



Scott Lewis

Wudinna Health Centre

Improving access to primary care in a remote community

This article forms part of our 'Access' series for 2012, profiling organisations that provide primary healthcare to groups who are disadvantaged or have difficulty accessing mainstream services. The aim of this series is to describe the area of need, the innovative strategies that have been developed by specific organisations to address this need, and make recommendations to help GPs improve access to disadvantaged populations in their own community.

Workforce issues present a major barrier to equitable access to health services for patients living in regional and remote areas. This article describes the development of a health centre to consolidate the major primary healthcare providers of a very remote community. The new health centre has resulted in measurable improvements in access to primary healthcare services in the region.

Keywords

rural health services, rural health; general practice, integrated delivery of health care; health services, community health services

Thirty-two percent of the Australian population resides in areas classified as regional and remote under the Australian Standard Geographical Classification (ASGC). However, only 0.8% of the population resides in areas classified as 'very remote'.¹ Providing access to equitable health services for patients in remote areas presents a number of distinct challenges. Barriers to accessing healthcare are very similar across most remote areas and include transportation difficulties, limitations to the quality and quantity of healthcare providers and financial constraints.² Some issues, such as distance from a healthcare facility, are difficult to overcome, but others, such as the supply of healthcare providers, are amenable to improvement strategies.

Workforce issues are a major factor limiting access to healthcare for patients in rural areas. Regional and remote areas have significantly lower numbers of medical and allied health practitioners proportional to the population of these health professionals in major cities. Very remote areas have just over half the full time medical practitioners per head of

population than major cities (259 vs 400 practitioners per 100 000 population) and these practitioners work longer average hours than those working in other geographical areas.³ Similarly, very remote areas have less than a quarter of the number of allied health services available in major cities.⁴

Integrated team-based care involving medical, nursing and allied health staff is generally associated with improved outcomes, particularly in the context of chronic illness.⁵ Team-based care also has the potential to improve access to healthcare via interdisciplinary working environments and the decentralisation of services.⁶ In remote areas, well structured team-based care has the potential to improve health outcomes, however the services providing healthcare in small remote communities can often be poorly integrated.

The township of Wudinna lies in the central Eyre Peninsula of South Australia and is classified as 'very remote' under the ASGC. It lies 550 km by road from the nearest capital city, Adelaide, and more than 220 km from the nearest regional centres of Whyalla and Port Lincoln. The town functions as a service centre for a farming region with a population of 1250 people.⁷ The medical practice services a patient population of approximately 1600, with patients travelling up to 80 km for healthcare services. Compounding this relative isolation, Wudinna is not served by a commercial air service and the only intra-state transport is via a bus service, which runs four times a week, but not directly to either Whyalla or Port Lincoln. As such, patients are highly dependent on the local provision of basic medical services and must rely on private car transport for specialist and radiological referrals. Unfortunately, the remoteness from a commercial air service also makes the location unattractive for specialists to provide a visiting service from Adelaide. General practitioner services have also been a challenge to maintain for the region, with no resident GP for the 3 years preceding the arrival of the current GP in early 2008.

The Wudinna Health Centre

Before the establishment of the Wudinna Health Centre, primary care health services within the Wudinna community were provided from three separate locations. These included the existing medical practice, a dental practice in the township and the community health service based at the local hospital. This arrangement had provided satisfactory healthcare for many years, however several improvements were needed to cater for a vision to meet the future health needs of the community.

Importantly, the existing medical practice infrastructure was old and there was no capacity for expansion of the practice at that site. With the new local GP planning to introduce a practice nurse, employ a general practice registrar and train students, a larger and more up-to-date facility was required. Likewise, the dental practice was old and lacked capacity for expansion and training. The community health service facility was located in converted nurse's accommodation at the local hospital, which, while adequate, did not provide an environment that was attractive to patients or allied health staff. The lack of physical integration between these services also limited care coordination for the elderly and patients with complex care needs.

The challenge of improving and integrating health facilities in Wudinna was taken up by the local council and a successful grant application was made to the Federal Government Rural Medical Infrastructure Fund. The council provided the remainder of the funding for the 'new' Wudinna Health Centre, which incorporated the medical practice, the dental practice and the community health service. The centre provides four consulting rooms and a treatment room for the medical practice, nine consulting rooms and offices for community health services and two chairs for the dental practice.

Since opening in 2010, the Wudinna Health Centre has become a hub for health services within the community. Combining the three services in one location has improved integration and access to services considerably.

The additional space provided in the new centre has allowed the medical practice to expand. The addition of a registrar to what has traditionally been a solo doctor practice has also improved access considerably. The number of patients seen per week since their arrival has increased by 26% and

waiting times for nonurgent appointments have fallen from an average of 6 days to less than 1 day. Based on Medicare billing data, case conferences have increased fourfold since the co-location, but this does not reflect the large increase in 'hallway' meetings between medical and allied health staff that has also occurred. Care planning and team care arrangements have also improved with a doubling of services provided annually since the co-location.

The community health service has also seen an increase in activity since shifting to the new centre. The number of full time staff at the service has increased from three to six, with the arrival of an occupational therapist and two health promotion staff. A visiting allied health service continues, providing podiatry, speech pathology, dietetics and physiotherapy services. There has been an increase of 44% in the number of clients and the number of individual contacts has increased by 17%. Feedback surveys from clients of the health centre indicate a high level of satisfaction with the services provided.

Recommendations

The consolidation of health services into one building has proved valuable for the town of Wudinna in terms of improving access to healthcare services and in the recruitment of additional practitioners. Importantly, while the three services maintain independence in terms of governance and business structure, the physical co-location has improved interaction and care coordination. As this community is not unique in its isolation or demographics, the benefits found here could be applicable to other rural communities.

The other important issue emerging from the experience at Wudinna is the importance of the involvement of local government. This is unusual in that medical and dental practices tend to be privately owned and hospitals and community health services are funded differently through state and federal government programs. In small communities, local medical practices are unlikely to have the financial resources to develop a large health centre, nor the time or expertise to dedicate to funding and development applications. Local government, however, is likely to have staff with expertise in grant application and project development.

Another lesson learnt from this process was the importance of planning for a larger facility than required. The planning brief for the Wudinna Medical Practice was to develop a centre large enough to

serve the community for the next 20 years. However, despite planning a facility much larger than required at the time, within 2 years of opening all rooms were regularly being utilised. In the future, it is hoped that more practitioners will be attracted to working in the centre, particularly visiting medical specialists.

Finally, the development of the health centre has allowed the recruitment of a registrar to the practice. Despite the community traditionally being served by a solo GP, and opinion within the area being that there was insufficient workload to support two doctors, the practice has flourished with the addition of a second practitioner. Most importantly, the reduction in on-call load and improved infrastructure addresses two of the major disincentives for working in remote areas, prolonging the term of service of the incumbent GP and assisting the recruitment of medical and allied health staff into the future.⁸

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