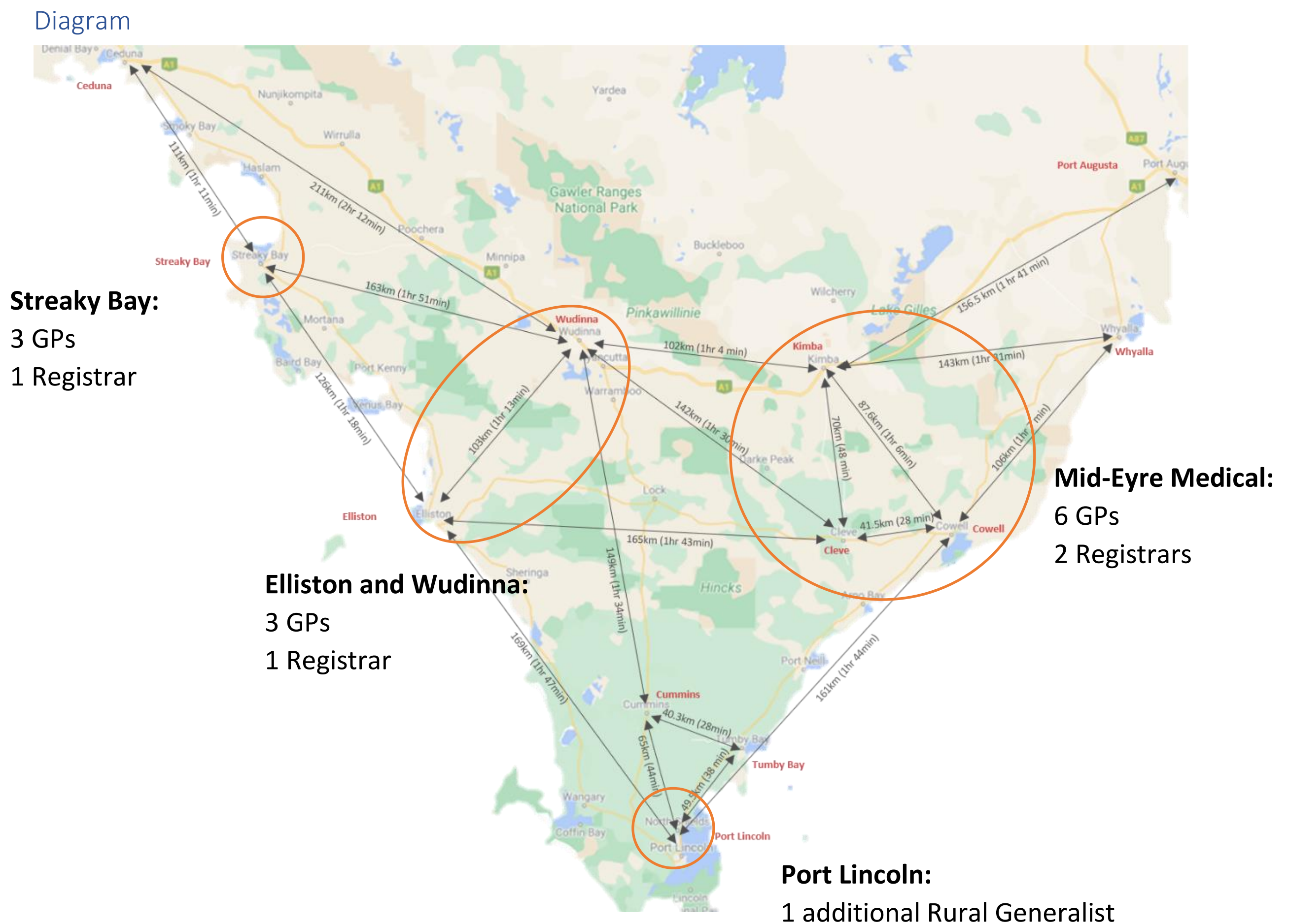


Figure 1: Configuration of Medical Practices

GPs would be required to service any town within their cluster as necessary to help achieve adequate service coverage.

The clustering of multiple GPs into three groups across the region will foster collegiality and enable the sourcing of doctors from a regional pool to help with backfill. Multiple GPs in each cluster allows for sustainability of services. Where possible GPs will have no human resources or corporate responsibility as the practices would be managed by an owner organisation, making the model flexible and dynamic, allowing GPs to fluidly enter and exit the model while maintaining workforce supply.

### *After Hours On-Call Structure*

Given the relatively low volume of hospital activity at each site, pooling contracted GPs in an on-call capacity is the only viable way to maximise economies of scale thereby allowing provision of the required level of medical services to NEP hospitals. It is recommended these arrangements remain in place on the NEP and all GPs in the model be contracted to participate in an on-call roster for emergency presentations.

To make hospital work attractive to potential recruits and to enable better work-life balance for current and future doctors working in the model, thereby reducing likelihood of burnout and

increasing likelihood of retention, NEPHA recommends an arrangement of a rotational afterhours on-call roster within each Cluster.

In 2022, Eyre and Far North Local Health Network will introduce a salaried Rural Generalist model at Port Lincoln Hospital, which includes the creation of 10 Senior Salaried Medical Officer positions to staff the Emergency Department and provide services to inpatients. It is recommended these Rural Generalists have a right of private practice, being able to earn Medicare when consulting in each Cluster and be used to backfill positions when GP's take leave. To allow this occur it is recommended EFNLHN employs an additional Rural Generalist.

## Diagram

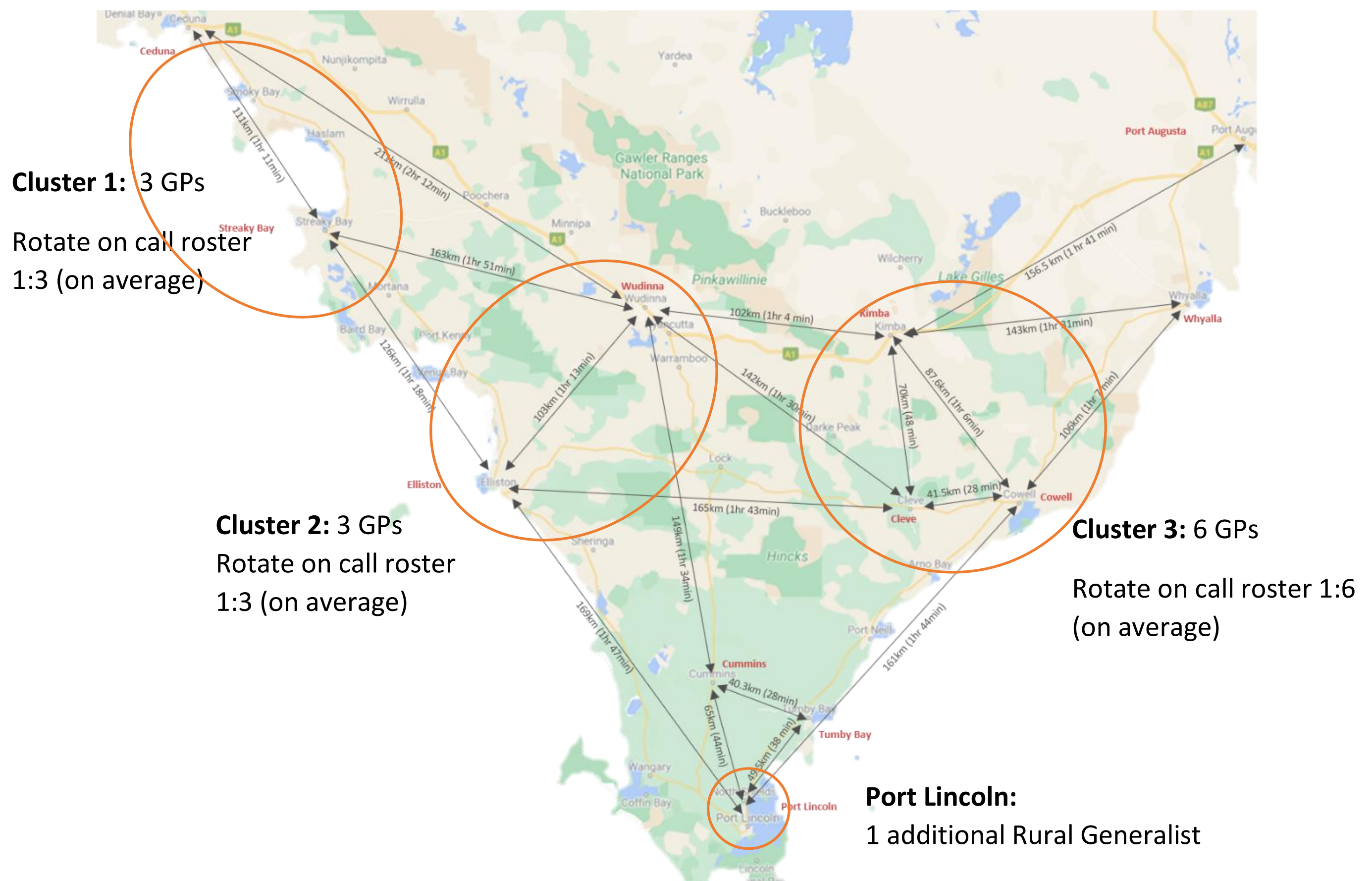


Figure 2: Geographic Structure recommended for After Hours On-Call

It is assumed that a 1:3 on-call roster is achievable but not sufficient to allow GPs working in the model to have adequate work/life balance. A roster of 1:4 or higher is ideal for an adequate work/life balance. It is also assumed that it is acceptable for GPs to do afterhours on-call remotely, from a one-hour drive away from the hospital. Any on-call arrangement requiring more than one hour and thirty minutes' drive between the doctor's location and the hospital is not acceptable. Finally, this structure is designed upon the assumption that the remote afterhours on-call arrangement will be supported by appropriate technology, procedures, and systems to ensure clinical safety. It is assumed that this structure will be supported by the development of solutions for electronic record keeping, and the ability to share information across the medical practices and hospitals in the NEP, to ensure continuity of care with multiple practitioners working within the model.