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The assessment of the health care needs of the community from a consumer and provider perspective

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THE ASSESSMENT OF THE HEALTH CARE NEEDS OF THE COMMUNITY FROM A CONSUMER AND A PROVIDER PERSPECTIVE

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EXECUTIVE SUMMARY

This project aimed at identifying the health care needs of a community from a consumer and a provider perspective using a combination of quantitative and qualitative research methodologies.

As stated in the objectives, this needs analysis has provided information on:

- the characteristics of the community served the local Division of General Practice (Chapter 2).
- the health status of the community, in terms of disease patterns, healthy lifestyles... (Chapter 3).
- the extent to which services exhibit qualities of convenient location, availability, equity of access, integrated care and providing education (Chapters 4 and 5).
- the various aspects concerning general practice interests, hours worked, training and education needs (Chapter 6).
- the gaps in services provided by GPs, specialists, community and allied health services and hospital services from the GP and the community perspectives (Chapters 5,6 and 8).
- the areas of health needs which should be specifically targeted by local Division of General Practice (Chapters 3, 7, 8 and 9).

Nearly 52,000 people live in the area serviced by the local Division of General Practice (1996 Census), with one half residing in the Regional Centre and the other half in the surrounding Shires: 2.2% of the population are Aborigines, 16.4% born overseas, 5% unemployed, 38% with a qualification, 26% of children and 10% of elderly (65+). The total population is projected to grow by 18.6% by the year 2006, while the population aged 70 years and over will be growing by 46% by 2006 (Chapter 2).

The assessment of the local health profile reflects some differences with the State and the Southern Region, and some significant differences between the sexes. The higher prevalence locally for diabetes, heart attacks, arthritis and hearing problems were due mainly to the higher prevalence in males. The higher prevalence in varicose veins and sinus were mainly attributable to females, while both sexes contributed to the higher prevalence in eyesight problems and high cholesterol. Cancer incidence locally was similar to the State (Chapter 3).

Against this background of long-term conditions, the health-enhancing behaviours of local residents were better or the same compared with the State: more non-smokers, more non-drinkers or safe drinkers, more fruit and vegetable eaters, more covering their body in the sun, nearly same proportions exercising. However, the sex differences in these health-related behaviours were significant: more men have ever smoked, undertook no activity, drank harmfully and did not use sunscreen. High proportions of local women have had their cancer screening tests.

undertook no activity, drank harmfully and did not use sunscreen. High proportions of local women have had their cancer screening tests.

The rates of utilisation of most health services were higher locally for GP, specialist, dentist and hospital. In fact the local hospitalisation rates and repeat episodes were significantly higher than the State for all conditions, and more for females than males. This has a significant impact on the increased workload of the local GPs. The local death rates were similar to the State rates, except for those due to respiratory causes which were higher locally. The five leading causes of death for local males and females were:

Leading Cause of Death	*Male*	*Female*
1	*CVD*	*CVD*
2	*Cancer*	*Cancer*
3	*Respiratory*	*Respiratory and digestive*
4	*Injury*	*Injury and mobility*
5	*Digestive*	

Education targeting the risk factors of these five leading causes of death should be on-going and coordinated between all primary care providers. The Division should also give a priority to investigating the local high prevalence of hearing problems in men and the higher rates of hospitalisations and mortality for respiratory conditions, as they may be related to the nature of work in rural areas.

The patient satisfaction survey determined the consumers' views on attributes of quality in general practice. Consumers had satisfaction levels which were high or comparable to the rest of the country except for the following attributes (Chapter 4):

- The accessibility of GP in terms of the ease of making an appointment, the times when the doctor is available to see you, the ease of having the doctor see you at home, the amount of waiting time at the surgery before seeing the doctor.
- The financial accessibility in terms of cost of the drugs prescribed by the doctor and the fee charged by the doctor.
- The accessibility to the practice in terms of ease of parking.

Difficulties in accessing GPs could be partly associated with the shortage of GP numbers per population, where this area is short of 11 GPs. Financial accessibility is related to bulk-billing which is preferred by consumers but is not an adopted method of payment by GPs for all population groups.

The GP needs survey revealed that local rural doctors worked just over eleven extra hours per week compared to the median national figures (69.0 hours vs 57.5 hours). The stress level experienced by local rural GPs was similar to that of metropolitan GPs, but their job satisfaction was lower (45.5% vs 60.0%). According to the "National Satisfaction Survey of GPs", 35.3% of GPs would leave general practice immediately if they thought there was somewhere else they could go. Aspects of work causing most stress for local

GPs were requests for forms/paperwork, unrealistic expectations by patients and after hours on-calls and unsociable hours which were up to 13 hours per week.

In the next 5 years, GPs feel they would be required to deliver less of anaesthetics, inpatient service and antenatal care and obstetrics/delivery (a field where most GPs have already acquired post-graduate qualifications). The services that GPs feel they will deliver more of in the next 5 years related to health screening, aged care and nursing home visits, preventive medicine, counselling, palliative care and health education. The Division training programs should target the upskilling of GPs in such fields of growing need for GPs' expertise. The list of topics for continuing medical education (CME) needs is extensive and is divided into four domains: the technical medical care, preventive medical care, doctor/patient interaction and practice management. This list forms the basis for programs in CME (Chapter 6).

The knowledge and use of community/self-help groups by the GPs support findings in the consultation phase that GPs are under-utilising them, either because they don't know that they exist or because they are reluctant to refer patients for more information and seek such cooperative assistance in the management of their patients. The Division can promote the presence and functions of these support services to GPs through the GP newsletter, by highlighting a few services in each issue.

GPs are mostly very satisfied with the service delivery/availability of and interprofessional communication with the majority of medical/surgical specialists, allied health services and others (Chapter 6). However there is a need for improvement in the following services, particularly in the public sector:

- The service delivery issues lacking in the local community in terms of specialist services are orthopaedics, dermatology, ENT surgery, physiotherapy, podiatry, dietitian, psychiatry, urology. These issues relate to the recruitment and retention of the health workforce in rural areas, and the Division could lobby the Health Department of WA to increase these services. Rehabilitation and disability services are partly related to resourcing issues in the area and partly to better liaison between specialists in these fields and the GPs.

- Counselling, drug and alcohol and other mental health support services have been identified as gaps in the local community and have also featured as needs for further education of GPs and gaps in doctor/patient interaction. In fact over 80% of GPs have identified their priorities for further education/training in alcohol and drug abuse and their related problems, recognising and dealing with childhood behavioural problems, adolescent mental health problems, child abuse and domestic violence, and providing supportive counselling.

- GPs have also recognised the need to improve staff selection, training and management, efficient storage of and rapid access to information and patient recall

systems to address some of the difficulties of access to general practice. Most of all, there is a pressing need to recruit more GPs, and particularly female GPs.

- Community consultation (face-to-face interviews with consumers and other service providers) also identified health and social concerns which mostly overlapped with the gaps perceived by the GPs in the fields of Aboriginal health, men's health, women's health, youth health and aged care (Chapter 5).

Focus groups discussed in depth the priority issues pertaining to the five groups of special needs and made recommendations that the Division can target as future projects (Chapter 9):

- Recommendations in aged care related to improved discharge planning and community liaison, medication management, access to information and education for consumers and service providers.
- Recommendations in youth health related to improved access to general practice, a detoxification/rehabilitation programme, GP education and support in Attention Deficit Disorder.
- Recommendations in women's health related to setting up a well-woman clinic, GP education and support in eating disorders, and the promotion of parenting skills.
- Recommendations in men's health related to setting up a recall system for regular male screening, community wide promotion of men's health issues, employers' schemes for annual health check-ups, detoxification and rehabilitation programme.
- Recommendations in Aboriginal health related to cultural awareness training for service providers and liaison and cooperation between Aboriginal health workers and GPs, in addition to other social issues such as accommodation, education and employment.

1. BACKGROUND AND OVERVIEW

This project is about identifying the health care needs of a community from a consumer and a provider perspective, the provider mainly being GPs in the local Division of General Practice.

The local Division of General Practice covers a Regional Centre, and four surrounding Shires in Western Australia. Its mission statement as stated in the strategic plan, highlights the aim of the Division "to identify problems which are a barrier to the health of the community, to work towards providing more effective solutions to those identified barriers, and to provide opportunities and incentives for General Practitioners to improve their skills in relevant areas".

In attempting to achieve this mission statement, this research project is designed to provide an indication of the needs of the community serviced by the Division and the needs of its GP members.

However, according to the Division's Field Support Unit, a divisional needs analysis is not a complete description of the community and all its needs. It is rather aimed at *"finding out the major priorities for the activities of the Division, and thus feeding into the development of the strategic plan and the creation of relevant and worthwhile projects".*

A project reference group was established comprising the GP project manager, the Division's project officer and a community representative and was joined, at the later stages, by a newly appointed community liaison officer.

The project is divided into two parts:

The GPs needs analysis and
The community needs analysis

The methodology combines quantitative and qualitative approaches to collecting data: GP surveys, patient satisfaction surveys, health statistics from the 1995 WA Health Survey, morbidity and mortality statistics. There is also an increasing importance attached to the notion of community consultation about health needs. This tendency is evident in the Division's endeavour to set up a Community liaison steering committee whose role was to form a consumer reference group. Therefore, for the purpose of this needs analysis, the use of focus groups has been advocated as a valuable method for exploring perceptions of need and enhancing the community involvement in and support for the activities of the local Division of general practice.

The **GPs needs analysis** aims at providing:

- information on the profile of local GPs, hours worked, job stress and satisfaction and future requirements in general practice
- the continuing medical education needs
- the knowledge and use of community/support groups
- satisfaction with service delivery/availability of other health service providers
- satisfaction with interprofessional communication with other health service providers
- perceived gaps or deficiencies in the service to the local community
- the role of the division in addressing GP needs

The **community needs analysis** uses a combination of needs assessment strategies:

- to describe the make-up of the local population serviced by the Division from the latest 1996 Census of the Australian Bureau of Statistics
- to assess the population health status and health service use from the Health Department 1995 WA Health Survey, and morbidity and mortality statistics
- to determine to what extent patients are satisfied with services exhibiting qualities of convenient location, availability, equity of access and providing education and preventive health care
- to consult with health agencies, community organisations, volunteer networks and self-help groups representing consumers on:
    - what are the main problems and concerns in the community
    - what groups of the population are experiencing these problems
    - what solutions are put forward by these agencies representing consumers
    - how can the GPs contribute to these solutions

Based on findings in these phases, a broad list of identified needs will be produced. Focus groups will be formed to narrow down this list of needs and barriers and set up priorities that can be translated into worthwhile projects for the Division to undertake.

2 POPULATION PROFILE

2.1 Age and Sex Distribution

2.2 Racial and Ethnic Composition

2.3 Marital Status and Family Type

2.4 Labour Force Status, Occupation and Industry

2.5 Qualification and Income

2.6 Comparison with the State

2.7 Population Projections

2. POPULATION PROFILE

This chapter of the report contains information about the demographic characteristics of the people who live in the area covered by the local Division of General Practice. The data is obtained from the recently released basic community profiles of the 1996 Census of population and housing. It provides an overview of the age and sex distribution of the population, the ethnic composition, the marital and employment status, the socio-economic status and family type.

The population figures at the postcode level have been obtained from the Australian Bureau of Statistics through a special request, for the Regional centre alone, and all the other postcodes in the Division.

Half of the population covered by the Division reside in the Regional Centre and half in the other postcodes. The total population amounts to 51,973. It increases to 52,018 when overseas visitors are included.

2.1 The Age and Sex Distribution

The proportions of children 0-14 years is higher in the other postcodes compared to the Regional Centre (28.8% vs 22.4%) (Table 2.1). However the proportions of youth (15-24) and the elderly (65+) are higher in the Regional Centre compared to the other postcodes:

	Youth	Elderly
Regional Centre	15.9	12.3
Other postcodes	11.9	7.1

Half of the population in the two areas are females.

Table 2.1 Age distribution - 1996 Census (excluding 122 overseas visitors)

	Regional Centre		Other Postcodes in GP Division		Total	
	Number	Percent	Number	Percent	Number	Percent
0-14	5,943	22.4	7,346	28.8	13,289	25.6
15-24	4,220	15.9	3,039	11.9	7,259	13.9
25-34	3,862	14.6	3,550	13.9	7,412	14.3
35-44	4,047	15.3	4,658	18.3	8,705	16.7
45-54	3,230	12.2	3,218	12.6	6,448	12.4
55-64	1,935	7.3	1,894	7.4	3,829	7.4
65-74	1,782	6.7	1,240	4.9	3,022	5.8
75+	1,473	5.6	536	2.2	2,009	3.9
Total	26,492	100.0	25,481	100.0	51,973	100.0

2.2 Racial and Ethnic Composition

3.2% (845) of the population in the Regional Centre is of Aboriginal background compared to 1.2% (295) in the other postcodes. However the proportion of Aborigines for the total area is 2.2% (1,140) slightly lower than the State proportion of 2.6%.

16.4% of the overall population were born overseas, with 11.3% born in mainly English speaking countries and 5.1% in non-English speaking countries. These proportions are slightly higher in the Regional Centre compared to the other postcodes (Table 2.2)

Table 2.2: Birthplace of local residents

Birthplace	Regional Centre	Other Postcodes in GP Division	Total
Born in mainly English speaking countries	**3,016 (11.4%)**	**2,860 (11.2%)**	**5,876 (1.3%)**
Canada	31	15	46
Ireland	105	67	172
New Zealand	434	423	857
South Africa	94	104	198
United Kingdom	2,287	2,179	4,466
USA	65	72	137
Born in Non-English speaking countries	**1,589 (5.9%)**	**1,046 (4.1%)**	**2,636 (5.1%)**
Chile	3	0	3
China	5	1	6
Croatia	20	7	27
Egypt	0	3	3
Fiji	6	12	18
Germany	119	128	247
Greece	29	1	30
Hong Kong	10	17	27
Hungary	9	0	9
India	54	32	86
Indonesia	22	0	22
Italy	433	211	644
Lebanon	21	0	21
Malaysia	65	49	114
Malta	8	16	24
Netherlands	147	151	298
Philippines	51	49	100
Poland	124	43	167
Singapore	17	31	48
Sri Lanka	9	8	17
Vietnam	50	5	55
Inadequately described	387	283	670
Total	**4605 (17.3%)**	**3906 (15.3%)**	**8512 (16.4%)**

2.3 Marital Status and Family Type

The Regional Centre had higher proportions of people who were separated (4.2%) divorced (7.5%), widowed (7.0%) or never married (31%), while the other postcodes of the Division had higher proportions who were married (64.2%) (Table 2.3).

The marital status is reflected in the type of families in the area. The Regional Cente has higher proportions of one-parent families (11.8%), persons living alone (8.9%) or group households (3.4%), while the other postcodes had higher proportions of couple families with children (62.8%) (Table 2.4).

Table 2.3 Marital Status (aged 15 and over)

	Regional Centre		Other Postcodes in GP Division		Total	
	Number	Percent	Number	Percent	Number	Percent
Married	10360	50.3	11602	64.2	21962	56.8
Separated	875	4.2	563	3.1	1438	3.7
Divorced	1563	7.5	903	5.0	2466	6.4
Widowed	1436	7.0	568	3.1	2004	5.1
Never Married	6368	31.0	4446	24.6	10814	28.0
TOTAL	20602	100.0	18082	100.0	38684	100.0

Table 2.4 Family Type

	Regional Centre		Other Postcodes in GP Division		Total	
	Number	Percent	Number	Percent	Number	Percent
Couple family with children	12615	47.5	16031	62.8	28646	55.0
Couple family without children	5013	18.9	4664	18.2	9677	18.5
One parent family	3129	11.8	1854	7.3	4983	9.6
Lone person	2369	8.9	1177	4.6	3546	6.8
Group households	915	3.4	369	1.4	1284	2.5
Other	2512	9.5	1443	5.7	3955	7.6
TOTAL	26553	100.0	25538	100.0	52091	100.0

2.4 Labour Force Status, Occupation and Industry

Higher proportions of unemployed (6%) or not in the labour force (36.2%) resided in the Regional Centre, while the proportions who were employed were higher in the other postcodes (62.1%) (Table 2.5).

There were twice as many managers and administrators who lived in the other postcodes of the Division (13.2% vs 5.8%) compared to the Regional Centre. Overall, there were more occupations in trades followed by intermediate sales/service workers and professionals (Table 2.6).

The most frequent types of industry were trade (19.3%), manufacturing (15.4%), construction (8.9%), finance, insurance and property (8.8%), health/community services (7.8%), education (7.4%) and agriculture, forestry, fishing (6.5%) (the latter particularly frequent in the other postcodes of the Division) (Table 2.7).

Table 2.5 Labour force status (aged 15 and over)

	Regional Centre		Other Postcodes in GP Division		Total	
	Number	Percent	Number	Percent	Number	Percent
Employed	11504	56.0	11209	62.1	22713	58.8
Unemployed	1229	6.0	687	3.8	1916	5.0
Not in labour force	7431	36.2	5815	32.2	13246	34.3
Not stated	383	1.8	346	1.9	729	1.9
TOTAL	20547	100.0	18057	100.0	38604	100.0

Table 2.6 Occupation (employed persons)

	Regional Centre		Other Postcodes in GP Division		Total	
	Number	Percent	Number	Percent	Number	Percent
Managers & Administrators	663	5.8	1485	13.2	2148	9.4
Professionals	1554	13.5	1394	12.4	2948	12.8
Associate professionals	1310	11.4	1130	10.1	2440	10.7
Tradespersons & Related Workers	1953	17.0	1848	16.5	3801	16.8
Advanced Clerical & Service Workers	374	3.2	327	2.9	701	3.2
Intermediate Clerical, Sales & Service Workers	1677	14.6	1420	12.7	3097	13.6
Intermediate Production & Transport Workers	1339	11.6	1317	11.7	2656	11.7
Elementary Clerical, Sales & Service Workers	997	8.7	758	6.8	1755	7.7
Labourers & Related Workers	1314	11.4	1256	11.2	2570	11.4
Inadequately described	115	1.0	102	0.9	217	0.9
Not stated	211	1.8	178	1.6	389	1.8
TOTAL	11507	100.0	11215	100.0	22722	100.0

Table 2.7 Industry (employed persons)

Industry	Regional Centre		Other Postcodes in GP Division		Total	
	Number	Percent	Number	Percent	Number	Percent
Agriculture, Forestry, Fishing	171	1.5	1321	11.7	1492	6.5
Mining	340	3.0	459	4.1	799	3.5
Manufacturing	1759	15.3	1742	15.4	3501	15.4
Electricity, Gas, Water Supply	222	1.9	249	2.2	471	2.2
Construction	1088	9.4	943	8.4	2031	8.9
Wholesale/Retail Trade	2432	21.1	1977	17.6	4409	19.3
Accommodation, Cafe, Restaurants	559	4.9	334	3.0	893	3.9
Transport and Storage	458	4.0	403	3.6	861	3.8
Communication Services	133	1.1	146	1.3	279	1.3
Finance & Insurance, Property & Business Services	1135	9.9	857	7.6	1992	8.8
Govt Administration and Defence	307	2.7	275	2.4	582	2.5
Education	840	7.3	840	7.4	1680	7.4
Health & Community Services	1016	8.8	763	6.8	1779	7.8
Culture & Recreation, Personal and Other Services	653	5.6	494	4.3	1147	5.0
Non-classifiable	152	1.3	146	1.4	298	1.3
Not stated	237	2.2	322	2.8	559	2.4
TOTAL	11502	100.0	11271	100.0	22773	100.0

2.5 Qualification and Income

38% of the population hold a qualification. Of those qualified, a third have a skilled vocational qualification, 13.1% have a bachelor degree and 10.2% a basic vocational qualification (Table 2.8). The median weekly individual income falls in the range $200 - $399 (Table 2.9).

Table 2.8 Qualification (aged 15 and over with a qualification)

Qualification	Regional Centre		Other Postcodes in GP Division		Total	
	Number	Percent	Number	Percent	Number	Percent
Higher degree	110	1.4	65	0.9	175	1.2
Postgraduate Diploma	166	2.2	169	2.4	335	2.3
Bachelor Degree	1021	13.3	885	12.7	1906	13.1
Undergraduate Diploma	626	8.2	762	10.9	1388	9.5
Associate Diploma	396	5.2	300	4.3	696	4.8
Skilled Vocational	2454	32.2	2317	33.3	4771	32.7
Basic Vocational	748	9.8	727	10.4	1475	10.2
Inadequately described	133	1.8	153	2.3	286	1.8
Not stated	1977	25.9	1585	22.8	3562	24.4
TOTAL	7631	100.0	6963	100.0	14594	100.0

Table 2.9 Weekly individual income (aged 15 years and over)

	Regional Centre		Other Postcodes in GP Division		Total	
	Number	Percent	Number	Percent	Number	Percent
Negative/Nil income	1168	5.8	1409	7.7	2577	6.6
$1 - 119	1856	9.0	2126	11.6	3982	10.2
$120 - 199	4605	22.4	3059	16.7	7664	19.7
$200 - 399	4694	22.8	3695	20.2	8389	21.6
$400 - 599	3351	16.3	3079	16.8	6430	16.5
$600 - 799	2052	10.0	1858	10.1	3910	10.1
$800 - 1499	1608	7.8	1905	10.4	3513	9.0
$1500 or more	257	1.2	233	1.3	490	1.4
Not stated	958	4.7	932	5.2	1890	4.9
TOTAL	20549	100.0	18296	100.0	38845	100.0

2.6 Comparison with the State

Compared with the State there are locally fewer Aborigines and people born overseas and fewer proportions who are unemployed or not in the labour market. The proportions divorced/separated are slightly higher, mainly in the Regional Centre, but the proportion of one-parent families are lower. The proportions aged 70 years and over is similar to the State for the total area but

higher in the Regional Centre, while the children proportions (0-14 years) is higher in the other postcodes of the Division (Table 2.10).

Table 2.10 A summary of selected characteristics (1996 Census) and comparison with the State

	Regional Centre %	Other Postcodes in GP Division %	Total (GP Division) %	Total State %
Aboriginal	3.2	1.2	2.2	2.6
Born - Overseas	17.3	15.3	16.4	28.9
- Mainly English Speaking	11.4	11.2	11.3	17.0
- Non-English Speaking	5.9	4.1	5.1	11.9
Female	50.0	50.0	50.0	50.0
Unemployed	6.0	3.8	5.0	9.3
Not in the labour force	36.2	32.2	34.3	46.1
Separated and divorced	11.7	8.1	10.1	8.8
One-parent families	11.8	7.3	9.6	12.7
0-14 years	22.4	28.8	25.6	23.6
70+ years	8.8	4.3	6.6	6.5

2.7 Population Projections

Within the next decade the percent increase will be 18.6% for the whole area, ranging from 3.0% to 42.3% (Table 2.11).

The population of the study area is expected to continue to age with the 70 years and over cohort projected to double in size between 1996 and 2006 in some postcodes within the Region (Table 2.12). This will have implications for residential care, nursing home accommodation, community based support services specifically and health services in general.

Table 2.11 Estimated Population Projections

	1996	2001	2006	% Change 1996-2006
Regional Centre	27,680	28,000	28,500	+ 3.0
Postcode 1	6,675	8,100	9,500	+ 42.3
Postcode 2	6,003	6,600	7,300	+ 21.6
Postcode 3	4,251	4,400	4,600	+ 8.2
Postcode 4	15,578	18,500	21,500	+ 38.0
TOTAL	60,187	65,600	71,400	+ 18.6

Source: Silver Thomas Hanley (1997)

Table 2.12 Projected 70^{+} population estimates

	1996	2001	2006	% Change 1996-2006
Regional Centre	2,480	2,725	2,775	+ 11.9
Postcode 1	225	350	450	+ 100.0
Postcode 2	295	450	650	+ 120.3
Postcode 3	250	325	375	+ 50.0
Postcode 4	860	1,275	1,750	+ 103.5
TOTAL	4,110	5,125	6,000	+ 46.0

Source: Silver Thomas Hanley (1997)

3. HEALTH PROFILE

3.1 Health Status

- Self-assessed general health rating
- Long-term health conditions and injuries within the previous year
- Body weight

3.2 Lifestyle factors

- Health-enhancing behaviour
- Consumption of fruit and vegetables
- Physical activity
- Skin protection
- Substance use (alcohol and smoking)

3.3 Health Service utilisation

- A & E and outpatient attendances
- Hospital admissions
- Specialist consultations
- Dentist consultations
- Optometrist consultations

3.4 Cancer screening for women

3.5 Other health statistics

a. Cancer incidence
b. Hospitalisation rates
c. Mortality rates

3.6 Summary and Conclusion

3. HEALTH PROFILE

The Health Department of WA conducted a survey on the health status of West Australians in 1995. A total of 5714 persons were surveyed with approximately 800 persons from each of the seven health authorities (3 metropolitan and 4 non-metropolitan). The survey was conducted by telephone for people aged fifteen and over.

Analysis of data was done at the level of the health authority. To obtain information on a much smaller geographical area (such as the one covered by the Division of General Practice, it was necessary to request the Health Information Centre to extract the data pertinent to the local postcodes in order for the data to be analysed locally. The extracted data had a significant amount of under-sampling in the age group 15-24 years, and over-sampling in the age group 45-64 years which necessitated applying weights for correction. Thus the local data could be compared to the State and the Southern Region data which are available in the Overview document (Daly et al 1996).

The sample size of residents of the Division was 188 persons, 42.2% males and 57.8% females and 79% of the sample were selected from the Regional Centre. The ethnic make-up of the sample consisted of 10.3% born in non-English speaking countries, 17.6% in English speaking countries and 72.1% born in Australia. There were no Aborigines in the sample. The following analysis is done by sex as the sample size is not large enough to break it down by age groups for some variables.

3.1 Health Status

Self-assessed general health rating

The majority of local residents (72%) rated their general health status as either good (36.7%) or very good (35.1%), similar to the State and the Southern Region ratings (Table 3.1). More females reported either having poor/fair health or very good/excellent health, while men reported a good health status in general. There were no significant sex differences at the State level, while the sex differences at the Southern level were nearly reversed to those at the local level, in that more men reported having poor/fair health or excellent health.

Table 3.1: Sex distribution of the self-assessed rating of general health (percent)

	Poor/Fair		Good		Very Good		Excellent	
	Males	Females	Males	Females	Males	Females	Males	Females
Local	13.4	15.1	43.3	33.3	31.3	36.6	11.9	15.1
Southern	13.6	11.7	34.2	33.4	36.9	41.0	15.3	13.8
State	13.0	13.8	34.4	34.4	36.9	36.9	15.7	14.9

Long-term health conditions and injuries

Table 3.2 presents the long-term health problems reported in the survey such as eyesight problems, hayfever, arthritis, sinus, migraines, hearing problems, eczema, asthma, high cholesterol, varicose veins, diabetes, high blood pressure, heart attack, other heart conditions and angina.

The conditions are listed from the most frequent to the least frequent. Eyesight problems, arthritis, sinus, varicose veins, high cholesterol, heart conditions, heart attack and diabetes were reported more frequently locally compared to the State and the Southern Region. Local diabetes and heart attack rates were double those reported in the state, or one and a half times those reported in the Southern Region.

Table 3.2: A comparison of percentages of adults who reported having a long-term condition and injuries within the previous year

Long-Term Conditions	**Local**	**Southern**	**State**
Eyesight problems	60.3	52.6	55.4
Arthritis	24.8	21.0	23.4
High blood pressure	22.6	23.5	22.4
Sinus	18.6	14.4	15.4
Hayfever	17.8	20.5	23.4
Varicose veins	15.7	10.9	9.3
Hearing problems	12.1	12.5	10.6
Migraines	10.0	11.9	12.1
High Cholesterol	8.8	8.1	7.9
Asthma	8.0	10.0	9.2
Eczema	6.9	8.0	10.0
Heart conditions	6.9	4.1	4.0
Diabetes	5.6	3.7	2.6
Heart attack	5.3	3.7	2.7
Angina	1.4	1.6	2.2
Injuries within the previous year	17.8	21.4	22.7

Table 3.3 breaks down these percentages by sex. The prevalence of diagnosed diabetes in men compared to women is nearly three times higher, that of heart attacks is nearly five times higher, that of angina three times higher, that of hearing problems three times higher, and that of arthritis one and a half times higher. Women had higher prevalences of sinus, hayfever, varicose veins, migraines and eczema.

It is worth noting that there was no difference in the prevalence of diabetes between males and females in the State and a small difference in the Southern Region (4.4% males vs 3.3% females). The prevalence of heart attacks was twice higher for males in the State and the Southern Region compared to five times higher locally. The hearing problems for men were similar in the Southern Region to the local ones, while the sex differences were smaller at the State level. The reason for this may be related to the type of occupations of men in rural areas.

Table 3.3: *Sex distribution of the reported long-term conditions and injuries at the local level (percent)*

Long-Term Conditions	**Male**	**Female**
Eyesight problems	60.3	60.2
Arthritis	30.9	20.4
High blood pressure	23.4	22.0
Sinus	11.8	23.4
Hayfever	16.2	19.4
Varicose veins	10.3	19.4
Hearing problems	20.6	6.4
Migraines	5.9	12.8
High Cholesterol	8.8	8.6
Asthma	7.4	8.6
Eczema	5.9	7.5
Heart conditions	7.4	6.4
Diabetes	8.7	3.2
Heart attack	10.3	2.1
Angina	2.9	-
Injuries within the previous year	17.4	18.3

17.4% of local residents reported injuries within the previous year, which is lower than the percentages at the State and Southern Region levels. There were no significant sex differences (Tables 3.2 and 3.3).

Body Weight

Females had the highest percentages for both underweight and obese in all three areas (Table 3.4). However the sex differences were larger locally for obesity as women were two and a half times more obese than men. Men were one and a half times more overweight than women, but the overweight proportions were

less than those in the Southern Region. A total of 55% of local residents were of normal weight.

Table 3.4: Comparison of percentages of people aged 25 years and over who were classified as underweight, normal weight, overweight or obese, according to body mass index

	Local			Southern			State		
	Male	Female	Persons	Male	Female	Persons	Male	Female	Persons
Underweight	-	2.6	1.5	0.6	2.8	2.0	1.7	4.3	3.1
Normal weight	53.4	57.1	55.4	48.2	59.0	54.6	52.6	60.8	57.2
Overweight	39.7	24.7	31.3	42.3	27.5	33.5	38.4	24.9	30.8
Obese	6.9	15.6	11.8	8.8	10.8	10.0	7.4	10.1	8.8

3.2 Lifestyle Factors

Most of the health-enhancing behaviours of local residents were comparable to those of the Southern Region and better than those of the State in terms of non-smoking (80%), covering in the sun (85%), use of sun-screen (72%) and consuming the recommended serves of fruits (66%) and of vegetables (37%). However local residents were safer drinkers (73%) but exercised (70%) and checked skin cancer (63%) slightly less than the State proportions (Table 3.5).

Table 3.5: Comparison of percentages of adults engaged in selected health-enhancing behaviours

	Local	Southern	State
Non-smokers	80.4	79.4	77.3
Cover body in sun	85.1	83.5	73.2
Some exercise	69.9	70.5	73.0
Use sunscreen	71.9	74.1	71.6
Non or safe drinkers	73.1	68.3	63.4
2 serves or more of fruit/day	66.2	64.7	56.6
5 serves or more of vegetables/day	36.9	36.2	31.9
Skin cancer checking	62.9	64.6	65.3

More men drank alcohol harmfully (26.9%) compared to women (14.0%), while fewer men (28.3%) did not drink in the last week to three months compared to women (50%) (Table 3.6). The highest percentages of people drinking harmfully/hazardously occurred for the age group 25-44 years (34.5%), followed by youth aged 15-24 years (29.2%). Equal proportions of men and women are currently smoking but more women had never smoked and more men were ex-smokers. The highest levels of current smokers occurred for the youngest age group 15-24 years (29.2%) followed by the middle age groups.

Table 3.9: A comparison of the percentages of women who have ever had these cancer screening tests

	Local	Southern	State
Breast examination by doctor	77.8	79.4	76.8
Breast examination by self	71.6	72.8	68.5
Pap smear test	90.2	90.8	90.5
Mammogram	48.9	38.0	37.5

3.5 Other health statistics

This section presents morbidity, hospitalisation and mortality statistics pertaining to the residents of the Regional Centre Health Service (RCHS) as defined by the Health Information Centre of the Health Department of WA: a population of 41,000 encompassing the Regional Centre and two surrounding Shires.

a. Cancer incidence

Table 3.10 summarises cancer incidence rates in the RCHS for the 5-year period 1991 - 1995, and compares them to the State rates. Cancer incidence rates reflect the number of new cases reported within the 5-year period.

Table 3.10: Cancer incidence rates: Regional Centre Health Service (RCHS) 1991 - 1995

	Male		Female		
Cancers	**Cases**	**ASR ***	**Cases**	**ASR ***	**RCHS compared with State**
All cancer	402	343.7	347	279.4	Similar
Female breast	-	-	94	83.7	Similar
Cervix uteri	-	-	13	10.9	Similar
Colo-rectal	50	41.4	52	36.9	Higher in females **
Lung	45	36.4	25	18.3	Less **
Melanoma (skin)	38	33.9	33	28.9	Less **
Prostate	103	84.5	-	-	Less **

** ASR is Age Standardised Rate per 100,000*
*** not statistically significant*

The RCHS all cancer incidence is similar to the State. Cancer incidence is higher for males in those less than 25-30 years or greater than 55-60 years of age. The incidence is higher for females in the intervening years and reflects the significant number of breast cancers in this age group. The higher age-specific incidence for males of the older age groups is mainly due to cancers of the prostate, lung, colo-rectum and melanoma of the skin.

Breast cancer and cervix cancer incidence generally increases from about the age of 25-30 years, and the local rates are similar to the State. Colo-rectal cancer and lung cancer incidence generally increases from about the age of 35-40 years. The increase in male lung cancer incidence (compared to female) becomes more apparent with age.

Melanoma incidence generally increases from about the age of 15-20 years. Males and females contribute almost equally. Prostate cancer incidence generally increases from about the age of 45-50 years. There has been a marked increase in the yearly number of prostate cancers from 1993 onwards, possibly due to an increase in screening.

b. Hospitalisation rates

The rate of hospitalisation for all persons in the RCHS was significantly higher than the State rate (Table 3.11). The age-specific rates were highest in infants and the frail aged and a peak occurred in youth and adult females. The ASRs in the were similar to the State in cancer, injury and poisining, mental disorders and childbirth and perinatal period complications. However the RCHS female hospitalisations for cancer and childbirth related complications were significantly higher than the State female population.

Table 3.11: Hospitalisation rates: Regional Centre Health Service (RCHS) 1994

Condition	ASR*			RCHS compared with State rates
	Male	Female	Total	
All persons	174	218	193.2	Significantly higher (156)
Cancer	8.8	12.2	10.4	Similar (9.2)
Cardiovascular Disease (CVD)	13.7	12.3	12.9	Significantly higher (8.7)
Digestive, endocrine & immunity disorders	32.4	36.5	34.0	Significantly higher (23)
Genitourinary disorders	10.8	24.3	17.2	Higher (14.9)
Injury and poisoning	19.1	12.5	15.7	Similar (14.8)
Mental disorders	3.1	4.1	3.6	Similar (3.7)
Mobility and senses disorders	29.4	26.0	27.4	Significantly higher (21.6)
Infectious, haematological and other diseases	19.2	20.0	19.3	Significantly higher (16.1)
Pregnancy and disorders in the newborn	14.2	49.3	30.9	Similar (29.3)
Respiratory disorders	23.4	20.9	21.8	Significantly higher (14.3)

** ASR is Age Standardised Rate per 1,000 person-years*

The RCHS rates of hospitalisations for CVD, digestive, genitourinary, mobility and senses (nervous/musculoskeletal/connective tissue) infections and haematological and respiratory disorders were significantly higher than the State rates of hospitalisations. RCHS female ASRs were higher than male ASRs for cancer and genitourinary disorders, and lower for injury and poisoning.

Whilst the rates in Table 3.11 count only the initial admissions, the rates for repeat hospitalisation episodes were also significantly higher locally than the State rate for all conditions.

c. Mortality rates

The RCHS mortality rate from all causes for females was higher than the WA rate, whilst the rate for males was similar to the WA rate (Table 3.12). The RCHS death rates for all separate causes were similar to the WA rates, except for respiratory disorders which were higher locally.

Table 3.12: Mortality rates: Regional Centre Health Service (RCHS) 1990-1994

Condition	SMR *			% Deaths		
	Male	Female	Total	Male	Female	Total
All causes	102.7	106.3	106.3	100.0	100.0	100.0
Cancer	98.2	108.2	102.5	27.0	25.0	26.1
Cardiovascular Disease (CVD)	110.0	106.7	108.1	42.7	43.9	43.3
Digestive, endocrine & immunity disorders	88.9	130.9	109.6	5.0	8.0	6.4
Genitourinary	125.5	113.6	118.9	1.7	1.5	1.6
Injury and poisoning	83.0	108.1	88.9	7.1	4.2	5.7
Mental disorders	44.7	108.2	81.1	0.6	2.2	1.3
Mobility and sense organ disorders	71.1	123.8	99.5	1.8	4.2	2.9
Infectious, haematological and other diseases	83.0	71.3	87.0	1.7	1.3	1.5
Pregnancy and newborn disorder	113.1	126.7	118.6	1.5	1.5	1.5
Respiratory disorders	131.5	140.8	134.9	11.0	8.0	9.6

** SMR: Standardised Incidence Ratios, SMR = 100 for WA. Values below or above 100 are indicative of the % variation to that expected if the WA age-specific rates applied.*

CVD was the leading cause of death for both sexes. Age-specific death rates for ages younger than 44 years were low for both sexes, and were higher for males aged 25 years or older. More males than females die annually from CVD.

For both sexes, more than one quarter of all deaths were attributed to cancer, making cancer the second leading cause of death. The percentage of deaths attributable to cancer was higher for males than females. Death rates for females aged 18-44 were higher than for males of the same age indicating the significant number of breast cancer deaths in this age group. Male deaths after 44 years were greater than female rates, reflecting the significant number of deaths caused by lung and prostate cancer.

Digestive disorders were the third leading cause of death for females and the fifth for males. Deaths attributable to digestive disorders were more for females than males.

3.6 Summary and Conclusion

The assessment of the local health profile reflects some differences with the State and the Southern Region, and some significant differences between the sexes. The higher prevalences locally for diabetes, heart attacks, arthritis and hearing problems were due mainly to the higher prevalences in males. The higher prevalences in varicose veins and sinus were mainly attributable to females, while both sexes contributed to the higher prevalences in eyesight problems and high cholesterol. Cancer incidence locally was similar to the State.

Against this background of long-term conditions, the health-enhancing behaviour of local residents were better or the same compared with the State: more non-smokers, more non-drinkers or safe drinkers, more fruit and vegetable eaters, more covering their body in the sun, nearly same proportions exercising.

This apparent anomaly of a healthier lifestyle but more reported disease might be explained (assuming no differences in self-reporting) by:

- the time interval between improvement in risk factors in the population and the effect on disease to appear
- the movement into the area of older people, for retirement, who will have a higher prevalence of the "lifestyle diseases" like diabetes and heart conditions. (The proportions of older people 65 years and over is 12.3% in the Regional Centre compared to 8.7% in the State).

However, the sex differences in health-enhancing behaviour were significant: more men have ever smoked, undertook no activity, drank harmfully and did not use sunscreen. High proportions of local women have had their cancer screening tests.

The rates of utilisation of most health services were higher locally: GP, specialist, dentist and hospital. In fact the local hospitalisation rates and repeat episodes

were significantly higher than the State for all conditions, and more for females than males. This has a significant impact on the increased workload of the local GPs.

This analysis of the health profile of the local community highlights the following issues for consideration:

- More women being at both ends of the body weight spectrum (underweight or obese) raises issues of eating disorders. Hospitalisations and deaths attributable to digestive (nutritional) disorders were higher for females than males.
- Men could be using the Accident & Emergency/Outpatients department at the hospital as a substitute to attending GP surgeries (23.5% of men compared to 13% of women), raising issues of men's access to general practice.
- The high prevalence of hearing problems in men raises issues of long-term occupational hazards in rural areas, where the most frequent types of industry relate to manufacturing, construction, agriculture and forestry (Chapter 2).
- Local young people are engaging in unhealthy behaviour such as smoking and alcohol drinking raising issues of youth education.
- The five leading causes of death for local males and females are -

Leading Cause of Death	*Male*	*Female*
1	*CVD*	*CVD*
2	*Cancer*	*Cancer*
3	*Respiratory*	*Respiratory and digestive*
4	*Injury*	*Injury and mobility*
5	*Digestive*	

The local death rates are similar to the State rates, except for those due to respiratory causes which are higher locally. Education targeting the risk factors of these five leading causes of death should be on-going and coordinated between all primary care providers.

- The higher utilisation rates of health services locally raise issues of community access to general practice and GPs' requirements to cope with the workload.

4. PATIENT SATISFACTION SURVEY

4.1 Characteristics of patients in general practice

4.2 Patient dissatisfaction levels with aspects of quality in general practice

4.3 Preventive Health care in general practice

4.4 Conclusion

4. PATIENT SATISFACTION SURVEY

Satisfaction surveys have been, so far, the predominant method of getting feedback from users of their views on the quality of services, mainly because of their apparent ease and lower cost.

Consumer views on attributes of quality in general practice have been prioritised in a Consumer's Health Forum report on "Integrating Consumer Views about Quality in General Practice" (1996):

The attributes which appeared to be most important were:

- accessibility of GP
- interpersonal skills/qualities of GP
- provision of information by GP

The second most important groups of attributes were:

- technical competence of GP
- length of consultation

The third most important groups of attributes were:

- accessibility to practice
- non-GP staff
- financial accessibility
- demographic characteristics of GP
- availability of other health services at the practice
- continuity of care
- cultural issues concerning GP
- consumer involvement in care
- GP knowledge and understanding of specific health issues
- prescribing practices
- referral and testing
- faith/trust/confidence in GP
- professional behaviour of GP

The Royal Australian College of General Practitioners (RACGP) conducted such satisfaction surveys in 1996. Twenty two GPs from three local practices, or 73% of total GPs participated in the survey. They asked their patients, who visited the surgery during a one-week period, to complete the RACGP standard questionnaire. A total of 540 patients responded. Tables 4.1 - 4.3 present amalgamated data from the three local practices.

As these surveys were done nationwide, results of local practices could be compared with the total average of all practices combined.

4.1 Characteristics of patients in general practice (Table 4.1)

Characteristics of local respondents were similar to those in the comparative data. There were twice as many female as male patients consulting, the majority of patients being in the 25-44 age group, followed by 45-64 age group. Nearly 60% have been using these practices for a long time (6 or more years) which is higher than the comparative proportion of 46%. About 11% of patients tended to regularly visit different GPs at more than one practice which is compatible with the comparative data. The frequency of visits, for half of the patients, tended to be between 1 and 6 visits per year, with about 20% visiting 10 or more times a year.

4.2 Patient dissatisfaction levels with aspects of quality in general practice (Table 4.2)

In general, local dissatisfaction levels fell within the range of comparative data, but some were above the mean of comparative data, particularly those rating 20% and over, such as:

- The accessibility of GP in terms of the ease of making an appointment (23.7%), the times when the doctor is available to see you (23.5%), the ease of having the doctor see you at home (53.4%), the amount of waiting time at the surgery before seeing the doctor (27.7%).
- The financial accessibility in terms of cost of the drugs prescribed by the doctor and the fee charged by the doctor (20.3%).
- The accessibility to practice in terms of ease of parking (25.3%).

The accessibility of GP which has been rated among the most important group of attributes of quality in general practice, did not score well locally. However within this top priority of attributes, interpersonal skills/qualities of GP and provision of information by GP have rated favourably. Also the second most important attributes such as the technical competence of GP and length of consultation were favourable. Among the attributes that rated third, only two out of thirteen were not favourable locally: the financial accessibility and the accessibility to practice (mainly ease of parking).

4.3 Preventive health care in general practice (Table 4.3)

Questions on preventive health care were very general and did not provide details of quantities of alcohol consumed, fresh fruit eaten, limits in animal fats or salt, or what is meant by regular exercise (as was the case in the health survey in Chapter 3). Therefore interpretation by patients has been left wide open.

The proportions of patients who had their blood pressure checked in the last 12 months (81%), those who received tetanus immunisation in the last 10 years (62%), and those who received adequate help and information to enable them to stop smoking (67%) were consistent with comparative data.

The patients' lifestyle factors were better than the comparative data in terms of proportions currently smoking (20% vs 24%) and those who exercise regularly (75% vs 66%). Other lifestyle factors were similar such as eating plenty of fresh fruit and limiting animal fats and salt. However the proportion of patients who discussed amount of alcohol consumed with doctor, and those who had their cholesterol checked in the last 5 years were slightly lower than the comparative proportions.

Female patients had preventive measures better than the comparative data. 79% had a pap smear in the past 2 years compared to 62% and 82% had adequate instruction in breast self-examination compared to 76%. Proportions who had a hysterectomy were lower locally (15% vs 20%).

4.4 Conclusion

In summary, consumers were generally satisfied with most aspects of quality care provided in the Division. The one aspect, which was not as favourable, related to bulk-billing: This is a preferred option for payment by consumers (as reported in the literature and later on in this report), but is not an adopted method of payment by local GPs for all population groups. The other unfavourable aspect basically related to the accessibility to GP which is a possible reflection of the shortage in GP numbers per population. Doctors could improve on their accessibility, if more of them were recruited. Locally there are 30.5 full-time equivalent GPs catering for a population of 52,000, which means that there is one GP per 1700 people. The recommended ratio for this area is 1 GP per 1250 people, meaning that this area is short of about 11 GPs (personal communication with the Department of General Practice in the University of Western Australia). This shortage is further exacerbated by the higher rates of hospitalisations and use of GP services locally compared to the State (Chapter 3).

Satisfaction surveys have their limitations. Groups with special needs may be subsumed and disappear in feedback systems which are too general and don't allow for detailed comment. Also such surveys are not appropriate for establishing what the issues of concern are. As different types of services were appropriate for different types of situations and groups of patients, one uniform questionnaire would not pick up the

different elements that people value or are dissatisfied with. This is why more in-depth consultations and group discussions were undertaken, in the next phases of the project, to provide sufficient detail, thus enabling GPs to pinpoint what changes to make.

Table 4.1 *Characteristics of local respondents to the patient satisfaction survey of the Royal College of General Practitioners (1996)*

		% **Local Practices**	% **Comparative Data**
Age of Respondents	0-14 years	1.5	2
	15-24 years	8.0	12
	25-44 years	38.4	37
	45-64 years	25.1	26
	65-74 years	8.5	13
	75+ years	5.1	6
	Unspecified	13.5	4
Sex	Male	25.4	30
	Female	57.0	64
	Unspecified	17.6	7
How long have you been visiting this Practice	0-1 years	9.8	15
	2-3 years	12.5	19
	4-5 years	7.8	15
	6 or more years	58.5	46
	Unspecified	11.5	5
Do you regularly visit different GPs at more than one practice	Yes	10.6	11
	No	77.3	83
	Unspecified	12.1	6
How many other times in past 12 months have you seen a GP	0	8.1	9
	1-3	26.8	26
	4-6	22.4	24
	7-9	9.2	11
	10-12	8.3	9
	13 or more	11.0	15
	Unspecified	13.7	6

Table 4.2: *Patient dissatisfaction levels with several aspects of general practice in the Division of General Practice, compared to the comparative data, from surveys conducted by the Royal Australian College of General Practitioners in 1996. (Number of patients = 540 & Number of GPs involved in the survey = 22 GPs or 73% of total GPs in local practices)*

Dissatisfied with the following aspects	% Local Practices	% Comparative Data	
		Mean	Range
1. General medical care received at this practice	1.9	1	0-5
2. The facilities at the surgery	2.1	2	0-10
3. The facilities for children in the waiting room	15.6	10	0-52
4. The ease of parking	25.3	10	0-62
5. The ease of making an appointment to see the doctor	23.7	5	0-37
6. The times when the doctor is available to see you	23.5	7	0-31
7. The ease of talking to a doctor on the telephone	22.4	Not available	Not available
8. The ease of seeing the doctor out of normal working hours	26.8	15	0-54
9. The ease of having the doctor see you at your home	53.4	17	0-90
10. The amount of waiting time at the surgery before seeing the doctor	27.7	18	0-61
11. The amount of time the doctor spends with you	4.9	3	0-14
12. The fee charged by the doctor	20.3	7	0-30
13. The handling of accounts by the doctor's office	5.6	2	0-33
14. The doctor's ability to deal with children	0.5	1	0-8
15. The doctor's willingness to spend time with you	4.3	2	0-12
16. The doctor's willingness to answer your questions	4.2	2	0-11
17. The respect shown to you by the doctor	1.9	2	0.7
18. The doctor's knowledge	2.3	1	0-10
19. The doctor's ability to treat your problems	4.0	2	0-9
20. The doctor's concern about your problems	6.5	2	0-8
21. The amount of preventive health care given by the doctor	6.8	5	0-22
22. Your ability to choose which doctor you see	9.0	4	0-50
23. The cost of the drugs prescribed by the doctor	20.3	12	0-33
24. The effects of the drugs prescribed by the doctor	7.9	4	0-16
25. The cost of the tests ordered by the doctor	15.7	9	0-44

Table 4.3 *Preventive health care in local practices, from surveys of the Royal Australian College of GPs.*

	% Local Practices	% Comparative Data	
		Mean	Range
1. Had blood pressure checked in the last 12 months	80.7	85	36-100
2. Received tetanus immunisation in the last 10 years	62.2	62	25-97
3. Smoke	20.0	24	5-59
4. Proportion of those smoking who are receiving adequate help and information to enable them to stop if they so desire	67.3	65	27-100
5. Had cholesterol checked in the last 5 years	51.8	61	15-93
6. Exercise regularly	75.0	66	43-85
7. Discussed diet and exercise with your doctor	40.5	50	21-100
8. Do you drink alcohol	60.3	55	6-89
9. If you do drink alcohol, has your doctor discussed amount	16.8	25	0-95
10. Eat plenty of fresh fruit	82.7	87	72-100
11. Limit animal fats	82.0	80	52-100
12. Limit salt	79.3	77	56-100
Number of female patients between ages 25 and 65 years = 225			
13. Had a hysterectomy	15.1	20	0-45
14. Had a smear in the past 2 years	78.9	62	10-91
15. Had adequate instruction in breast self-examination	81.7	76	40-100

5. COMMUNITY CONSULTATION

5.1 Main Problems and Concerns

- Aboriginal health
- Aged care
- Arthritis
- Asthma
- Attention Deficit Disorder
- Cancers
- Diabetes
- Disability
- Heart disease and conditions
- Women's health including Domestic Violence
- Youth mental health/substance use and abuse

5.2 Agency Solutions to Service Delivery Problems

- Aboriginal health
- Aged care
- Attention Deficit Disorder
- Cancers
- Diabetes
- Disability
- Domestic violence

5.3 Service Delivery issues specific to General Practice

- Common issues to community/health organisations
- Aboriginal health
- Diabetes
- Disability
- Women's health
- Youth health

5.4 Conclusion

5. COMMUNITY CONSULTATION

"Divisions are not alone in being encouraged to open their doors to consumers. It is a world wide movement in health... Consumers have a great deal of knowledge about services; their perspective is derived from receiving them rather than providing them. The ideas, feedback and practical solutions provided by consumers have the potential to make a major impact on the delivery of quality services. Better processes are developed, better services are designed and better outcomes are achieved" (Consumers' Health Forum, 1996, p5). It is within this context that community consultation was a necessary component of needs assessment within this locality.

The consultation process consisted of talking to people living and working in the community, whether service providers or representing consumers on a variety of issues:

(i) Health and/or social issues: asthma, heart disease, cancer, diabetes, arthritis, Attention Deficit Disorder, drug and alcohol abuse, mental health, domestic violence, disability.

(ii) Population groups with special needs: the aged, Aborigines, adolescents and youth, women.

(iii) Service delivery issues (in general and specific to general practice).

The consultation process involved 18 face to face interviews with 13 community organisations, health agencies and volunteer networks such as:

> Asthma Resource Centre, Heart Foundation, Cancer Foundation, Diabetes Association Support Group, Arthritis Resource Centre, Attention Deficit Disorder Support Group, Aged Care Assessment Team, Silver Chain, Home and Community Care, Community Health Services, Aboriginal health workers and members of a Coordinated Care Trial, Alcohol and Drug Authority, Youth Accommodation Project, Senior High School Youth Education Officer, School Nurse and School Psychologist, Women's Health and Information Centre, Centre for Domestic Violence, Disability Services Commission.

The framework of this consultation consisted of finding out:

- what are the main problems and concerns in the community
- what groups of the population are experiencing these problems
- what solutions are put forward by these agencies representing consumers
- how can the GPs contribute to these solutions

In addition, local reports and surveys have been reviewed to substantiate this consultation phase where appropriate.

5.1 Main Problems and Concerns

Aboriginal Health

This consultation found that health care services may be available (eg privately or on a visiting basis), but Aboriginal people are reluctant or unable to use them (transport, cost, availability of consult times, social stigma, feelings of 'shame' etc). The reported health issues were heart disease, diabetes, asthma (especially with babies) and upper respiratory diseases with young children (often smoking and housing-condition related). Smoking over a long period of time is one of the main contributors to chronic airway obstruction. The incidence of smoking is higher than the population at large but is often not seen as a problem in itself by the majority of the Aboriginal community. Binge alcohol drinking was reported as more of a problem, and one which often leads to accident, injury, domestic violence, inadequate diet, mental ill health and other social health issues. Table 5.1 presents hospitalisation rates associated with some of these conditions.

Table 5.1 *The hospitalisation rates of Aboriginals for various conditions compared to non-Aboriginals (Western Australian Aboriginal Coordinated Care Trial, WAACCT 1996)* (X means times more).

	Aboriginal Women	**Aboriginal Men**
Chronic airway obstruction	4 X	3X
Heart disease	2.5 X	2X
Diabetes	16 X	10 X
Alcohol related disease	1 X	8 X
Use of mental health services	8 X	8 X

Huggins, Somerford and Rouse (1996) highlight male Aboriginal health as one of the main priorities for men's health in Western Australia. They identify the lack of appropriate healthy role models and family systems in society as some of the *"non-traditional"* factors contributing to men's ill-health (p.123).

Skin disorders are almost always diagnosed by GPs as 'scabies', with the associated implication that environmental disorder/lack of hygiene are the cause. Prescribed medication is often inappropriate. Family members are reluctant to return to the GP and Aboriginal community health workers are often asked to advocate to the GP on behalf of their clients.

The 'Well Women Clinic' was not well attended by Aboriginal women as the clinic would not accept a 'block booking'. These women often could not attend individually (lack of transport, child care etc), with the result that they did not attend at all. Most are now seeing one main female GP and report satisfaction with service and attitude. However, a question remains as to how long a single GP can continue to service this population alone? Comments expressed by other service providers on the attitudes and service provided by surgery clerks/reception staff is reinforced under section 5.3 of this chapter.

The senior Aboriginal Community Health worker in the Regional Centre has difficulty supporting another local worker because they are in different health administration regions, even though they share a lot of clients. Families may have to travel in different directions for services. GPs may be accessed in the Regional Centre, and in other towns representing different Divisions of General Practice, with potentially different priorities.

In addition to being a medical issue, respiratory conditions are also linked to inadequate environmental factors such as poor housing and overcrowding. This consultation found that liaison and communication with Homeswest has a history of being poor. For example, letters from GPs and health workers, in support of families living in inadequate conditions, are ignored. Recent attempts, however, to improve liaison between health workers and Homeswest have been moderately successful.

Aged Care

All agencies surveyed complained that the discharge planning process was inconsistent, often muddled, with no clear pivot person. Community Home Care (CHC) services may not be notified that a person is being discharged, and the GP may be pressured by lack of beds for an early discharge when backup services are not in place. Drug regime information needs to be clear to the patient, especially on discharge from hospital and when leaving the GP. (The hospital and community pharmacists may be in a position to input here). Several gaps and weaknesses were acknowledged: follow-up after discharge, transfer between hospital and nursing home, links between all transfers, hospital and community, interagency and hospital communication. Dowden-Parker (1995) quotes from the 1995 local audit report of the Aged Care Assessment Team:

"19.1% of patients included in the audit had been admitted repeatedly during the 6 month period. Some patients were discharged home and were readmitted in to hospital care less than 24 hours to 2 weeks post discharge." (p.3)

Although poor discharge planning cannot be held totally responsible for aged care patients' early readmission to hospital, it may be that a clear, consistent and coordinated process, linked to community services and resources may reduce inappropriate, preventable readmissions. Some patients are placed at risk by their confusion over medication once discharged from hospital. The Webster pack does help this situation, but once the pack has finished they may again be unsure as to the purpose/dosage of different medications, especially if they have old prescriptions left over in the home.

Social support networks are often lacking - eg. entertainment, companionship if friends/family are not available or don't exist. Community Home Care (CHC) and other Home and Community Services (HACC) would do well to adopt a centralised assessment and case management model as per the Aged Care Assessment Team (ACAT). Currently, each service does its own assessment which can lead to duplication of services, confusion for the client and a potential security issue. Home support services (CHC, HACC etc) may be competing for the same resources base to provide similar services.

A number of agencies suggested that a barrier to effective service delivery is the different boundaries between different services, ie Local/State/Federal Government, support groups, Divisions of GP etc. HACC cited a situation where buses and volunteers' cars transporting clients to and from recreation/appointments often passed each other coming to a Regional Centre service. Elderly people (especially) can be separated for health care, eg one partner in hospital in the Regional Centre, the other in respite care in another town within the region.

Arthritis

The swimming pool currently available to arthritis sufferers is not suitable as it is freezing cold and exacerbates the condition. Arthritis sufferers also need access to pain management services (such as the pain management clinic).

Asthma

Most people are poorly educated about asthma and underestimate their illness. They need to be functionally 'sick' before they present, often after lung damage is evident. Some GPs and hospital accident and emergency have been known to minimise people's presenting problems, with the implication that they are not in control of their symptoms. GPs may not always have the consulting time to fully inform patients about the asthma process/implications/social issues. Women may accept GP information without question and do not report the family and social situation and the financial affordability of medication.

Most sufferers purchase relief medication direct from pharmacies, without the necessary information about monitoring their situation or without a medical assessment. The Asthma Foundation wants to offer a preventive service which could provide a more accurate and direct referral route for patients and would like to see people other than their existing clients in hospital or once they are home (on referral from the GP before discharge). This could provide a link in to the family for other issues, which can be exacerbated by asthma. The local office receives little assistance with promotion of its service and resources from the Asthma Foundation head office.

Attention Deficit Disorder

The "Learning and Attentional Disorders Society" (LADS) estimates that currently 5% of the population could have a learning and attention deficit disorder diagnosis (LADS personal communication, 1997), with males almost six times more likely to be diagnosed. Local advocates for ADD reported:

- There are no specific established services and there is disagreement among 'professionals' (to whom most families are referred) as to whether there is such a syndrome, and if there is, how to treat it and what role, if any, medication has to play in the treatment and management;
- The local support group would like to see an acknowledgment of their role and of the accurate and up to date information they access through LADS in Perth;
- The stress and financial burden on families is considerable.
- An increase in use of medication for ADD management is supported by current literature:

"..WA prescriptions for Dexamphetamine have increased from 38 in 1990 to 7780 in 1993. ....WA has a disproportionately higher usage of both Dexamphetamine and Methylphenidate (indicating) that either Western Australia is mis-diagnosing and /or over-prescribing stimulant medication or that the other States and Territories are yet to 'catch up'" (Technical Working Party on Attention Deficit Disorder, 1996, pp 5,6).

Cancers

The current controversy over prostate screening is not exclusive to the South West, and impacts on GPs and all concerned men. There is an ongoing need for community and GP education on diet, smoking and sun protection measures. GPs seem to be reluctant to intervene and / or advise patients to give up smoking unless the smoking has direct bearing on their presenting condition. In addition to the increased risk of cancers from an unhealthy diet, excessive sun exposure and smoking, harm associated with drug use, alcohol use and its related problems have also been identified as issues of high risk to men's health, in need of urgent medical attention and community support to change social peer perceptions of 'healthy behaviour' (Huggins et al 1996).

Diabetes

Diabetes has a higher prevalence locally compared with the State or the Southern region (Chapter 3). This Needs Analysis coincided with a review of services to diabetics, being undertaken by the Regional Centre Health Service Diabetic Project Team. The consultation revealed that most diabetics knew of the existing services specifically set up for them. The exceptions were the visiting Endocrinologist and the Women's Health Centre, who were not well known. Most people thought the services were easy to find out about and the GP was the most common source of information about diabetic services, followed by Silver Chain, word of mouth (friends, other diabetics), health professionals, Pharmacists, Diabetic Association and Aboriginal health workers.

The ease of access, good, helpful information and professional expertise were the most common 'best liked' points about the local services. Also indicated was the ease of accessing supplies locally (open every day) in whatever quantities were needed, at lower cost than being sent from Perth. Having a number of points from which to gain information, advice and friendly support was also noted. The Silver Chain diabetic service was seen as the most appropriate service provider, with a good reputation for quality service, with other stakeholders sparsely mentioned.

Those seen as potentially missing out on services include non-English speaking people. Even using a telephone interpreter service does not guarantee full comprehension or compliance. Gaps also exist for those with mental health problems or who are in denial about the condition, elderly, those geographically isolated or working and are unable to access services in regular working hours. Aboriginals were identified as a group with a high risk of diabetes and associated complications, with women hospitalised 16 times more and men 10 times more than non-Aboriginal people (WAACCT, 1996). Aboriginal people are also difficult to access and may be missing out on services (confirmed by the Aboriginal section of a local Health Service Survey, 1997). The services for children were deemed to be good, with the PMH team visiting from Perth providing useful input; adult services were not as good, but still acceptable to good.

The Division of General Practice Survey of Diabetes Services identified five main gaps in service delivery:

a. insufficient Diabetic Clinic time for the consumer need;
b. patient recall system is inadequate or non-existent;
c. monitoring of blood sugar levels (BSLs) is problematic;
d. availability of support at diagnosis;
e. accessing Aboriginal patients.

Disability

- There is a shortage of community-based accommodation for people aged 18 years and over (ie on a cost-sharing basis). Mixing with others of similar ages would also contribute to disabled people's social and entertainment needs.
- Secondary health issues are not given as much credence as the predominant disability, ie a person with a degenerative condition may not be given access to the same treatment for other health conditions as a non-disabled person.

Heart Diseases and Condition

The National Heart Foundation's (NHF) regional office feels it has a reasonable profile in the community and with GPs. This is due to a prolonged and deliberate strategy to keep GPs informed of NHF priorities, resources and services and to encourage reciprocal referrals. The local office devotes a lot of time, energy and resources into liaising with GPs in return for a modest (but increasing) number of referrals. Most referrals are appropriate for dietary advice and resources (cookbooks). The GPs seem to be happier to refer to the NHF because of the heavily promoted medical research background utilised by the NHF in its training and publications. The NHF has a much better community reach when it works with other agencies to promote similar messages (eg Cancer Foundation, Community Health). Intersectorial collaboration provides a broader outreach base and a more efficient service. Heart attacks and other heart conditions were reported more frequently locally compared with the State and the Southern region, and the prevalence is nearly five times higher for men (Chapter 3). Huggins et al (1996) report that heart disease is a significant health issue for Australian men, and reflects an opportunity for this service to be innovative in its delivery of heart health messages to this section of the population.

Women's Health (including Domestic Violence)

This consultation process found that eating disorders are being ignored, misdiagnosed and/or mistreated by GPs. The prevalence of eating disorders could be reflected in the 1995 WA Health Survey, where there were more women than men who were underweight or obese (Chapter 3). Eating disorders have implications for mental health, especially depression. As with domestic violence, depression can manifest in many ways and present to the GP with many 'faces'. When a disorder is diagnosed, women are most often sent to Perth for treatment, which can be disruptive to the person and their family/supports. Often when they return home they are in the same environment (physical/social etc) which may be detrimental to their recovery.

Fertility services are not well catered for in the area. For example, pregnancy termination is only available in Perth. There is a feeling amongst service providers that prescription drugs are overused, especially amongst women and the elderly. This use may be of short term intention, but often takes on longer usage and may mask an underlying social/mental health/family problem.

The incidence of domestic violence is grossly underestimated/underreported. Sherwood (1996) suggests that many victims are not cognisant of the services available. Hence, they do not report their circumstances and do not represent on the area statistics. Services for domestic violence in the Regional Centre, over the 12 months July 1995 to June 1996, reported over 200 counselling sessions, with the women's refuge seeing over 300 women and children. A smaller town within the region has a high incidence of domestic violence as indicated by police call outs and cases reported by the South West Mobile Counselling Service. GPs are not recognising or acknowledging the presenting symptoms, which may not be obviously indicative of domestic violence.

The role of domestic violence as a contributor to the ongoing patterns of violence and abuse of young males has been identified as a significant cause of men's ill-health, as well as that of women and the family system, with community - wide implications (Huggins et al, 1996).

Youth mental health/substance use and abuse

Drug use, especially the easily available alcohol, is widespread amongst youth. Binge drinking is popular. The prevalent attitude is that a person needs to be intoxicated to enjoy themselves. Violence and drug use contribute to young men's risk-taking behaviours. While they constitute a significant part of the "rights of passage" to adulthood, these behaviours will be difficult to modify, at a community level, especially in the absence of appropriate role models of masculinity (Huggins et al, 1996).

Tobacco use is increasing and is not seen as a health issue. Cannabis and amphetamines are used by a smaller group, heroin by a smaller group again, but their attitudes are pervasive. That 'everyone is doing it' describes how a lot of young people feel about drug use. Analysis of the 1995 WA Health Survey at the local level (Chapter 3) revealed that the highest percentages of current smokers and of people drinking alcohol harmfully occurred in the young age group of 15 -24 years (29.2%)

Similarly, the 'Student Lifestyle Survey' of TAFE students, (Lundy, 1995) found that 45% of males and 31% of females consumed more than the National Health and Medical Research Council (NHMRC) recommended levels of alcohol. The same survey reported 57% of males and 58% of females smoked either regularly or on a 'social' basis. 63% of students (69% of males and 60% of females) reported having ever tried cannabis. Even if we assume this report to be the 'upper levels' of usage, and to include some experimentation, and although the interpretation of these findings may be open to question, the figures do provide some indication of usage levels. Hilbers and Meyer (1993) make the comment, based on key informant interviews, that *"....drug use was extremely common among this group of people, being very much a part of their lifestyle."* (p.33)

The Student Lifestyle Survey also found that the life skills issues *of "stress, nervousness/low confidence, weight/dieting, boredom, communicating with family/friends, drug use and sports injury prevention"* (p7) were of top concern to students. However, the young people themselves may not perceive these issues as indicative of 'poor life skills', but may instead identify problems accessing appropriate services (Hilbers & Meyer, 1993).

Despite the Regional Centre Youth Policy, there is still a paucity of recreation and other services specifically for youth who have limited income, access to transport, training and employment opportunities. With 21% of TAFE students relating 'boredom' to health issues, it may well be that even those who have access to training still see themselves as being bored (Lundy, 1995).
Family dysfunction, lack of family/social support may be behind most 'escapist' behaviour, which, because of the nature and endurance of the trauma, usually extends

beyond the experimental stage. Children and youth who originate from broken and dysfunctional families and unsupportive environments are more likely to engage in *".....health damaging behaviours such as misuse of drugs, poor eating habits, high risk sexual relationships, intentional violence and mental breakdown"* (WHO, 1986 cited in Hilbers & Meyer, 1993, p26).

The domestic violence and accommodation services are the agencies most referred to for youth issues within the local community. This finding supports the link between drug use, family breakdown, domestic violence and homelessness. That is, young people who come from dysfunctional family homes with domestic violence (and probable drug use) are more likely to need counselling and support from agencies dealing with domestic violence and alternative short - term accommodation . Family and Children's Services are viewed with distrust and fear because of their child protection mandate and referral to them is on a 'last resort' basis.

Young males do not readily access medical and health services in general and are ill-informed about health issues and their own health status (Huggins et al, 1996). The Hilbers (1992) survey asked students where young people get most of their health information. Seven in ten reported parents as the most popular source, six in ten GPs, five in ten magazines, and four in ten from peers, teachers and television. Unfortunately, this information was not broken down by gender, so there is still a paucity of information as to how and where young men access health information.

5.2 Agency Solutions to Service Delivery Problems

Aboriginal Health

The "WA Aboriginal Coordinated Care Trial" (WAACCT, 1996) outlines the health state of Aboriginals in various regions of WA, as compiled by a partnership between Government, Aboriginal health organisations and medical services, as well as an initiative model for health care service delivery. The Trial is currently being undertaken in the Regional Centre through an Aboriginal Medical Corporation, as well as through agencies in three other sites in WA. The Regional Centre was chosen to represent a *"large rural town without an Aboriginal Community Controlled Health Organisation (ACCHO)"* (p.23).

A model of service delivery, based on existing health care service providers, but differing to the conventional Aboriginal Medical Service is proposed, involving the two major hospitals, hospitals in other target towns, government, community and mental health services, specialists and GPs. In the Regional Centre the trial predicts

".....that the care team for each family and the individual will be their own private GP, an Aboriginal Care Coordinator and an appropriate other health professional. Care coordination will not be provided by the patient's GP. The Care Coordinator will work with the GP and be responsible for addressing the many reasons why Aboriginal people do not access health services and for linking the various elements of the health care system. The GP will be responsible for the

medical care and medical planning for the patient and as such they will be the key person in the care team..... " (WAACCT, 1996, p.25).

The service delivery phase of the trial is expected to be carried out 1/7/97 - 31/7/99. Service providers have high expectations that provision of coordinated care will improve the access of Aboriginal people to GP and other medical and health services.

Aged Care

Funding:
(from both Commonwealth and State sources) is needed to address shortfalls in the following areas:

- for hospital beds for patient assessment while waiting for hostel placement;
- to provide for a wider consumer base (anticipated in the future) being maintained at home;
- for emergency respite care, especially to cater for elderly couples within one location;
- for more Community Aged Care Packages (CACP) for the local Region, as an alternative to hostel placement.

Home Support Service Delivery:
This consultation suggests there needs to be a review of the provision of these services in the local Division area, especially when they are administered from different 'areas'. The Warren Blackwood Health Planning Study (1994) noted that the:
".....respective roles of Silver Chain & HACC had not been fully resolved. We consider that there are opportunities through improved coordination of existing services to improve the overall effectiveness of current resources". (pp. 69,70).

The different geographical boundaries of a number of community and government services cause problems for both service delivery and consumers across the board. As a consequence, consumers may become confused by services being delivered under differing guidelines with distinct eligibility criteria. Time, money and energy may be spent maintaining contact between service providers to avoid overlap and duplication.

Attention Deficit Disorder

Local advocates reported a need for:

- parenting programmes;
- remedial education services;
- school resources (classroom and funding for aides);
- psychological services (programs have been written but there is a lack of trained personnel to run them);
- specialist dietary assistance/advice;
- occupational therapy, speech and physiotherapy services to be long term not just 6 weekly as is currently the case;
- a second Paediatrician.

Cancers

The cancer support group could be better utilised (by GP referral), as could the Cancer Foundation office, which has information as to what services can be provided, such as accommodation in Perth if patients need to travel for treatment.

The Regional Centre office suggests that better coordination of follow up procedures, coordinated locally, could assist with the transition from Perth to home with treatment regimes/support groups etc.

An oncology nurse specialist would be useful in the hospital to complement GP based services, eg administering daily/weekly injections/medications. This service could aid in reducing the bottleneck for GP services.

Diabetes

This consultation and the Regional Centre Health Service Review highlighted the need for:

- A daily clinic, better publicised, with more staff;
- Better labelling of products in shops and a better range of products in local shops;
- Access to podiatry services for all patients (only a private service is available);
- Financial assistance with medical costs (medication, Specialist referral);
- Hospital staff more informed about diabetes;
- Food choices at the patient level in hospital be guided by trained staff.

Disability

Service providers identified the following needs:

- Promote a more caring community to enable disabled people to be integrated into existing support, and "normal" sporting and social networks.
- Better funding support to enable families in outerlying areas to travel to medical/therapy services until the population base is large enough to have the services based locally. The Patient Assisted Travel Scheme (PATS) is limited with strict eligibility criteria.
- The Community Aids Equipment Programme (CAEP) entered into by the Regional Centre Hospital has made a big difference to local families, by making physical assessments and loan of independent living and other equipment available through the hospital.

Domestic Violence

Progress (albeit slow) has been made toward the implementation of the Domestic Violence Plan (Sherwood, 1996). Regional workshops are being conducted to put in place advocacy services and to increase community awareness of the dynamics of domestic violence. Police are now more responsive and positive toward the victim and family and have clearer guidelines about their intervention role. Children's and perpetrator programs have recently received funding.

An integrated, legally binding, counselling programme is needed, as anecdotal evidence would suggest that even with a perpetrator counselling programme (alone), a court order is often needed to get the perpetrator to attend.

There is still a high need for a community education officer, awareness campaign (including highlighting the link between alcohol use and domestic violence), advocacy services, legislative reforms, community liaison between perpetrator and advocacy services, a consistent police response across the region and services which are culturally appropriate for Aboriginal offenders (Sherwood, 1996).

5.3 Service Delivery Issues Specific to General Practice

The service delivery issues raised in this consultation phase have been consistent with those reported in the literature: Consumers' Health Forum (1993a); Hall & Dornan, (1988); Steven & Douglas (1988); Smith & Armstrong (1989); Lloyd, Lupton, & Donaldson (1991); Gabbott & Hogg (1994); Calnan (1988); Rashid, Forman, Jagger & Mann (1989); Baker (1990); Williams & Calnan (1991); AGB Australia (1992), all cited in the Consumers' Health Forum and the Commonwealth Department of Human Services and Health report (1996).

Issues common to community/health organisations

- GPs need to be more aware of the range and diversity of services and agencies in the community. Where they are aware of the existence of agencies, GPs do not refer patients for source information, they do not seek source and up to date information or cooperative assistance from agencies and services in the management of their patients.

- The difficulty of accessing GPs relates to how busy GPs are (waiting times can be up to 10 days). Agencies reported advocating on behalf of clients to assist in the accessing of appointments and self help groups report the above problem (even with acute cases) as well as members not always being able to see the doctor of choice. Seeing a doctor 'who knows me' was reported as important to patients' trust and more time efficient to both patient and GP. GPs being available outside usual working hours was reported as being important to Aboriginal people and for those in paid employment. Men are known to leave consulting a GP until their condition is serious and urgent. Finding a GP who is able to see them immediately can then be difficult, and may contribute to more men attending hospital Accident and Emergency Departments, as suggested by the WA Health survey (Chapter 3): 23.5% of men compared with 13% of women attended A & E/ outpatients locally.

- The usual 10 minute consultation was seen as hindering the patient/doctor relationship, potentially putting the GP under pressure, as well as stressing disadvantaged patients who may not be sufficiently eloquent to 'tell their story' in such a short time. This was a particular issue with Aboriginal people, elderly and those presenting with the physical symptoms of domestic violence. This group may be willing to present a 'more palatable' story to fit in with the GP's expectations and time constraints. Elderly may not be happy with a treatment/management regime, but may be unwilling to pose questions in the confines of the consultation period. GPs need to spend more time explaining the Diabetes condition and medication.

- Services of GPs were rated good by 42% of agencies, adequate by 29% and poor by a further 29%. Women GPs were often singled out as being 'very good'. This was especially in terms of communicating with patients, understanding of social issues, taking more time with patients and seeking interventions with socio-medical backgrounds which have wider family and social implications for management. Female GPs were often the choice of young women, including Aboriginal women. A female GP being available for consultation was an important attribute discussed in the above mentioned reports.

- Most respondents understood the 'gatekeeping' role of the surgery clerks/receptionists. However, they felt this role often extended too far and wondered (for example) if information/materials/resources sent to the GPs actually reached them? Some complained that such staff needed advanced communication skills. They could be rude, offhand and judgmental with patients and their presenting conditions and situations. The suitability of surgery clerical staff's

interpersonal skills has been highlighted as important by the studies mentioned above.

- Respondents reported dissatisfaction that there are not private/cornered-off sections in surgery reception areas where people's confidential issues can be discussed. Women and Aboriginal people can be intimidated by this (perceived) lack of respect and privacy.

- GPs need better assessment/diagnosis/training/management/interagency communication skills with dementia, psychiatric assessment (especially aged, women and youth), substance abuse, eating disorders, domestic violence and ADD. These issues can often present with many 'faces' and it takes a skilled clinician to accurately identify issues, especially when cultural aspects are considered. Adequate competency in the specific areas of mental health, disability, youth health and women's health issues were all highlighted in the above mentioned literature.

- GPs are reluctant to attend in-services/training locally unless it is conducted by a person with medical qualifications, preferably a 'doctor/specialist'. Respondents have reported poor GP attendance in the past which precluded a number of high quality/well informed presenters, as if there is a perception that non-medically trained expertise is not of value to the GP.

- Bulk billing, especially for young people, women and Aboriginals, would assist in the early accessing of the GP. This point was cited as an important issue for GP accessibility in Chapter 4 and by a number of studies, as cited above.

Finally, respondents' feelings re local GP services can be summarised as follows:

*"GPs mostly provide a good quality **medical** service, but not a comprehensive, wholistic good quality **health** service".*

Aboriginal Health

Some GP surgeries are getting better at fitting in urgent patients at the request of the health workers. Some GPs are improving their liaison with the health workers with health maintenance issues. The health workers would like to accept more of these referrals as they feel they can work preventively with more serious issues (especially with children).

Diabetes

Solutions already identified by the Division include:

a. a register of diabetics to allow for recall of those needing screening for complications;
b. patients to carry a passbook detailing their management and education objectives, for use by a multidisciplinary team. Some patients have such a record, but may need GP reinforcement to carry and use it;

c. ongoing GP liaison with Silver Chain , Community Nursing and a dietitian to assist with monitoring of patients' progress (BSLs, diet etc);
d. closer GP liaison with Aboriginal health workers to ensure follow up of these patients and adherence to treatment and management regimes.

Disability

GPs need to liaise more with disability specialists, both in Perth and those visiting the Region. This liaison would improve the GPs' knowledge of the conditions of different disabilities and improve patients' access to local services.

Women's Health

There is a very great need for the resumption of a Well Women's Clinic, which offers a wholistic, non judgmental service (ie more than just pap smears) to all women. The service needs to be well promoted, especially to other service agencies and cater for the special needs of Aboriginal, migrant, young and older women. This consultation found that GPs need to be more receptive to the issues of domestic violence and child abuse and attend training to improve their role in screening. The Domestic Violence Centre would like to work actively with local GPs and feel they have the expertise to help improve GP assessment skills and to work cooperatively towards a more active diagnostic and referral process. Several studies reported that female consumers feel it is vital that GPs have a thorough knowledge, and be accepting of women's health issues.

Youth Health

The night clinic at one surgery is popular with young people who may be on the streets at that time. Several studies note that having access to bulk billing and after-hours services, including weekends and public holidays, are important issues for youth access to GP services. Regular attendance by a GP representative on the Regional Drug Coordination Committee is recommended and would be welcomed by service providers.

5.4 Conclusion

This chapter identified the major health and social concerns of consumers and service providers about the community in general. One issue of concern, which became evident is that of men's health. Men have been identified as a group with special need for heart disease, cancer, mental health, drug / alcohol abuse and access to general practice by the various community and health organisations. The local health data from the 1995 WA Health Survey (Chapter 3) identified that men had higher prevalence of diabetes, heart attacks, angina, hearing problems, arthritis and drank alcohol more harmfully, compared with women. Furthermore, some of these local disease prevalences were higher than the State prevalences in general. This is further supported by Huggins et al, (1996), who report that

" The physical and psychological health of rural men is considered urgent, especially in the areas of mental illness, youth suicide, injury, road trauma and substance abuse. Rural men are seen to identify strongly with a conventional gender role, often work in dangerous environments and are wary of the advice of GPs and other health professionals, especially if they are new to the area". (p 1.25)

Some issues discussed in this chapter, like diabetes, are being dealt with currently, while others still have gaps in service delivery and coordination. However, only those issues which impact onto the interface between general practice and the consumer will be further addressed in this report.

6. GP NEEDS SURVEY

6.1 Objectives and Methodology

6.2 Profile of GPs

- Demographic characteristics
- Qualifications/interests
- Hours worked
- Personal stress and job satisfaction
- Aspects of work causing stress
- Future requirements in general practice

6.3 Continuing Medical Education Needs in:

- Technical Medical Care
- Preventive Medical Care
- Doctor/patient interaction
- Practice Management

6.4 Knowledge and use of Community/Self-Help Groups (Support Services)

6.5 Satisfaction with Service Delivery/Availability of:

- Medical/surgical specialists
- Allied Health services
- Other Health Service Providers

6.6 Satisfaction with Interprofessional Communication with:

- Medical surgical specialists
- Allied Health professionals
- Other Health Service providers

6.7 Gaps and Deficiencies in the Service to the Local Community

as perceived by the GPs in terms of:

- Specialty areas in patient care
- Service delivery and communication with other health service providers

6.8 Summary and Conclusion

6. GP NEEDS SURVEY

6.1 Objectives and Methodology

The objectives of the GP survey were:

- to provide information on the profile of local GPs
- to assess the continuing medical education (CME) needs
- to rate the satisfaction of GPs with the availability/service delivery of and the interprofessional communication with other health service providers
- to describe various aspects of general practice work locally
- to identify gaps in services to the community as perceived by the GPs

The contents of the GP questionnaire was discussed and approved by the reference group and the division's CME coordinator.

All GPs in the Division were invited to complete the questionnaire in March 1997, and return it in reply-paid addressed envelopes. At the time of the survey 31 GPs were working and 2 were on leave. Completed questionnaires were returned by 26 GPs, representing an excellent response rate of 84%.

The GP questionnaire was adapted from the one used by the Swan Hills Division of General Practice in their needs analysis (Hughes et al 1996). Thus the results from the local survey can be compared in order to highlight differences between rural GPs ($n = 26$) and metropolitan GPs ($n = 55$), where appropriate.

6.2 Profile of GPs in the Division

Demographic Characteristics

The gender distribution of respondents consisted of 81% male (21 GPs) and 19% female (5 GPs). The mean age was 49.6 years (SD = 11.6), ranging from 38 to 80 years. However, 80% of the GPs were aged between 35 - 44 years (38.5%) and 45 - 54 years (42.3%) (Table 6.1).

The mean number of years in general practice was 18.6 years (SD = 11.2), ranging from 5 to 50 years. Nearly 50% of GPs had experience between 5 and 14 years, followed by 31% between 15 and 24 years. 20% of GPs had practices outside the Regional Centre . Half of the GPs were in a large practice of 16 practitioners, followed by 23% in a practice of two (Table 6.1).

Table 6.1: Characteristics of Local GPs

	Number	Percent
Gender		
Male	21	80.8
Female	5	19.2
Age in years		
35-44	10	38.5
45-54	11	42.3
55-64	1	3.8
65+	4	15.4
Years in general practice		
5 - 14	12	46.2
15-24	8	30.8
25-34	3	11.5
35+	3	11.5
Location of Practice		
Regional Centre	21	80.8
Postcode 1	3	11.5
Postcode 2	2	7.7
Size of Practice (No. of GPs)		
One GP	2	7.7
Two GPs	6	23.1
Four-five GPs	5	19.2
Sixteen GPs	13	50.0
Total	26	100

Qualifications and interests

Nearly a third of the GPs have graduated overseas, a half have graduated in Western Australia and 15% in other Australian States. (Table 6.2a).

Four GPs had competency in a language other than English (namely Italian, French/Arabic, Afrikaans and Dutch). Just over two-thirds (69%) had additional medical and post-graduate qualifications (other than MBBS), the most frequent being a diploma in obstetrics/gynaecology (Table 6.2b).

The main medical interests of GPs apart from general practice are listed in Table 6.2c. Over half of the GPs indicated interests in Obstetrics and Gynaecology.

Table 6.2a: Place of Graduation from Medical School

	Number of respondents	%
Western Australia	14	53.8
Other Australian States	4	15.4
United Kingdom	5	19.2
New Zealand	1	3.8
South Africa	1	3.8
Ireland	1	3.8
Total	**26**	**100**

Table 6.2b: Additional Medical and Postgraduate Qualifications (other than MBBS)

	Number of respondents	% of GPs*(n=26)
Diploma, Royal Australian College of Obstetricians & Gynaecologists (DRACOG)	14	53.8%
Diploma, Royal College of Obstetricians and Gynaecologists (DRCOG)	5	19.2%
Fellow, Royal Australian College of General Practitioners (FRACGP)	4	15.4%
Member, Royal College of Surgeons (MRCS) (UK)	2	7.7%
Licentiate, Royal College of Physicians (LRCP) (UK)	2	7.7%
Diploma of Anaesthetics	2	7.7%
Graduate Diploma in Family Medicine	1	3.8%
Member of the Royal College of General Practitioners (MRCGP)	1	3.8%
Fellow of the Royal College of Surgeons (FRCS)	1	3.8%
Fellow of the American College of Surgeons (FACS)	1	3.8%
MBBS only	8	30.8%
Total number of GPs reporting additional qualification	18	69.2%

**Total exceeds 100% due to provision of multiple responses*

Table 6.2c: Medical Interests other than General Practice

	Number of respondents	% of GPs*(n=26)
Obstetrics/Gynaecology	14	53.8
Anaesthetics	3	11.5
Chronic pain management	2	7.7
Dermatology	2	7.7
Diving Medicine	2	7.7
Mental Health/Psychiatry	2	7.7
Minor Surgery	2	7.7
Sports Medicine	2	7.7
Women's Health & Family Planning	2	7.7
Asthma	1	3.8
Aviation Medicine	1	3.8
Female & Teenage Medicine	1	3.8
Geriatrics/Gerontology	1	3.8
Industrial Medicine	1	3.8
Orthopaedics	1	3.8
Paediatrics	1	3.8
Palliative Care	1	3.8
Preventive Medicine	1	3.8
Public Health	1	3.8
Rheumatology	1	3.8
None	2	7.7

**Total exceeds 100% due to provision of multiple responses.*

The extent of work in terms of number of hours per week

GPs in the division worked a total median number of 66 hours per week (Table 6.3a): of these, 49 hours were spent consulting (booked appointment, hospital and nursing homes visits during working hours), 6 hours on practice issues (not seeing patients) and 11 hours being on-call or conducting after-hours surgery. This means that half of the GPs consulted for more than 50 hours per week, and were on-call between 5 and 19 hours a week.

Table 6.3a: Number of hours at work per week (percent of GPs)

	Consulting (Booked appointments)	Non-patient contact (Practice issues)	On-call or after-hours surgery
Less than 5 hours	-	30.8	15.4
5 - 9 hours	-	34.6	23.1
10 - 19 hours	11.5	30.8	26.9
20 - 29 hours	3.8	3.8	7.7
30 - 39 hours	15.4	-	7.7
40 - 49 hours	19.2	-	7.7
50 - 59 hours	34.6	-	-
60+ hours	15.4	-	11.5
Median (all GPs)	**49.0**	**6.00**	**11.00**
Median (full-time GPs)	**50.0**	**6.00**	**13.00**

The 1996 Interpractice Comparison (IPC) document reported on the profile of typical Doctor's week (in full-time doctor equivalent terms). Table 6.3b highlights the differences between the median national figures and the local ones.

Table 6.3b: Median hours worked per week

	Local Survey	IPC
Hours working and on-call	63.0	53.0
Practice issues/non-patient contact	6.0	4.5
Total	69.0	57.5

Local rural doctors worked just over eleven extra hours per week compared to the median national figures.

Personal Stress and Job Satisfaction

Respondents were asked to rate their level of stress in the last 12 months on a 1 - 5 scale. Similarly they were asked to rate their level of job satisfaction.

Table 6.4: (%) GPs' ratings of their levels of stress & job satisfaction

	Very low	Low	Medium	High	Very high
Stress Level	4.5	9.1	40.9	36.4	9.1
Job Satisfaction	9.1	9.1	36.4	40.9	4.5

77.3% of GPs reported a medium to high level of stress as well as job satisfaction.

The stress level experienced by rural and metropolitan GPs is similar (45.5% vs 43.6% respectively for high to very high stress level). However the job satisfaction level is lower for local rural GPs compared to the metropolitan GPs of the Swan Hills Division (45.4% vs 60.0%).

Aspects of Work Causing Stress

The aspects of general practice work that generated a "high" stress level were:
Requests for forms/paperwork (64%) followed by unrealistic expectations by patients (55%), and after hours on-calls and unsociable hours (41%). However over 70% of GPs rated 9 aspects as causing a "medium to high" amount of stress. These are listed in Table 6.5. Communication with patients seemed to cause the least stress.

*Table 6.5: % of GPs' reporting aspects of General Practice generating **medium to high stress:***

Aspect of Practice	%
Requests for forms/paperwork	95.4
Unrealistic expectations by patients	86.3
Unsociable hours	81.8
Undervalued by patients	81.8
After hours on-call	77.3
Hospital calls	77.2
Government Regulations	77.2
Unrealistic expectations by Community Agencies	72.8
Financial Management	72.7
Remuneration of GPs	68.2
Demands of CME	59.1
Non-compliance in patients	59.0
Communication with patients	45.5

By comparison, the three aspects of practice that generated the highest stress levels for metropolitan GPs were: Government regulations, remuneration of GPs and requests for forms. Therefore it seems that the lower job satisfaction experienced by rural GPs could be caused by the unrealistic expectations by patients and the after hours on-calls and unsociable hours, which were 13 hours per week for full-time local GPs.

Future Requirements in General Practice

Respondents were asked to state which services they will be required to deliver more or less of, in the next 5 years. Table 6.6c gives a detailed description of the services, while summary information is provided in Tables 6.6a and 6.6b.

*Table 6.6a: The services the GPs felt they would be required to deliver "**less**" of were:*

	%
Anaesthetics	86.4
Inpatient Service	72.7
Antenatal Care & Obstetrics/Delivery	50.0

*Table 6.6b: Over 70% of the GPs felt they would be required to deliver "**more**" of these services:*

	%
Health Screening	95.2
Nursing Homes visits	90.9
Preventative Medicine	86.4
Counselling	86.4
Aged Care	81.8
Palliative Care	81.8
Health Education	72.7

Table 6.6c *The services GPs might be required to deliver more or less of in the next 5 years (percent of GPs)*

	MORE	LESS	MISSING
Inpatient service	18.2	72.7	9.1
Restorative care	50.0	36.4	13.6
Antenatal care	36.4	50.0	13.6
Obstetrics/Delivery	40.9	50.0	9.1
Nursing Homes visits	90.9	4.5	4.5
Health education	72.7	22.7	4.5
Health screening	95.2	4.8	-
Anaesthetics	4.5	86.4	-
Palliative care	81.8	9.1	9.1
Counselling	86.4	4.5	9.1
Teaching (Junior Doctors)	68.2	22.7	9.1
Aged care	81.8	9.1	9.1
Preventative medicine/Primary health care	86.4	4.5	9.1

Rural and metropolitan GPs agreed closely on the future direction of general practice in terms of the services they will be doing more or less of, in the next 5 years.

6.3 Continuing Medical Education Needs (CME)

GPs were asked to rate their priority for CME, on a 3-point rating scale, on a variety of topics which will improve the quality of care of their patients.
These topics fell under 4 domains:

- Technical Medical Care
- Preventive Medical Care
- Doctor/patient Interaction
- Practice Management

Technical Medical Care

Over a third of GPs have rated the following topics as a **high** priority for CME.

First	Musculoskeletal & connective tissue disorders	54.5%
Second	Dermatological disorders	45.5%
	Female genito-urinary disorders	45.5%
	Palliative Care	45.5%
Third	Cardiovascular disorders	36.4%
	Obstetrics	36.4%
	Pain Management	36.4%

However, over 70% of GPs rated the following 16 out of 38 CME topics as having a medium to high priority.

*Table 6.7: The GPs' **medium to high** priority for further training/education in the areas of Technical Medical Care.*

Technical Medical Care	**% of GPs**
Orthopaedics	86.4
Cardiovascular disorders	86.4
Dermatological disorders	86.4
Musculoskeletal and connective tissue disorders	86.3
Neurological disorders	86.3
Pain Management	81.9
Palliative Care	81.9
Ophthamological Disorders	81.8
Psychiatric disorders	81.8
Pulmonary disorders	81.8
Sexual dysfunction	81.8
Sports medicine	81.8
Female genito-urinary disorders	77.3
Infectious Diseases	77.3
ENT disorders	77.3
Rheumatology	71.7

Preventive Medical Care

The topics that ranked **highest** in this domain were:

First	Alcohol use and its related problems	36.5%
Second	Harm associated with drugs	31.8%
Third	The well being of women during & after menopause Asthma Dietary and nutritional advice	27.3% 27.3% 27.3%

However, over 70% of GPs rated the following 9 out of 21 CME topics as having a medium to high priority.

*Table 6.8: The GPs' **medium to high** priority for further training/education in the areas of Preventive Medical care.*

Preventive Medical Care	**% of GPs**
Diet & Nutritional Advice	90.9
Harm associated with Other Drugs	86.3
Medical Travel Advice	86.3
Alcohol use & its related problems	81.9
The Wellbeing of Women during & after Menopause	81.8
Screening & Treatment of Skin Cancer	77.3
Menstrual Problems	77.3
Physical Activity/Exercise Advice	72.7
Occupational Safety	72.7

Doctor/Patient Interaction

The topics that ranked **highest** in this domain were:

First	Recognising and dealing with adolescent mental health problems	63.6%
Second	Recognising and dealing with childhood behaviour problems Recognising and dealing with child abuse	50% 50%
Third	Dealing with substance abuse	45.5%
Fourth	Recognising and treating psychological problems	40.9%

However, over 70% of GPs rated the following 14 out of 19 doctor/patient interpersonal aspects as having a medium to high priority (Table 6.9).

*Table 6.9: The GPs' **medium to high** priority for further training/education in the areas of Patient/Doctor Interaction.*

Patient/Doctor Interaction	**% of GPs**
Recognising & Dealing with Childhood Behaviour Problems	100.0
Administering Palliative Care	95.5
Recognising & Dealing with Adolescent Mental Health Problems	90.9
Providing support for Terminally Ill Patients	90.9
Recognising & Dealing with Child Abuse	90.9
Implementing Strategies to Increase Patient Compliance	86.8
Recognising & Treating Psychological Problems	86.4
Dealing with Patients with Stress Related Problems	86.3
Dealing with Substance Abuse	81.9
Treating patients who are Frail - Aged	81.8
Recognising & Dealing with Domestic Violence	81.8
Preparing Patients for Potentially Threatening News	81.8
Provide Supporting Counselling	81.8
Increasing Patients' Knowledge & Control of Sexual/Reproductive Issues	72.7

Practice Management

The topics regarded by the GPs as having a **high** priority for improving the quality of care of their patients were:

First	Efficient storage of and rapid access to information	54.5%
Second	Patient recall systems	50.0%
Third	Staff selection, training and management	45.5%

However, other issues were rated as having a medium to high priority by over 70% of GPs (Table 6.10).

*Table 6.10: The GPs' **medium to high** priority for further training/education in the areas of Practice Management.*

Practice Management	**% of GPs**
Patient Recall Systems	87.3
Efficient Storage of & Rapid Access to Information	86.3
Improved Medical Audit	77.3
Time Management	74.5
Staff Selection, Training & Management	72.8
Budget Setting & Control, including Billing Procedures	72.7

6.4 Knowledge and Use of Community/Self-help Groups (Support Services)

The respondents were asked to indicate which support services they know of in the area they service and which of them they have ever used from a list of 17 names (Table 6.11). Seven support services were ever used by over a half of the GPs, which means that 38% of the commonly listed support services were ever used by the majority of GPs.

	% ever used
Centacare	95.5
Drug & Alcohol Authority	90.9
Diabetic Clinic/Association	90.9
Domestic Violence Centre	77.3
Asthma Resource Centre	68.2
Suicide Intervention Counsellor	68.2
HACC Services (Home & Community Care)	57.1

Two other support services that GPs know of but have not used to the same extent as the above list, were:

- Heart Foundation (68.2%)
- Women's Health & Information Centre (54.3%)

However, there are some support services that over 45% of GPs did not know of:

- Migrant Resource Group (63.6%)
- Mental health support group (59.1%)
- Youth Accommodation project (57.2%)
- Attention Deficit Disorder (50.0%)
- Relationships Australia (45.5%)

Table 6.11: The support services the GPs know of but never used, have ever used, or don't know of (percent of GPs)

	%	%	%
Support Services	**Know of**	**Ever used**	**Not known**
Centacare	-	95.5	4.5
Asthma Resource Centre	22.7	68.2	9.1
Heart Foundation	68.2	18.2	13.6
Domestic violence	18.2	77.3	4.5
Suicide Intervention Counsellor	22.7	68.2	9.1
Attention Deficit Disorder Group	45.5	4.5	50.0
Relationships Australia	13.6	40.9	45.5
Drug and Alcohol Authority	4.5	90.9	4.6
Diabetic Clinic/Association	4.5	90.9	4.6
Migrant Resource Group	27.3	9.1	63.6
Mental health support group	27.3	13.6	59.1
HACC Services (Home & Community Care)	38.1	57.1	4.8
Aboriginal Health Worker	40.9	40.9	18.2
Youth Accommodation Project	33.3	9.5	57.2
Living Skills Centre	42.9	14.3	42.8
Women's Health & Information Centre	54.5	27.3	18.2
Day Centre for disabled people	42.9	42.9	14.2

Some of the additional disease support groups specified by a few GPs included (1 group per GP):

SIDS (Sudden Infant Death Syndrome)	Arthritis
Al Anon	Silver Chain
Palliative Care	Nursing Mothers' Association
Eating Disorders	Cancer Foundation
Alzheimers	GP Family Therapy Program
Pain Management Centre	Post Natal Depression
SANDS (Stillborn & Neonatal Death)	Crohns
Multiple Sclerosis	Huntingtons

The support services most referred to in the past 12 months were:

- Diabetic Clinic/Association (28.6%)
- Centacare (18.6%)
- Suicide Intervention Counsellor (14.3%)
- Domestic Violence (8.6%)

These results support findings in the consultation phase (Chapter 5) that GPs are under-utilising these support groups, either because they don't know that they exist, or because they are reluctant to refer (low proportions of GPs have used four support groups in the past year).

6.5 Satisfaction with Service Delivery/Availability

GP respondents were asked to state whether they were satisfied or dissatisfied with the service delivery/availability of 3 categories of health service providers in the public and private sectors.

- Medical/Surgical specialists 19
- Allied Health services 13
- Other Health Service providers 13

Medical/Surgical Specialists

Table 6.12 highlights the top ranking medical/surgical specialists in terms of service delivery, ie. those with the highest satisfaction level according to the GPs, as well as the lowest ranking specialists ie. those with the highest dissatisfaction level, for both the public and the private sectors.

Table 6.12: Service delivery/availability of Medical/Surgical Specialists

Highest Satisfaction				Highest Dissatisfaction			
Public		Private		Public		Private	
%		%		%		%	
Radiologist	100	Pathologist	100	Orthopaedic Surgeon	77	Dermatologist	55
Pathologist	96	Ophthalmologist	100	Dermatologist	55	Orthopaedic Surgeon	46
Anaesthetist	95	General Surgeon	100	Urologist	50		
Obstetrician	91	Obstetrician	96	ENT Surgeon	50		
Ophthalmologist	91	Paediatrician	96				
General Surgeon	91	Cardiologist	96				
Paediatrician	86	Radiologist	91				
Cardiologist	82	ENT Surgeon	86				
		Anaesthetist	82				
		Psychiatrist	82				
		Urologist	82				

Orthopaedic surgery and dermatology have scored the lowest satisfaction levels in terms of availability for both the public and private sectors. Urology and ENT surgery scored low for the public sector only. All the other medical/surgical specialists scored high satisfaction rates, with little difference between public and private, except for psychiatry services which were more satisfactory for the private sector (82% vs 59%)

Allied Health Services

Table 6.13 highlights the Allied Health Services delivery with the highest satisfaction and dissatisfaction levels, as rated by the GPs for the public and private sectors.

Table 6.13: Service delivery/availability of Allied Health Services

Highest Satisfaction				Highest Dissatisfaction			
Public		Private		Public		Private	
%		%		%		%	
Pathology Service	91	Pharmacy	100	Physiotherapy	59	Dietitian	46
Community Nurse	82	Physiotherapy	100	Clinical Psychology	55	Social Work Services	32
Pharmacy	77	Pathology	96	Podiatry	41		
Speech Pathology	73	Counselling service	86	Counselling service	36		
		Podiatry	82	Dietitian	32		
		Clinical Psychology	82				
		Optometry	82				

There were some significant differences between the levels of satisfaction with private and public sector allied health professionals:

	Public	Private
	%	%
Physiotherapy	40.9	100.0
Podiatry	36.4	81.8
Clinical psychology	22.7	81.8
Counselling service	54.5	86.4
Pharmacy	77.3	100.0
Speech pathology	72.7	45.5
Social work	63.6	50.0
Dietitian	59.1	36.4

More respondents rated the private sector professionals' service delivery higher than that of the public sector professionals except for speech pathology, social work and dietitian.

Other Health Services

Table 6.14 highlights the satisfaction and dissatisfaction level of GPs with 13 other health services.

Table 6.14: Service delivery/availability of other health services

Highest Satisfaction		Highest Dissatisfaction	
	%		%
Public Hospital	86-96	Child & Adolescent Psychiatry	68
Private Hospital	77 - 91	Men's Health	67
Palliative Care	91	Drug & Alcohol services	64
Silver Chain	91	Rehabilitation - public	55
Aged Care Support	86	Developmental Disability	46
Women's Health	76		
Rehabilitation - private	73		

Local services related to child and adolescent psychiatry, men's health, drug and alcohol and developmental disability have scored low satisfaction levels in terms of service delivery in general.

There were some significant differences between the levels of satisfaction with private and public sector other health services such as:

	Public	Private
	%	%
Rehabilitation services	36.4	72.7
Hospital Accident and Emergency	95.5	77.3

Only 45% to 50% of GPs were satisfied with the service delivery of Aboriginal services and family planning services. However 32% of GPs did not respond to this question as they probably have not used them to comment.

6.6 Satisfaction with Interprofessional Communication

GP respondents stated whether they were satisfied or dissatisfied with the interprofessional communication with 3 categories of health service providers in the public and private sectors:

- Medical/Surgical specialists
- Allied Health services
- Other Health services

Table 6.15: Interprofessional Communication with Medical/Surgical Specialists

Highest Satisfaction	Highest Dissatisfaction			
Public and Private (85 - 100%)	Public	%	Private	%
Pathologist	Orthopaedic surgeon	36	Anaesthetist	23
Paediatrician	Anaesthetist	23		
Obstetrician	Dermatologist	23		
Ophthalmologist	Endocrinologist	23		
ENT Surgeon				
Radiologist				
General Surgeon				

The two services (orthopaedics and dermatology) that had high dissatisfaction levels in terms of availability, were also in this category in terms of interprofessional communication. Also 23% of GPs had a communication difficulty with the Anaesthetist, in both the public and private sectors, although the availability of anaesthetics was highly satisfactory.

Table 6.16: Interprofessional Communication with Allied Health Professionals

Highest Satisfaction	Highest Dissatisfaction			
Public and Private (90 - 100%)	Public	%	Private	%
Physiotherapy	Counselling services	46	Counselling services	46
Pharmacy	Clinical Psychology	41	Chiropractor	46
Pathology	Dietitian	32	Dietitian	41
	Podiatry	32	Podiatry	36

GPs were dissatisfied, in the private and public sectors equally, with the communication with allied health professionals in the counselling services, podiatry services and dietitian. Also the public clinical psychology services and the private chiropractor services scored low on interprofessional communication.

Table 6.17: Interprofessional Communication with the other Health Service Providers

Highest Satisfaction		Highest Dissatisfaction	
	%		%
Silver Chain	91	Child & Adolescent Psychiatry	59
Private Hospital	86-91	Men's Health	59
Public Hospital	77-91	Drug & Alcohol Services	50
Palliative Care	86	Developmental Disability	41-46
Aged Care Support	77	Rehabilitation - public	36
		Aboriginal Services	32

The dissatisfaction with communication is related to the same health services that scored low on availability and service delivery, that is child and adolescent psychiatry, men's health, drug and alcohol services, developmental disability, public rehabilitation and Aboriginal services.

6.7 Perceived Gaps and Deficiencies in the Service to the Local Community

Gaps in speciality areas in patient care

GPs were asked to identify priority areas in patient care which are perceived as gaps or deficiencies in the service to the local community. 25% to 44% of GPs did not respond to questions relating to the community.

Table 6.18: Gaps in Technical Medical Care

	%
Orthopaedics	29.6
Dermatology	14.8
Psychiatry	14.8
Sports Medicine	7.4
Sexual Dysfunction	7.4

Table 6.19: Gaps in Preventive Medical Care

	%
Harm associated with Drugs other than Alcohol	14.9
Alcohol use & its related problems	12.8
Diet & Nutritional advice	10.6
Occupational Safety	8.5
Preventing Injuries	8.5
Immunisation	8.5

Table 6.20: Gaps in Doctor/Patient Interaction

	%
Recognising and dealing with Adolescent Mental Health Problems	19.5
Recognising & dealing with Childhood Behaviour Problems	14.6
Dealing with Substance Abuse	12.2
Recognising & dealing with Child Abuse	9.8

Table 6.21: Gaps in Practice Management

	%
Patient Recall Systems	23.8
Time Management	19.0
Efficient Storage of & rapid access to information	16.7
Staff Selection, Training & Management	11.9

Gaps in service delivery and communication

GPs were also asked to state priority problems in service delivery and communication, which are perceived as barriers to improving the health of the community. A significant 44% of GPs did not respond to this question. For those who responded, the problems are listed by priority order in table 6.22.

Table 6.22: Gaps in Service Delivery & Communication

Service Delivery	Communication
Orthopaedic Surgery (Public & Private)	Aboriginal Services
Drug & Alcohol Support Services	Orthopaedics
Psychiatry (Public)	Psychiatry
Urology (Public & Private)	Dermatology
Physiotherapy (Public)	Counselling Services
Aboriginal Services	Disability Services
ENT Surgery	Drug & Alcohol Support Services
Dermatology	Men's Health
Diet/Nutrition	
Aged Care Support	
Disability Services	
Men's Health	

6.8 Summary and Conclusion

84% of GPs in the Division participated in the GP survey. Female GPs represented a quarter of total GPs, the mean age for the whole group was 49.6 years and the mean number of years in general practice was 18.6 years. A third have graduated overseas, and two thirds had additional medical and post-graduate qualifications (other than MBBS), mainly in obstetrics and gynaecology. Local rural doctors worked just over eleven extra hours per week compared to the median national figures (69.0 hours vs 57.5 hours). The stress level experienced by local rural GPs was similar to that of metropolitan GPs, but their job satisfaction was lower (45.5% vs 60.0%). According to the "National Satisfaction Survey of GPs", 35.3% of GPs would leave general practice immediately if they thought there was somewhere else they could go (cited in Hughes et al, 1996). Aspects of work causing most stress for local GPs were requests for forms/paperwork, unrealistic expectations by patients and after hours on-calls and unsociable hours which are up to 13 hours per week. The patients satisfaction survey (Chapter 4) and the community consultation (Chapter 5) phases have highlighted the difficulties of access to GPs in this area, which have a direct relation to the shortage of doctors locally. About 11 GPs more are needed to service this area.

In the next 5 years, GPs feel they would be required to deliver less of anaesthetics, inpatient service and antenatal care and obstetrics/delivery (a field where most GPs have already acquired post-graduate qualifications). The services that GPs feel they will deliver more of in the next 5 years related to health screening, aged care and nursing home visits, preventive medicine, counselling, palliative care and health education. The Division training programmes should target the upskilling of GPs in such fields of growing need for GPs' expertise.

The list of topics for continuing medical education (CME) needs is extensive and is divided into four domains: the technical medical care, preventive medical care, doctor/patient interaction and practice management. This list forms the basis for programmes in CME.

The knowledge and use of community/self-help groups by the GPs support findings in the consultation phase that GPs are under-utilising them, either because they don't know that they exist or because they are reluctant to refer patients for more information and seek such cooperative assistance in the management of their patients. The Division can promote the presence and functions of these support services to GPs through the GP newsletter, by highlighting a few services in each issue.

GPs are mostly very satisfied with the service delivery/availability of and interprofessional communication with the majority of medical/surgical specialists, allied health services and others. However there is a need for improvement in the following services, and particularly in the public sector.

Highest Dissatisfaction in Service Delivery

Med/Surg Specialist		Allied Health		Other Health Services
Public	**Private**	**Public**	**Private**	
• Orthopaedics • Dermatology • Urology • ENT Surgery	• Dermatology • Orthopaedics	• Physiotherapy • Clinical Psychology • Podiatry • Counselling • Dietitian	• Dietitian • Social Work	• Child and Adolescent Psychiatry • Men's health • Drug/Alcohol Support • Rehabilitation (public) • Developmental disability

Highest Dissatisfaction in Interprofessional Communication

Med/Surg Specialist		Allied Health		Other Health Services
Public	**Private**	**Public**	**Private**	
•Orthopaedics •Anaesthetics •Dermatology •Endocrinology	• Anaesthetics	• Counselling • Clinical Psychology • Dietitian • Podiatry	• Counselling • Chiropractor • Dietitian • Podiatry	• Child and Adolescent Psychiatry • Men's health • Drug/Alcohol Support • Developmental disability • Rehabilitation (public) • Aboriginal services

GPs identified what they perceive as gaps in the service to the local community. It is interesting to note that results from gaps in medical specialties, in service delivery and interprofessional communication have highlighted areas of concordance about definite perceived needs by the GPs. For instance drug and alcohol abuse problems have featured as a need for further education of GPs, a gap in doctor/patient interaction and a gap in service delivery and communication. Similarly mental health issues, counselling services, psychiatry, Aboriginal health and men's health, orthopaedics, dermatology and ENT surgery have featured strongly. Practice management gaps that can be improved to the benefit of the community are patient recall systems, time management, efficient storage of and rapid access to information, staff selection, training and management.

The next chapter puts together overlapping issues from the GP survey, the consultation phase and the patient satisfaction survey in order to focus on the priority issues.

7. COMMON NEEDS FOR CONSUMERS AND PROVIDERS

This chapter identifies the common needs raised in the patient survey (Chapter 4), consultation phase (Chapter 5) and GP survey (Chapter 6).

Table 7.1 highlights the health care needs that have overlapped or recurred, according to the following criteria, for both GPs and the community from the GP survey.

1. GPs' CME needs
2. GPs' dissatisfaction with service delivery
3. GPs' dissatisfaction with interprofessional communication
4. Perceived gaps in patient care
5. Service delivery barriers to improving the health of the community
6. Interprofessional communication barriers to improving the health of the community

Table 7.1: The identified health care needs by the GPs and those perceived for the community, from the GP Survey

	GP			COMMUNITY		
	1	2	3	4	5	6
Health care needs	**CME needs**	**Dissatis-faction with service delivery**	**Dissatis-faction with Commun-ication**	**Gap in patient care**	**Barriers in service delivery**	**Barriers in commun-ication**
Orthopaedics	**	**	**	**	**	**
Dermatology	**	**	**	**	-	**
Psychiatry (Public)	**	*	-	**	**	**
ENT (Public)	**	**	-	*	**	*
Urology	**	**	-	-	**	-
Physiotherapy (Public)	n/a	**	-	-	**	-
Diet/Nutrition	**	**	**	**	*	-
Podiatry	n/a	**	**	-	-	-
Counselling	**	**	**	-	**	**
Mental health of children/adolescents	**	**	**	**	*	**
Drug & alcohol abuse	**	**	**	**	**	**
Aboriginal care	*	*	**	-	**	**
Rehabilitation (Public)	n/a	**	**	-	*	*
Disability	*	**	**	-	*	**
Men's Health	n/a	**	**	-	*	*

** *means high needs* * *means moderate needs* *n/a means not applicable*

Specialist services

The service delivery issues lacking in the local community in terms of specialist services are orthopaedics, dermatology, ENT, physiotherapy, podiatry, dietitian, psychiatry, urology (Chapter 6). These issues relate to the recruitment and retention of the health workforce in rural areas, and the Division could lobby the Health Department of WA for better provision of these services. Similarly, rehabilitation and disability services are partly related to resourcing issues in the area.

GP related services

Counselling and other mental health support services have been identified as gaps in the local community. However these are issues that are related partly to better resourcing and partly to further education and training of GPs. In fact over 80% of GPs have identified their priorities for further education/training in alcohol and drug abuse and their related problems, recognising and dealing with childhood behavioural problems, adolescent mental health problems, child abuse and domestic violence, and providing supportive counselling (Chapter 6). Issues relating to disability would improve with better liaison between the GPs and the disability specialists.

Access to general practice

In their survey, GPs have recognised the need to improve staff selection, training and management, efficient storage of and rapid access to information and patient recall systems to address some of the difficulties of access to general practice. Most of all, there is a pressing need to recruit more GPs which is highlighted in Chapter 4.

Difficulties of accessing GPs have been reported in the patient satisfaction survey and the consultation phase: the waiting time to make an appointment, the waiting time at the surgery, not seeing the doctor of choice, the receptionist creating further barriers. Although the amount of time the doctor spends with patients was highly satisfactory in the patient satisfaction surveys (Chapter 4), this has been pinpointed as a problem for special groups such as the Aboriginal people, the elderly, cases of domestic violence and patients with multiple chronic illnesses and medications, in the consultation phase (Chapter 5). This is one of the limitations of patient satisfaction surveys referred to in Chapter 4, where issues of concern for groups with special needs are not highlighted.

Therefore the priority issues, common to previous chapters, will be discussed in terms of population groups with special needs.

- Aboriginal Health
  Aboriginal health is a major common concern for GPs and the community, although a lot of social problems are intermingled with health.

- Aged Care
  Discharge planning and coordination of services in this field have been long-term concerns for the GPs and other service providers, the elderly community and their carers. Such problems will be further exacerbated by the doubling of the 70+ population in some areas of the Division over the next decade (Chapter 2).

- Men's Health
  Men's health was a concern for GPs and the community in terms of physical and mental health and is further supported by data from the WA Health Survey in Chapter 3.

- Women's Health
  Women's health was not identified as a concern in the GP survey, however there are a few gaps concerning consumers, and it is an issue on the Division's agenda and its strategic plan.

- Youth Health
  Mental health, substance abuse and access to health services were the main concerns under youth health, expressed by GPs and the community.

The next chapter addresses these priority issues through focus groups in an attempt to find solutions that can be taken on by the Division as future projects.

8. FOCUS GROUPS

8.1 Aged Care

- Discharge planning/community liaison
- Medication management
- Community aged care packages
- Palliative care
- Access to information
- Transport

Aged care priorities

8.2 Youth health

- Access to medical care and other services
- Substance use (including ADD medication)
- Family breakdown, stress, depression

Youth health priorities

8.3 Women's Health

- Isolation
- Access to GPs
- Fertility and menopause
- Domestic violence
- Eating disorders

Women's health priorities

8.4 Men's health

- Prostate cancer
- Access to GPs and other services
- Mental health, drug and alcohol abuse
- Lifestyle issues

Men's health priorities

8.5 Aboriginal health

- Access to GPs and other services
- Women, children and the aged
- Mental health/alcohol and drugs/prisoners' health
- Employment/training/housing

Aboriginal health /social priorities

8. FOCUS GROUPS

In the previous phases of this needs analysis (GP survey and community consultation), GPs, other service providers and consumer representatives gave their opinion on a variety of health and service delivery issues. This phase, using the focus groups, concentrates on the common priority issues highlighted in the previous phases.

Focus groups techniques are now a well established component of Community Health research (Planning Healthy Communities, 1996). This particular methodology allows for a free exchange of ideas, feelings, needs, wants, experiences, knowledge and attitudes, beyond which the individual, in an interview setting, may be willing to participate. Other advantages include time and cost efficiency, a way of maximising sample size and minimising individual bias and a process potentially refreshing for both participants and the facilitator/researcher.

Focus group techniques also have several advantages over survey methods of data collection (Planning Healthy Communities, 1996). The researcher is able to ensure that consumer input reflects the specific demographics of an area (age groupings, ethnicity, special health characteristics etc) and specific topics can be investigated in more depth, with any apparent contradictions in data clarified. Data collection can be adapted to informal settings to allow for the input of those who would not normally contribute to surveys (for example, illiterate and disenfranchised members of the community) and consumers have an opportunity to raise and explore issues which may not be known to, or which may not be important to researchers in the survey format.

The priority needs fell into five groups, with issues sometimes common to all groups.

- Aged Care
  Particularly discharge planning, medication management, community aged care packages, access to information, palliative care, transport, community liaison.

- Youth Health
  Access to general practice, mental health, substance abuse, access to information, Attention Deficit disorders.

- Women's Health
  Isolation, minority groups, access to general practice, fertility and menopause issues, domestic violence, eating disorders.

- Men's Health
  Prostate cancer, access to general practice and other services, mental health, alcohol abuse, access to information.

- Aboriginal Health
  Access to the medical service, prisoner's health, mental health, alcohol and drug abuse, employment, training and housing.

All GPs were invited to indicate which of the five focus groups they were interested to attend. Two GPs indicated an interest to participate in each focus group. The rest of the participants were other health professionals, service providers, advocates and /or consumers. The size of each focus group varied between 10 and 20 participants. Each group had a good representation from the main areas of the Division. Recruited participants had characteristics which matched those of the specified target population for each focus group. Two of the focus groups (aged care and youth health) required two sessions each to cover the content. The following list of participants does not include those who apologised from attending shortly before the meeting.

Aged Care (Friday 8 August 1997 and Tuesday 7 October 1997)

Participants: 2 GPs, 1 pharmacist and representatives from the Regional Centre Hospital (admission and discharge), Regional Centre Council, Silver Chain Association (Diabetes service), Community Home Care, Aged Care Assessment team, Community Aged Care Packages, Hospital extended care (smaller town), Arthritis Foundation, Asthma Foundation and five senior citizens as consumers.

Youth Health (Thursday 14 August 1997 and Tuesday 9 September 1997)

Participants: 2 GPs, 3 consumers (high schools and university students) and representatives from Youth Accommodation Project, Agencies for South West Accommodation, Lunch Centre for homeless, Department of Social Security, WorkReady - Youth Outreach Programme, Mental Health regional team, Police, Centacare, Teenage Support group for pregnant teens, Community Development worker from a smaller town and WA Alcohol and Drug Authority.

Women's Health (Friday 22 August 1997)

Participants: 2 GPs and representatives from the Centre for domestic violence, Community health (post-natal depression), Women's Health and Information Centre, Nursing Mother's Association, Stillbirth and Neonatal Death Support Group, Tuesday Club, Migrant Resource Group, Community house.

Men's Health (Thursday 28 August 1997)

Participants: 1 GP and representatives from Relationships Australia, Accommodation Service, Lunch Centre for homeless, Cancer Foundation, Heart Foundation, Asthma Foundation, the Anglican Parish, Regional Centre Hospital, Rotary Club, Lions Club and three other male consumers from the Regional Centre and outlying areas.

Aboriginal Health (Friday 5 September 1997)

Participants: 2 GPs, the Division's Community Liaison Officer and representatives from Aboriginal Medical Service, the Regional College of TAFE, Aboriginal Corporation, Centacare, Prison, Community Health, Silver Chain, Asthma Foundation, Heart Foundation, Community Aged Care Packages, Skilled Directions (training agency).

The findings are presented in terms of strengths that offer promising starting points which can be built on, needs, in the form of ideas for further work, and priorities as classified by the participants from the list of needs.

8.1 Aged Care

Discharge planning/community liaison

Strengths:

- A new admission form is being trialed in Regional Centre Hospital; the number of extensive forms to be completed was causing anxiety and confusion for patients;
- An outlying town has a smaller hospital facility, a more streamlined process and community support; parts of the process could be replicated in the Regional Centre;
- Silver Chain is promoting a one - stop information shop for its own and other aged care services and has employed a hospital liaison officer for their clients.
- The Aged Care Assessment team (ACAT) provides centralised assessment of all potential nursing home and hostel patients. The team has a good working knowledge of all the 'players' in the admission/discharge process and would be a necessary participant in any review of discharge procedures.

Needs:

- Recognition that discharge planning starts **before** admission and must consider the wholistic need of the patient (ie, community service needs before admission and after discharge);
- Better communication between the patient, hospital, GP and community services would be provided by a liaison form to notify all those involved which seniors patients are currently accessing what community services. The form could originate from the GP, community agencies or the hospital and be placed at the front of the patient's hospital file, and be updated as necessary by discharge staff in consultation with the GP;

- Surgical and medical patients have different needs which must be considered on admission. For example, the length of stay in hospital, after care needs, the possibility of having to access new services;
- A 'systems analysis' approach was suggested whereby all 'players' in the discharge planning process 'map' their roles and processes. When put together, these flow charts should allow for a review of where the system is working well and where weak points exist.

Medication Management

Strengths:

- The Regional Centre Hospital Pharmacy has provided a home visit service to selected patients (there is confusion over the use of different brand/generic names for the same medication, the use of medication which has expired etc);
- Church of Christ in an outlying area is investigating several options for medication dispensing packs which are more 'user friendly' than the Webster pack;
- GPs can prescribe directly to a community Pharmacy (after the hospital prescription Webster Pack has expired), so elderly patients need never handle prescriptions, reducing the potential for confusion;
- One town in the Region has a system, whereby a single, A4 size medication chart is given to the patient, for use by the community Pharmacy and hospital, being updated as required.

Needs:

- The Discharge planning process must consider medication management needs;
- The type of dispenser needs review (Webster pack can be difficult to open);
- A single medication chart for use by the GP, hospital (including Pharmacy) and Community Pharmacy is recommended. The chart needs to be A4 size, large print, easy to read and able to be followed by elderly patients;
- Ongoing patient education with medication is necessary at community and mass media levels (TV may be a good, but expensive avenue);
- Broader community education (such as via nursing homes, senior citizens' centres etc) with conditions such as asthma and arthritis.

Community Aged Care Packages

Strengths:

- 22 packages are available in the wider Regional area providing 7 days/week, 24 hours/day service; 21 packages are available in the Regional Centre;
- The Aged Care Packages service provider visits the two hospitals in the Regional Centre daily and maintains contact with ward and admissions staff;
- The Community Home Care coordinator receives referrals from GPs, ACAT, friends, family, hospitals, but has no need to visit the hospitals unless looking for a 'lost' client;
- The Aged Care Packages service provider has been invited to hold an information session with the Regional Centre's Hospital staff to inform them about the packages and other relevant community services and resources.

Needs:

- Lobbying of the Commonwealth Government for more packages for the Regional area. The current system provides only for Packages to be available to areas on a rotating basis. The waiting list for the availability of Packages is very long and the urgency of a local need is not considered by the funding body.

Palliative care

Needs:

- An increase in home - care services for country people. A limited service, covering the greater Regional area (as serviced by Silver Chain) is provided. Some outlying towns have no specific service. One town's extended care sister liaises with the Palliative Care service in the Regional Centre for advice and resources only. A patient in need in an outlying area would wait for the Regional Centre's home care services to be available or move closer to the Regional Centre.
- Lobbying for more funds for increased services. Palliative care services are currently funded by the Commonwealth Government, through the Medicare Incentive programme and the Palliative Care Project (six year funding due to finish at the end of 1997), to the State Government via the Health Department of WA (HDWA), who in turn, allocates on a needs basis.

Access to information

Strengths:

- The Regional Centre's Council is completing a Directory of Aged Care Services which resulted from community consultation about the lack of information in this field.

Needs:

- The well aged need access to service information, including Nursing Homes (as in the Directory, above);
- Older people need to be encouraged to apply for a Seniors' Card as soon as they are eligible, so they can access information from the Seniors' Interests mailing lists;
- GPs be encouraged to invite questions from elderly patients, who may be afraid to ask, seek clarification re medication etc;
- GPs to be kept informed (through Division's consumer liaison group or electronic database) of the quality and types of community services available.

Transport

Needs:

- A high need exists for access to transport services for those travelling to Perth and other towns for treatment; (Patient Assisted Travel Scheme, PATS, eligibility criteria is stringent, and taxi subsidies are difficult to access);
- Improved communication is needed between service providers, especially of home support services, and consumers to make it clearer who is eligible and what services are available.

Aged care priorities

- The need to coordinate a planned approach between service providers and consumers, including what services are needed, those already utilised, and gaps in service provision. A one - stop - shop to house all services related to aged care in one location would facilitate the coordination of services and act as a source of information in this field for providers and consumers.

- Education for GPs and hospital staff re what community services are available for discharged patients, and how to better access and utilise these services. A forum should be set up where GPs are informed by those working in the field about Aged Care Packages and other services available in the area. This would allow an opportunity to emphasise to GPs the need for early estimates of discharge times and dates to allow for necessary services to be coordinated and accessed.

- The creation of a standard form (A4 size, large print) for patient medication, which is supplied by the GP, carried by the patient and presented to hospital or community service as needed. It can be updated by the GP as required and reduces the problems associated with 'doctor - shopping'.

- A liaison form to inform all hospital staff and the GPs of the community services used by patients and to provide a medium to prepare and plan discharge of patients. The form will have a list of all community services and is included in the patient's file upon admission (a proforma has been designed in this focus group).

- A review whereby all 'players' in the discharge planning process map their roles and processes, how all their functions fit together, to assess the strengths and weaknesses in the system, and reduce gaps or duplication.

- A Directory of Aged Care Services and other Senior Citizen's information should be made available to GPs, service providers, consumers and those well - aged who are not yet using services.

8.2 Youth Health

Access to Medical Care and other Services

Strengths:

- The Night Clinic at one surgery is less formal than day clinics and preferred by young people as it provides a walk - in basis instead of formal appointments;
- The Lunch Centre for homeless and others on low incomes provides an informal, 'safe' environment for young people to seek help;
- Good communication and cooperation exists between the Dept. of Social Security (DSS, income support, entitlements etc) and local accommodation services;
- Having a Medicare card can offer young people independence and privacy when accessing a GP.

Needs:

- Bulk billing would help encourage youth to access more GP services;
- More information (school - based, Yr 9) about accessing a Medicare card;
- A 'one stop information shop' where young people can access all information eg health, accommodation, DSS entitlements etc;
- Extend the current DSS - accommodation services network and active communication to include GPs, to ensure adequate, two - way and ongoing provision of wholistic health care needs;
- A large forum of GPs, young consumers and representatives from the Regional Centre's Youth Advisory Council be organised to further debate and update these needs.

Substance use (including ADD medication)

Strengths:

- Trained volunteer drug and alcohol counsellors live and work throughout the region. Their existence and expertise needs to be more widely publicised;
- Existing youth outreach and mentor services (as provided by Workready) provide a valuable resource for disenfranchised youth, and are accessed directly by young people, and via schools, police, DSS, Department of Juvenile Justice etc;
- A number of community agencies within the Region have within their brief the capacity to participate in alcohol and drug rehabilitation programmes.The diversity offered by these agencies strengthens the opportunities for a possible range of rehabilitation options.

Needs:

- Alcohol and drug rehabilitation services need to be linked with existing community support services. There is not a high success rate for those treated in Perth. Local people (16 - 21 years) have no services catering for their needs, and it is not beneficial to mix them with the older generation for detoxification and rehabilitation;
- More resources, education and people to deliver drug education in a 'real life' way, (not "value laden moralising"). These people could be identified by young people in the Forum, as recommended under "access";
- More alcohol & (non - prescription) drug education for GPs, who, with accurate information, can have a valuable role in early intervention;
- A wider resource base is needed for GPs to refer to when they have identified alcohol and drug issues. GPs need to be involved with the services replacing the WA Alcohol and Drug Authority;
- More alcohol - free entertainment (music etc) is needed for young people, with separated age groups, 12 - 14 and 15 +;
- Funding for the 'Mentor' system be maintained so as to have the option of being more widely promoted to service providers;
- Concern was expressed by the GP representative, health care service providers and consumers regarding the over - prescription of medication for Attention Deficit Disorder (ADD). Focus group members felt that this issue needs to be addressed by the medical profession and protocols established. Thorough diagnosis and assessment with a multidisciplinary team is recommended and treatment/medication plans must have goals stated with review inbuilt.

Family breakdown, Stress, Depression

Strengths:

- Youth support and counselling services exist within the community, but adequate funding needs to be maintained;
- The GP is ideally placed to take an early intervention and active role in youth health and can make appropriate referrals to community support services, especially for stress related issues;

- A pilot stress management programme, as part of core school curriculum, is being taught in one town through an Accommodation services' funded project. This programme can be delivered to other areas if funding options can be explored.

Needs:

- Adequate stress management strategies need to be taught throughout a child's life (at school or home) to break the cycle of short term stress relief with alcohol and drugs (as with the pilot programme outlined above);
- Emotional assistance is required for young people changing schools from Yr 10 to Yrs 11 & 12, especially when a move from a town to the Regional Centre is involved;
- Promotion of minimal cost drug alternatives is necessary, such as recreation, and connecting with peers and friends. Education about other coping skills including anger management has been identified as an area of high need;
- Youth require wholistic information, in places where young people go and feel comfortable, to improve their knowledge of, access to and liaison with such services.

Youth Health Priorities

- Detoxification services be established in the Regional Centre, catering for the whole region. Rehabilitation could be run on an individual case management basis, with a coordinator directing people to appropriate counselling and support options. This could keep local people in the system and minimise the possibility of re-abuse of alcohol and drugs. The GP has a central role in the team overseeing the detoxification/rehabilitation programme.

- A drop - in centre for youth which facilitates access to appropriate services: the Lunch Centre has been proposed as some agencies, such as social security and accommodation support, are already represented there. However, the services of a GP are sought on site to cover health aspects and improve the access of youth to general practice.

- The Division needs to provide ongoing and up to date education for GPs about ADD, which includes diagnosis criteria, management strategies, including drug and non-drug treatment options and guidelines for review (this priority is consistent with recommendations of the Technical Working Party on Attention Deficit Disorder, 1996).

- Education in schools about substance abuse and coping skills such as stress and anger management.

- The GPs to market themselves to young people and promote a user - friendly service for this age group.

8.3 Women's Health

Isolation imposed by domestic violence, post - natal depression, sole parenting and culture:

Strengths:

- A Childbirth Stress and Depression project (CSDP) has commenced under the auspices of the Division which will initially include counselling and a therapeutic group is planned;
- Red Cross are training child care workers for respite care in the home of women identified in need, or attending the CSDP.

Needs:

- The CSDP be maintained and extended to cater for a growing need;
- Counselling services consider providing creche facilities for women (and families).

Access to GPs

Strengths:

- Some GPs are referring to the Women's Health and Information Centre (WH&IC) for a wide range of biological, social and medical information, education and support;
- An out - of - hours GP is always available on call for emergency care in cases of domestic violence;
- Excellent publications are available from the Health Department of WA (HDWA) to assist GPs with the different cultural expectations of patients from non - English speaking backgrounds.

Needs:

- An electronic information, reference system is needed to enable GPs to keep abreast of dynamic information, such as community services and agencies (such as the Community Organisation Resource Directory);
- The Division to organise information sessions for GPs on migrant women's health needs and other cultural issues which may impact on the health of these women.
- A Well - Women Clinic, to cater for the 'wholistic health needs of women', run through either Community Health (free service, GP service bulk billed), or within an existing GP practice;
- The need for more female GPs to cater for the drift of female patients from neighbouring smaller rural areas which are serviced by male GPs..

Fertility and Menopause

Strengths:

- Fertility issues, including pre and post termination, family planning and other counselling, are available through GPs and WH&IC, despite the closure of the "Babychase" support group;

- A GP referral is not needed for women to attend the Perth clinic for pregnancy termination.

Needs:

- Issues related to women travelling to Perth for pregnancy termination remain unresolved (eg, costs involved with transport and accommodation, family dislocation, care of other children etc).
- Menopausal women need adequate information and choice before being automatically prescribed the Hormone Replacement Therapy (HRT).

Domestic Violence (DV)

Strengths:

- Information on DV is available to the community via GP surgeries, the domestic violence centre and other outlets. There is an acknowledgement amongst service providers that they must constantly sort and tidy pamphlets in GP surgeries to maintain an adequate profile;
- Funding has been received for perpetrator and children's programmes;
- The Domestic Violence Centre and Migrant Resource Group are co - hosting a DV workshop for migrant women (under a more 'neutral' title, such as "how to maintain a positive relationship").

Needs:

- Funding for perpetrator programs must be fully maintained;
- More emergency accommodation is needed for victims and families of DV;
- Ongoing GP education is required for identification of DV and possible plans of management and other appropriate actions, including referral to community agencies. It is suggested that the Division and the Domestic Violence Centre provide combined education programmes.

Eating disorders

Strengths:

- WH&IC is setting up a multidisciplinary team for a treatment group, counselling and support for people (mainly women) with eating disorders.

Needs:

- There is a significant local need for services, such as that proposed by WH&IC;
- More Psychiatric services, including a Psychiatrist, are urgently needed to add to the multidisciplinary team approach, perhaps negating the need for treatment in Perth and the associated trauma and inconvenience involved with travel;
- Ongoing GP education is needed for diagnosis and treatment and management of eating disorders and other self - abuse behaviours.

Women's Health Priorities

- A Well-Women Clinic for pap smears, breast examination, family planning etc. Advantages would include:
  - able to be run with a nurse practitioner and GP, as in other regional towns;
  - cuts waiting time for non - urgent screening;
  - frees up GPs' time for other patients , especially female GPs' time;
  - provides a cheaper (bulkbilling), wholistic service for women, who currently have to pay for an extended consult;
  - allows for a longer time per patient, with no pressure regarding other patients
  - waiting for urgent matters; appointments can be either booked or on a 'drop in' basis on some days;
  - would target migrant, Aboriginal and older women who don't readily utilise mainstream services and postpone health checks (target groups for cervical cancer);
  - a Clinic would have 'friendly' waiting rooms, reception areas (for waiting with young children), and clinical staff.

- GP education in eating disorders, such as that provided by Princess Margaret Hospital, (PMH). Such education would include diagnosis, treatment options and management of eating disorders and other self - abuse behaviours. The GP to be part of the multidisciplinary team set up by the Women's Health Centre.

- More affordable or free counselling and parenting skills education, with childcare provided, to be provided within existing community services and agencies.

8.4 Men's Health

Prostate Cancer

Strengths:

- The Cancer Foundation (Perth) has funded a Men's Health project officer. His role will involve education and awareness of male cancer issues, and the brief will cover the South West area;
- The Cancer Foundation's awareness and education roles in workplaces provide a valuable link with a vast number of males;
- In the last 5 years there has been an increase in the number of men visiting GPs for prostate cancer checks (source: anecdotal evidence from the GP in the focus group).

Needs:

- Community (consumers, Division of GP) need to lobby and pressure Governments (at all levels) to place a high priority on and fund men's health issues.
- Men need to be encouraged, via differing strategies, such as mass media, education and awareness campaigns and peer support, to act preventively. That is, to seek regular health checks, to be active in their own health maintenance (good nutrition, physical activity etc), and not to wait until they are sick to see the GP.

Access to GP and other services

Strengths:

- GPs are more frequently referring patients to Cancer and Heart Foundations for specialist health input.

Needs:

- A Directory for men's issues and services is needed. This could be taken from the existing 'Community Organisations Resource Directory' (CORD);
- Men need communication and social skills to be able to discuss health issues with GPs and other health professionals;
- Male consumers may be unfamiliar and uncomfortable discussing their health problems and concerns. Male GPs should be aware of this potential communication barrier to providing a health and medical service for fellow males;
- Men (beginning with young boys) need to be encouraged, at all levels within the community, to be more aware (and caring) of their own and fellow male's health and risk taking behaviours.

Mental Health, Drug and alcohol abuse

Strengths:

- Centacare provides some preparation/support for reintegration of ex - prisoners into the community;
- One local house currently provides accommodation (Homeswest funded), but not a good environment for men wanting to be alcohol and drug free;
- The Regional Centre Accommodation Service provides good support and understanding for homeless men, despite a shortage of accommodation options.

Needs:

- A detoxification and drug rehabilitation service for youth and men (mainly); options for rehabilitation may include farm - stay, work trial, volunteer placement;
- A replacement service for accommodation for single men, similar to that previously offered, eg short and medium term, which has now been closed due to funding cuts;
- An alcohol and drug - free 'safe house' (with partial supervision) for those with mental and psychiatric conditions to stay on short and longer term basis;

- Communication and social skills, self esteem, assertion training need to be part of the core school curriculum, balanced with 'life education' (what you do well, what needs to be done better) , with appropriate role models (such as the mentor scheme identified under youth health) in the absence of family figures.

Lifestyle Issues

Strengths:

- Some 'lifestyle' courses (exercise, nutrition etc) are available through, for example, the Regional Centre's Recreation services, but are not well marketed or targeted to men (using men's language, flexible times etc).

Needs:

- Education and awareness programmes are needed for men's health, utilising minimal pamphlets, with other men (role models), providing the bulk of the education, with practical, hands - on information, demonstrations etc.

Men's Health Priorities

- Detoxification/Rehabilitation programs are urgently needed in the Regional Centre, with a wider need to service the wider regional area;

- A computerised recall system for regular male checkups (40 years and over), similar to the existing system for pap smears. Such a mechanism could promote preventive, proactive health measures to men. GPs need to be more proactive in health screening and their services more user - friendly for men.

  "Men perceive the doctor as someone you go to when you are sick as they are not familiar with the Wellness maintenance model";

- Ongoing education, and awareness and promotion of men's health issues is needed, utilising multi-strategies such as Radio, with peer and 'professional' discussions, talk - back facilitated by a male GP, group information, skill building rather than formal courses, employer supported worksite programmes and peer support programmes from other men only;

- Education, through employers, (an underutilised resource) would help lift the profile of men's social and health issues. Specifically, employers encouraging employees to have an annual health checkup. Programmes could be promoted and supported through existing service clubs such as Lions, Rotary and Apex, though initiated by the Division of GPs.

8.5 Aboriginal Health

Access to GPs and other services

Strengths:

- Some Regional Centre Hospital staff liaise well with Aboriginal Community Health workers regarding the issues of families they have in common; communication is especially good for paediatric and aged care patients;
- Community health workers visit Regional Centre hospital on set days (especially for paediatric care), and arrange for and follow up after discharge;
- The Aboriginal Medical Service has drawn up a list of health priorities for Aboriginal people and is a good opportunity to trial a new model of health service delivery to Aboriginal people;
- Health workers hope that the proposed Aboriginal Health Unit at the new hospital will allow for continued partnerships between themselves, GPs and hospital staff in the delivery of health care. That is, with medical and surgical patients in the hospital, with follow - up, counselling and wholistic care in the community.

Needs:

- Cultural awareness/communication skills training for staff at the Regional Centre Hospital and in GP reception areas is timely;
- A need for GPs to explain any medication prescribed in lay terms;
- GP reception areas need to allow for a private area to discuss confidential issues;
- Community Health workers need to advertise the extent of the services offered, especially to GPs, to allow for more confident referral;
- The Aboriginal Medical Service needs to promote itself to GPs and the community (perhaps through the Division newsletter), as GPs do not know of the community services Aboriginal health workers are providing.

Women/children/aged

Strengths:

- Access to Community Health workers for transport to medical appointments is appreciated and valued as it allows for time and space for the patient, their family and the health worker to develop rapport and build a trusting relationship;
- A female family violence worker has been appointed by the Aboriginal Medical Service and the Women's Refuge;
- HACC will have a health worker from early September '97 to work on a one - to - one basis with aged and disabled people;
- Because the Aboriginal community is more family oriented than other non - Aboriginal communities, many aged care needs are met within the existing family and community networks.

Needs:

- Women have been identified as good targets for health education and promotion, as a way of influencing the whole family;
- Ongoing health education and promotion for children in schools.

Mental health/alcohol and drugs/prisoner's health

Strengths:

- Good Aboriginal community support exists for people with Psychiatric and mental health needs;
- The wholistic approach of the Aboriginal Medical Service is valued by health workers as being conducive to good mental health management;
- The Regional Prison runs anger management and substance abuse courses for inmates;
- The Nursing Sister at the Regional prison has good liaison with Community Health workers;
- Prisoners are given pre - release information ('survival kits'), with information on community resources;
- Centacare has funding for a post-release support program.

Needs:

- More liaison between GPs, the Aboriginal Medical Service and health workers is needed to confirm a psychiatric diagnosis;
- More Aboriginal nurses, health workers and counsellors, especially males, are urgently needed. The Aboriginal Medical Service has one male care coordinator and no male nurses;
- Workshops, run by men, for Aboriginal men, on health issues such as cancer, mental health, alcohol and other drugs are necessary
- More older males to act as role models/mentors for young men are needed within the Aboriginal community;
- A local detoxification facility is required. Separate accommodation and staffing would cater for the needs of Aboriginal people;
- Early intervention strategies for young people, such as mentor, training and employment programs are needed to prevent alcohol and drug abuse.

Employment/Training/Housing

Strengths:

- A good opportunity exists to influence young people through the possibility of health education in work training programmes, for example, through TAFE and Skilled Directions;
- Many good, culturally appropriate nutrition curricula exist, and can be included in work and other skills training programmes;

- The Asthma Resource Centre (ARC) can provide training for health workers from Community Health and the Aboriginal Medical Service; High school students are welcome to visit the ARC as part of their visit to 'Community Resources'. This practice might raise awareness of young Aboriginal people regarding asthma and the resources and support facilities available to manage the condition;
- Homeswest meets with Community Health and Aboriginal Medical Service workers monthly to discuss housing maintenance issues. Health workers are now able to exert some pressure to upgrade housing conditions if necessary;
- Aboriginal people trust their Corporation as advocates of Aboriginal issues, and make contact for help and possible referral for housing and other social problems.

Needs:

- Access to adequate housing is an ongoing need, both through Homeswest and the private rental market;
- More compassionate attitudes from those involved with housing (Agents, Caravan Park managers etc) is needed to enable more equitable access to housing options;
- Aboriginal people to be trained, and work as Real Estate Agents with their own Agencies.

Aboriginal Health/Social Priorities

- Cultural awareness training for all health workers, medical services, GPs and GP reception staff;

- Liaison and cooperation between Community Health, Aboriginal Medical Service (AMS) workers and the Division is needed to promote AMS, and effective ways of working with GPs. (AMS can be promoted in the GP newsletter);

- A 'safe' house, free from alcohol and other drugs, for ex-prisoners. (Centacare is currently investigating an option with Homeswest);

- A 'cooling off house' (as per AMS wholistic health care priority plan, 1996, and the Sherwood Domestic Violence Plan, 1996). AMS is currently negotiating with Homeswest and other possible funding sources or a suitable house;

- Recruiting more male Aboriginal counsellors and health workers;

- Providing Years 10, 11 and 12 school leavers practicum time in different workplaces and occupations would allow young people to test their job expectations without fear of failure;

- Increasing the number of Aboriginal people into the health professions will allow for more appropriate role models and mentors and will help change negative community attitudes towards Aboriginal people in the workforce.

9. RECOMMENDATIONS

As the trend in health care is moving away from institutional care (reducing the demand for hospital care), there is more emphasis on the delivery of primary care and community-based care. Therefore the GPs need to work in partnership with other primary care providers such as allied health and community health professionals to ensure a comprehensive:

- health promotion program
- disease control service, including education, screening and immunisation
- assessment and treatment service

This partnership, to develop an integrated primary care service to the community, has been reiterated throughout this needs analysis. It is especially needed to help reduce the prevalence of conditions which are the leading causes of death in this community (particularly cardiovascular disease and cancer). There is a need to develop programmes which encourage GPs to routinely assess risk factors and provide advice about lifestyle factors to patients, especially those at higher risk and in particular men and the Aboriginal people.

A priority needs to be given to investigating the local higher prevalence of hearing problems in men and the higher rates of hospitalisations and mortality from respiratory conditions, revealed by the epidemiological analysis and may be closely related to occupations in rural areas (Chapters 2 and 3).

The other type of care, which will be placed at the forefront of the priorities in this area, is aged care as the aging population of the Division grows by 46% in the next ten years. This triggers the need for a continuing care service in the form of community based support services, residential and respite care and palliative care.

The following recommendations pertain to more specific issues raised by the GPs and the community in this study.

9.1 Recommendations Based on GP Needs

The GPs have indirectly formulated their own recommendations in response to problems that are hampering their efficiency at work and to their perceptions of the role of the Division in addressing their needs.

It is recommended that the Division undertake:

- patient education in the appropriate use of GP services (a possible role for the consumer reference group)
- time management skills for GPs to reduce their stress
- improving selection and training of staff in GP surgeries

- introducing computerised patient recall systems and administration
- organising training programmes, particularly in the services that GPs feel they will deliver more of in the next five years: health screening, aged care, preventive medicine, counselling, palliative care and health education. These broad topics are included in more detail in the extensive list of CME priorities in Chapter 6.
- promoting the existence, functions and benefits of community/self-help groups to GPs through the GP newsletter or GPs educational sessions or other medium/forum. Thus GPs can become more aware of the range and diversity of these services.
- addressing the GP dissatisfaction in interprofessional communication with other health services by improving liaison between the GPs and the different groups of health providers.
- addressing gaps in services to the community particularly orthopaedic surgery, drug abuse and aged care
- addressing GP recruitment issues (more multiskilled GPs and female GPs) to reduce some of the experienced difficulties of access to general practice
- lobbying for improved remuneration and maintaining GP presence in hospitals, local and general medical politics.

9.2 Recommendations based on community needs

Some of the following recommendations can be specifically targeted by the Division, and others can be promoted or initiated by the Division in collaboration with other service providers.

Aged Care

- A liaison form to inform all hospital staff and the GPs of the community services used by patients and to provide a medium to prepare and plan discharge of patients. The form will have a list of all community services and is included in the patient's file upon admission (a proforma has been designed in this focus group).

- The creation of a standard form (A4 size, large print) for patient medication, which is supplied by the GP, carried by the patient and presented to hospital or community service as needed. It can be updated by the GP as required and reduces the problems associated with 'doctor - shopping'.

- A Directory of Aged Care Services and other Senior Citizen's information should be made available to GPs, service providers, consumers and those well - aged who are not yet using services.

- Education for GPs and hospital staff re what community services are available for discharged patients, and how to better access and utilise these services. A forum should be set up where GPs are informed by those working in the field about Aged Care Packages and other services available in the area. This would allow an

opportunity to coordinate with the GPs discharge times and dates to allow for necessary services to be accessed.

- The need to coordinate a planned approach between service providers and consumers, including what services are needed, those already utilised, and gaps in service provision. A one - stop - shop to house all services related to aged care in one location would facilitate the coordination of services and act as a source of information in this field to providers and consumers.

- A review whereby all 'players' in the discharge planning process map their roles and processes, how all their functions fit together, to assess the strengths and weaknesses in the system, and reduce gaps or duplication. The findings need to be included in the GP information forum.

Youth Health

- A drop - in centre for youth which facilitates access to appropriate services: the Lunch Centre has been proposed as some agencies, such as social security and accommodation support, are already represented there. However, the services of a GP are sought on site on a sessional basis to cover health aspects and improve the access of youth to general practice.

- Detoxification services be established in the Regional Centre catering for the whole region. Rehabilitation could be run on an individual case management basis, with a coordinator directing people to appropriate counselling and support options. This could keep local people in the system and minimise the possibility of re-abuse of alcohol and drugs. The GP has a central role in the team overseeing the detoxification/rehabilitation programme.

- There is a need to provide ongoing and up to date education for GPs about Attention Deficit Disorder, which includes diagnosis criteria, management strategies, including drug and non-drug treatment options and guidelines for review.

- The GPs to market themselves to young people and promote a user - friendly service for this age group.

- Education in schools about substance abuse and coping skills such as stress and anger management.

Women's Health

- A Well - Women Clinic for pap smears, breast examination, family planning etc. Advantages would include:
  - able to be run with a nurse practitioner and GP, as in other towns within the region;
  - cuts waiting time for non - urgent screening;
  - frees up GPs' time for other patients , especially female GPs' time;
  - provides a cheaper (bulkbilling), wholistic service for women, who currently have to pay for an extended consult;
  - allows for a longer time per patient, with no pressure regarding other patients waiting for urgent matters; appointments can be either booked or on a 'drop in' basis on some days;
  - would target migrant, Aboriginal and older women who don't readily utilise mainstream services and postpone health checks (target groups for cervical cancer);
  - a Clinic would have 'friendly' waiting rooms, reception areas (for waiting with young children), and reception staff;

- GPs' education in eating disorders, such as that provided by Princess Margaret Hospital. Such education would include diagnosis, treatment options and management of eating disorders and other self-abuse behaviours. The GP needs to be part of the multidisciplinary team set up by the Women's Health Centre;

- More affordable or free counselling and parenting skills education, with childcare provided, to be provided within existing community services and agencies.

Men's Health

- A computerised recall system for regular male checkups (40 years and over), similar to the existing system for pap smears. Such a mechanism could promote preventive, proactive health measures to men. GPs need to be more proactive in health screening and their services more user - friendly for men.

- Ongoing education, and awareness and promotion of men's health issues is needed, utilising multi-strategies such as Radio, with peer and 'professional' discussions, talk - back facilitated by a male GP, group information, skill building courses rather than formal courses, employer supported worksite programmes and peer support programmes, only from other men;

- Education, through employers, (an underutilised resource) would help lift the profile of men's social and health issues. Specifically, employers encouraging employees to have an annual health checkup. Programmes could be promoted and supported through existing service Clubs such as Lions, Rotary and Apex, but initiated by the Division of GPs.

- Detoxification/Rehabilitation services are urgently needed in the Regional Centre, with a wider need to service the whole region.

Aboriginal Health

- Cultural awareness training for all health workers, medical services, GPs and GP reception staff;

- Liaison and cooperation between Community Health, the Aboriginal Medical Service (AMS) workers and the Division is needed to promote AMS services, and effective ways of working with GPs. AMS services can be promoted in the GP newsletter;

- A 'safe' house, free from alcohol and other drugs, for ex-prisoners. (Centacare is currently investigating an option with Homeswest), and a 'cooling off house' (as per SWAMS wholistic health care priority plan, 1996, and the Sherwood Domestic Violence Plan, 1996). SWAMS is currently negotiating with Homeswest and other possible funding sources for a suitable house;

- Recruiting more male Aboriginal counsellors and health workers;

- Providing Years 10, 11 and 12 school leavers practicum time in different workplaces and occupations (particularly in the health field) would allow young people to test their job expectations without fear of failure. Thus increasing the number of Aboriginal people into the health professions would allow for more appropriate role models and mentors and would help change negative community attitudes towards Aboriginal people in the workforce.

REFERENCES

AGB Australia (1992). *Patients' Choice of General Practitioners*, a report to the Department of Health, Housing and Community Services.

Baker, R (1990). Development of a questionnaire to assess patients' satisfaction with consultations in general practice. *British Journal of General Practice,* 40 (341), 487 - 490.

Calnan, M (1988). Towards a conceptual framework of lay evaluation of health care. *Social Science and Medicine,* 27(9), 927 - 933.

Commonwealth of Australia (1997). *Basic Community Profile, Catalogue No. 2020.0, 1996 Census of Population and Housing.* Australian Bureau of Statistics.

Daly, A., Milligan, R., Unwin, E and Thomson, N (1996). *The 1995 Western Australian Health Survey: Overview No. 1, 1/96.* Health Information Centre, Health Department of Western Australia (HDWA), Perth Western Australia.

Dowden-Parker, R (1995). *A Proposal for Colocation of a Community Nurse Practitioner with General Practice to address health issues of the over 65 population.* Community Health Services, Bunbury/Wellington Health Service.

Field Support Unit (1996). *Checklist: Needs Assessment.* Department of General Practice, University of Western Australia.

Gabbott, M and Hogg, G (1994). *Patient information for Primary Care.* Final Report to the Chief Scientist's office for Research, University of Stirling.

Hall, J and Dornan, M (1988). What patients like about their medical care and how often they are asked: a meta-analysis of the satisfaction literature. *Social Science and Medicine,* 27(9), 935 - 939.

Hilbers, J (1992). *Bunbury Student Lifestyle Survey: Research Findings.* Health Promotion Services Branch, Health Department of Western Australia.

Hilbers, J and Meyer, S (1993). *Youth Health South West Region.* Health Promotion Services, South West Health Region, Health Department of Western Australia.

Huggins, A.K., Somerford, P., Rouse, I et. al. (1996). *A Report on Men's Health Western Australia 1996.* School of Public Health, Curtin University, in collaboration with Epidemiology Branch, Health Information Centre, Health Department of Western Australia.

Hughes, C., Rouse, I., Huggins, A and Northey, C (1996). *The Needs Analysis, Swan Hills Division of General Practice,* Perth, Western Australia.

Lloyd, P., Lupton, D and Donaldson, C (1991). Consumerism in the health care setting: an exploratory study of factors underlying the selection and evaluation of primary medical services. *Australian Journal of Public Health,* 15(3), 194 - 201.

Lundy, L (1995). *South West College of TAFE Student Lifestyle Survey: Research findings at Orientation, 1995.* Southern Public Health Unit, Health Department of Western Australia.

Planning Healthy Communities: A Guide to doing Community Needs Assessment (1996). South Australian Community Health Research Unit, South Australian Health Commission.

Rashid, A., Forman, W., Jagger, C., and Mann, R (1989). Consultations in general practice: a comparison of patients' and doctors' satisfaction. *British Medical Journal,* 299 (6706), 1015 - 1016.

Report of the Technical Working Party on Attention Deficit Disorder to the Cabinet Sub Committee : A Document for public consultation (1996).

Sherwood, P (1996). *South West Region Domestic Violence Plan, 1997 - 1998.*

Silver Thomas Hanley (1994). *Warren Blackwood Health Planning Study.*

Silver Thomas Hanley (1997). *South West Health Services Strategic Directions (1997-2006).*

Smith, C and Armstrong, D (1989). Comparison of criteria derived by government and patients for evaluating general practitioner services. *British Medical Journal,* 299, 494 - 496.

Steven, I and Douglas, R (1988). Dissatisfaction in general practice: what do patients really want? *Medical Journal of Australia,* 148(6), 280 - 282.

The Consumers' Health Forum (1993a). *Building Links with Consumers: The Key to Quality General Practice.*

The Consumers' Health Forum and the Department of Human Services and Health (1996c). *Integrating Consumer Views about Quality in General Practice.*

The Consumers' Health Forum of Australia Inc. (1996a). *Consumers and General Practice: Understanding and Assessing Consumers' Experiences by Using Patient Satisfaction Surveys.*

The Consumers' Health Forum of Australia Inc. (1996b). *Working with Consumers: A Guide for Divisions of General Practice.*

The Inter - Practice Comparison Report (1996). Inter - Company Comparison Centre, Victoria.

Western Australian Aboriginal Co-ordinated Care Trial Proposal (1996). Office of Aboriginal Health, Health Department of Western Australia, South West Aboriginal Medical Corporation, Perth Aboriginal Medical Service, Geraldton Regional Aboriginal Medical Service and the Marwarnkarra Health Service.

Williams, S and Calnan, M (1991). Key determinants of consumer satisfaction with general practice. *Family Practice,* 8 (3), 237 - 242.