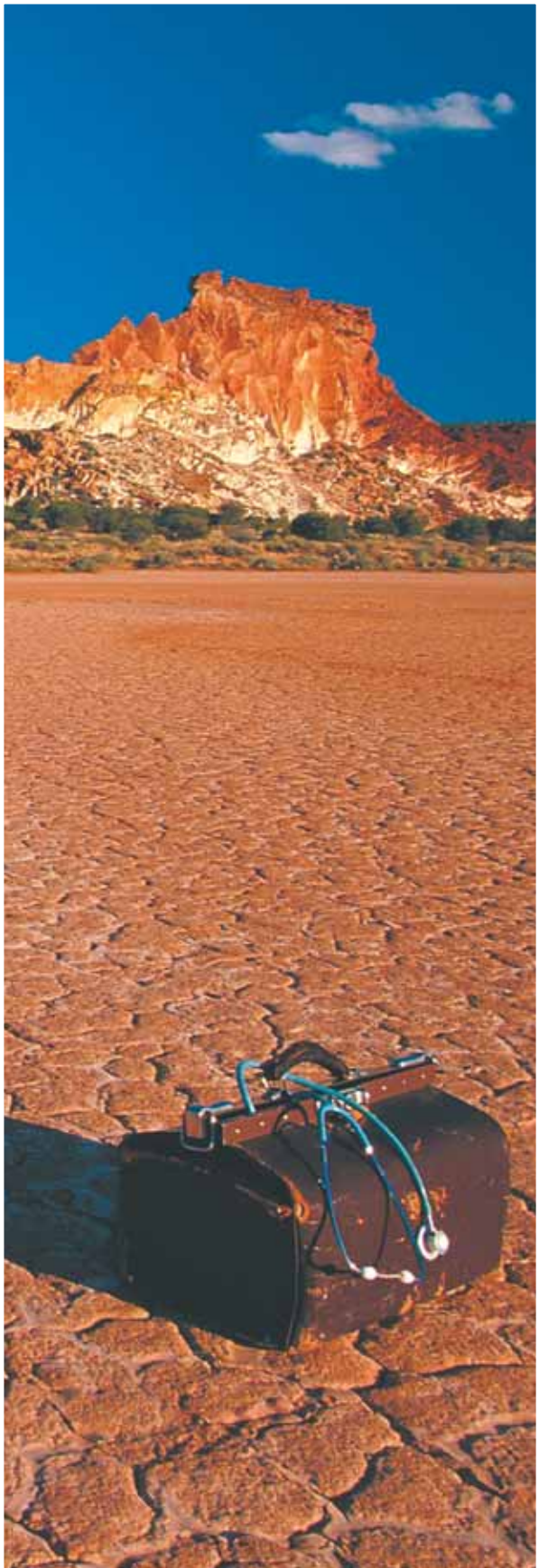
annual report 2004-05

general practice and primary health care northern territory



“come for two weeks
...or stay a lifetime”

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preamble and strategic plan

ABOUT US

General Practice and Primary Health Care Northern Territory (GPPHCNT) is the peak body representing the Territory's non-government General Practice and Primary Health Care sector. We were created through the merger of NT Remote Health Workforce Agency (NTRHWA) and General Practice Divisions NT in October 2004. GPPHCNT works to improve the health of Territorians by:

- Improving recruitment and retention of doctors in rural and remote NT
- Fostering collaborative relationships among health care providers
- Supporting the work of the Divisions of General Practice in the NT
- Leading General Practice and Primary Health Care policy development
- Representing the Divisions and other stakeholders at the Territory and national level
- Advocating for innovative and improved health services in the Northern Territory.

"General Practice and Primary Health Care Northern Territory is the peak body representing the Territory's non-government General Practice and Primary Health Care sector"

Purpose of GPPHCNT

GPPHCNT exists to promote the development of General Practice and Primary Health Care in the Northern Territory through organisational, leadership and policy capacity.

Vision of GPPHCNT

To improve health by making a significant contribution to the development of the health care systems and services in the NT.

Objectives of GPPHCNT

The primary objectives of GPPHCNT are:

1. To alleviate the poverty, sickness, destitution, distress, suffering, misfortune or helplessness and severe problems encountered by people living in Northern Territory communities in accessing health care and health facilities, and
2. To improve health outcomes in the Northern Territory.

The primary goals will be achieved by pursuing the following action objectives of GPPHCNT:

- Improve recruitment and retention rates of General Practitioners and the recruitment and retention of Primary Health Care Practitioners to enhance and sustain General Practice.
- Enable Divisions, General Practitioners and Primary Health Care providers to work together and with the wider health care system to improve health care quality and the continuity of health care, meet local health needs, and promote preventive care.
- Lead health policy development in General Practice and Primary Health Care.
- Advocate to improve the viability and sustainability of equitably distributed General Practice and Primary Health Care resources and services.
- Strive to improve public health by enhancing General Practice and Primary Health Care services.
- Promote and develop collaborative relationships including working to build consensus and commitment among communities, funding bodies, service providers and support agencies to improving health services.
- Pursue opportunities for diversification and expansion that will strengthen GPPHCNT's ability to meet its objectives.
- Support, collaborate and co-ordinate policy and the work of the Divisions in the Northern Territory.

GPPHCNT STRATEGIC PLAN

Key operating areas

1. Primary health care

- Support and co-ordinate the contribution of General Practice in the Northern Territory to the development and implementation of an integrated and sustainable Primary Health Care system.
- Contribute to Northern Territory and national population health approaches.
- Support the improvement of primary mental health care in the Northern Territory.
- Support the improvement of immunisation rates in the Northern Territory.
- Support improved access to quality primary medical care for residents of aged care facilities in the Northern Territory.

2. Leadership and engagement, collaboration and partnership

- Lead, represent, advocate for, and support Divisions in the Northern Territory.
- Engage Divisions, consumers, Aboriginal and Torres Strait Islander people, other service providers, and the Northern Territory and Commonwealth Governments, in the enhancement of the General Practice and Primary Health Care workforce and services in the NT.
- Ensure that organisational activities appropriately reflect stakeholder (including consumer, community, and workforce) views.

3. Policy and advocacy, capacity building, and research

- Take a leadership role in policy development and advocacy relating to General Practice and Primary Health Care across the NT, particularly in the priority policy areas of equitable access to GPs, chronic disease, primary health care reform, and health services reform.
- Support capacity building within Divisions and General Practice and Primary Health Care in the Northern Territory.
- Support research and evidence based practice within Divisions, general practice, and primary health care in the NT.

4. Workforce planning, data, and information management

- Lead the development of improved data collection and workforce planning relating to the General Practice and Primary Health Care workforce in the Northern Territory.
- Support Divisions and GPs to manage clinical and business management information more effectively.

5. Attraction of practitioners to General Practice and Primary Health Care in the Northern Territory

- Increase interest among current and future practitioners in working in General Practice and Primary Health Care in the Northern Territory.

6. Recruitment of practitioners to General Practice and Primary Health Care in the Northern Territory

- Develop, implement, evaluate, and continually improve programs to effectively recruit practitioners to General Practice and Primary Health Care in the Northern Territory.

7. Retention of practitioners in General Practice and Primary Health Care in the Northern Territory

- Develop, implement, evaluate, and continually improve programs to effectively retain practitioners in General Practice and Primary Health Care in the Northern Territory.

8. Organisational governance and management

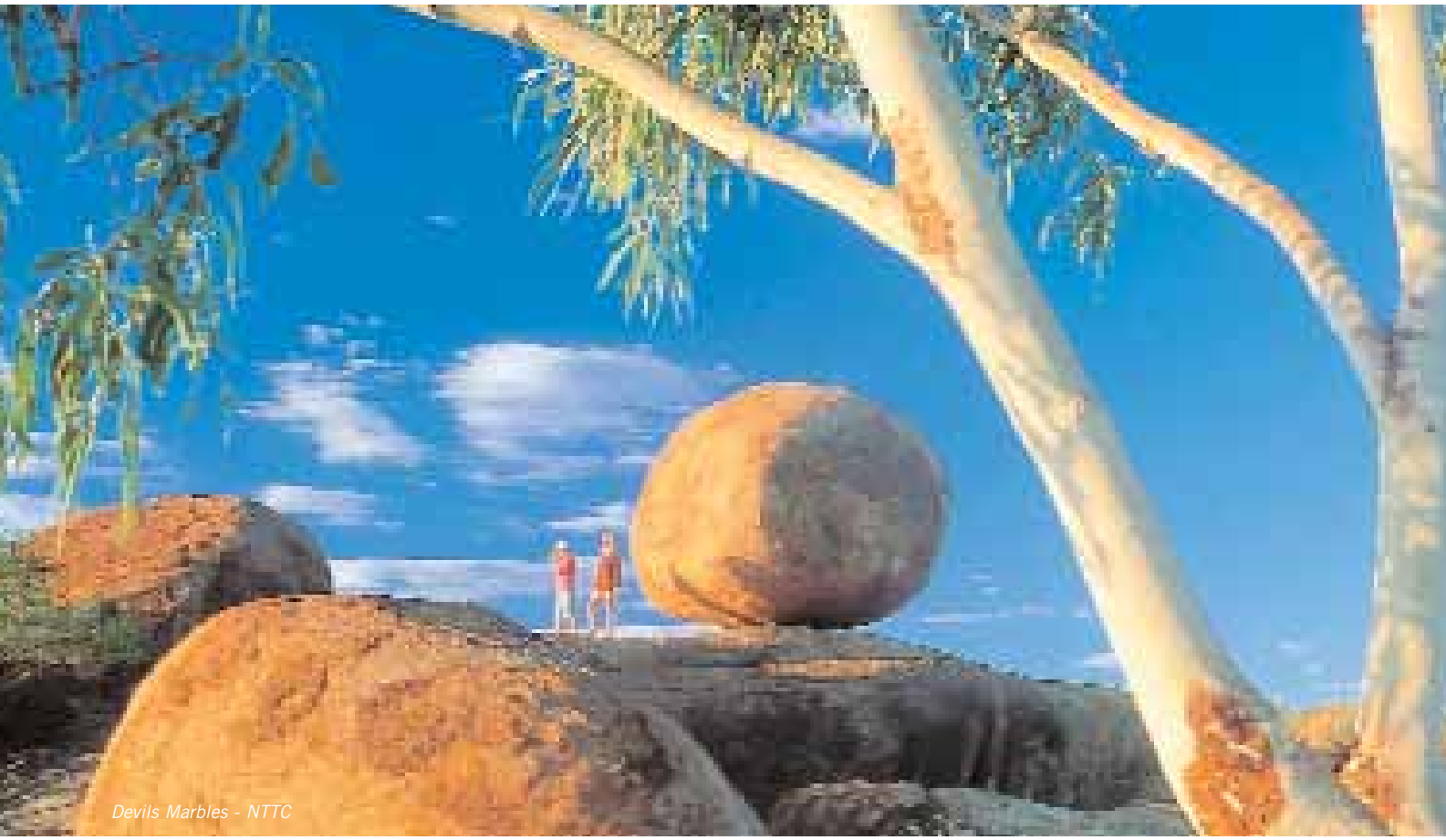
- Develop and maintain an effective, efficient, and accountable organisation.

Sunset at Ubirr - Sandie Dean

chair's report

Thanks to a CEO who communicates well and trusts the Board. Kathy Bell continues to focus on building a good team and a good business. I know the Board appreciates the efficiency with which Board business is conducted and working with quality information makes our Board more effective. I am grateful that, despite the huge job involved in getting the organisation in order, we still have the capacity to press on with strategic policy and have continued to contribute to Northern Territory and national Primary Health Care and Workforce policy. Our staff work hard and understand quality. Thanks for their work in realising the vision.

I thank Board members who are committed to the job and consider both governance and strategic matters properly both in and out of session. Thank you for doing extra work sitting on subcommittees, being nominated to other organisations including the Australian Rural and Remote Workforce Agency Group (ARRWAG) and Northern Territory General Practice Education (NTGPE), and using these roles to progress our goals. There is always a challenge on representative Boards to develop the governance and financial skills to do the job properly. We will continue to provide formal learning opportunities and continue to debate what acting "in the best interests of GPPHCNT" means. Thanks to observers



Devils Marbles - NTTC

and associate member Board representatives for their valued organisational, strategic and context contribution.

There has been active input into policy debate about Primary Health Care definition, Overseas Trained Doctor (OTD) policy, review of Remote Area Grants (RAGs), and our role in support of OTD's. For our business to succeed we need to have an understanding, not just of our environment, but of the policies which will advance General Practice and Primary Health Care in the Northern Territory. The Board understands and has embraced this. We will not always agree but are not afraid of robust debate. With our need to increase the size of our membership under the new Associations Act, we hope to expand membership to include the experience of other health professionals involved in Northern Territory Primary Health Care.

We have continued to improve our communication, through our website and face to face, with stakeholders, Divisions and the community. Thanks to those GPs and other health workers who talk to board members and staff about their experiences on the ground and keep us on our toes. Ongoing work on clearly articulating our business and our goals will establish our leadership role in preventing duplication and clarifying roles in our sparsely-resourced Territory.

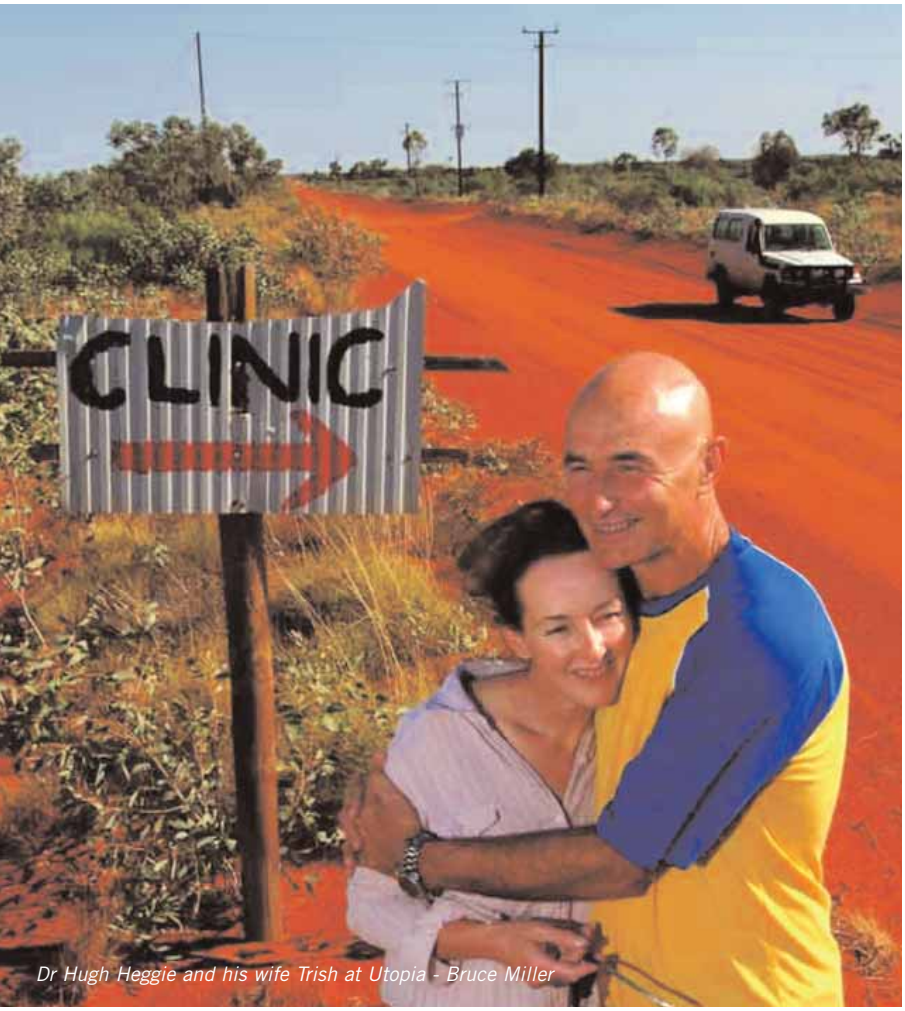
We have adapted using the new funding framework and in understanding the new Divisions performance indicators. We have taken up the challenge to become accredited as an organisation recognising that it is a measure of quality in governance as well as in business.

I commend to you the contents of this Annual Report, you will see that a small organisation has been ambitious.

Dr Sarah Giles
Chair

"We will continue to provide formal learning opportunities and continue to debate what acting 'in the best interests of GPPHCNT' means"

board report



Dr Hugh Heggie and his wife Trish at Utopia - Bruce Miller


Sarah Giles


Pat Anderson


John Boffa


Nigel Gray


Liz Scott


Susan Wearne


David Ashbridge


Rob Curry


Jenny Norris


Lesley Woolf

GPPHCNT BOARD AT 30 JUNE 2005

Voting Board members:

Dr Sarah Giles, Top End Division of General Practice, Chair

Ms Pat Anderson, Aboriginal Medical Services Alliance Northern Territory

Dr John Boffa, Aboriginal Medical Services Alliance Northern Territory

Dr Gerry Goodhand, Top End Division of General Practice (from 2004 AGM)

Dr Nigel Gray, Central Australian Division of Primary Health Care (from 2004 AGM)

Ms Liz Scott, Health Consumer Rural Remote Australia

Dr Susan Wearne, Central Australian Division of Primary Health Care

Associate members/observers:

Dr David Ashbridge, Northern Territory Department Health and Community Services

Dr Max Chalmers, Rural Doctor's Association Northern Territory (from early 2005)

Mr Rob Curry, Services for Australian Rural and Remote Allied Health (from 2004 AGM)

Ms Jenny Norris, Australian Government Department of Health and Ageing

Dr Penny Roberts-Thomson, Australian Divisions of General Practice

Ms Lesley Woolf, Council of Remote Area Nurses of Australia (from 2004 AGM)

Other members of GPPHCNT Board during 2004/05, prior to 2004 AGM:

Dr Peter Tait, Central Australian Division of Primary Health Care, Chair

Dr Denis Chew, Top End Division of General Practice

Mr Chris Wilson, Council of Remote Area Nurses of Australia (non-voting)

BOARD MEETING ATTENDANCE 2004-05:

NAME	29.07.04	09.09.04	25.11.04 AGM	03.02.05	10.03.05	19.05.05	30.06.05
VOTING MEMBERS							
CADPHC							
Dr Peter Tait	✓	✓	✓	N/A	N/A	N/A	N/A
Dr Susan Wearne	✓	✓	✓	✓	✓	✓	✓
Dr Nigel Gray	N/A	N/A	N/A	✓	Dr Peter Tait	✓	✓
TEDGP							
Dr Sarah Giles	A	✓	✓	✓	✓	✓	✓
Dr Gerry Goodhand	N/A	N/A	✓	A	✓	✓	✓
Dr Denis Chew	✓	A	A	N/A	N/A	N/A	N/A
AMSANT							
Dr John Boffa	✓	✓	✓	✓	✓	✓	✓
Ms Pat Anderson	Ms D Ah Chee	A	✓	✓	✓	Ms C Anderson	A
HCRRA							
Ms Liz Scott	✓	✓	✓	✓	✓	✓	✓
NON – VOTING MEMBERS							
ADGP							
Dr Penny Roberts – Thomson	✓	✓	✓	A	✓	A	A
NTGPE							
Dr Doug Lloyd	A	✓	A	✓	✓	Dr E Chalmers	✓
CRANA							
Mr Chris Wilson	A	✓	N/A	N/A	N/A	N/A	N/A
Ms Lesley Woolf	N/A	N/A	✓	✓	✓	A	✓
DOHA							
Ms Jenny Norris	Mr Tony Rutter	A	Mr Tony Rutter	✓	✓	✓	Mr Tony Rutter
NTDHCS							
Dr David Ashbridge	✓	✓	Ms N Swanson	✓	✓	✓	Ms N Swanson
SARRAH							
Mr Rob Curry	N/A	N/A	✓	✓	✓	✓	✓
RDANT							
Dr Max Chalmers	N/A	N/A	N/A	N/A	N/A	A	A

✓ – Attended A – Apology N/A – Not applicable Name – Proxy

"I thank board members who are committed to the job and consider both governance and strategic matters properly"

Dr Sarah Giles, Chair

chief executive officer's report

The focus for GPPHCNT and its predecessors over the 2004-05 financial year was squarely on consolidation and continuous improvement.

The merger of the former remote health workforce agency and the state based organisation for divisions, to form GPPHCNT, was finally completed on 1st October 2004. The organisation was formally launched at NT Parliament House on 24th November 2004. The merged organisation has already shown itself to be greater than the sum of its parts, as the efficiencies arising from the merger have enabled us to increase the profile, influence, and effectiveness of the organisation.

GPPHCNT Board also undertook a review of the organisation's Constitution, including its membership, during 2005. The 2005 Annual General Meeting will vote on proposed membership changes which aim to broaden the voting membership to include nursing and allied health representatives, thereby making GPPHCNT even more reflective of the multidisciplinary primary health care team.

"GPPHCNT ends the financial year with a healthy balance sheet, and we can look forward to developing new programs in 2005."

A key achievement in 2004-05 was improving the financial base of the organisation. Due to overspends in the programs of its predecessors in previous years, GPPHCNT commenced operations on 1st October 2004 with a considerable liability. Through a range of cost cutting measures over the financial year, along with earnings from project management, GPPHCNT ends the financial year with a healthy balance sheet, and we can look forward to developing new programs in 2005. We also put new policies and procedures for financial management in place, to ensure no recurrence of previous financial problems; and the Board established a Finance and Audit Sub-Committee in March 2005 to improve its governance of GPPHCNT's financial affairs.

By June 2005, GPPHCNT was registered for accreditation, reflecting our intent to continue to strive for a culture of continuous improvement.

Our major programs – workforce and divisional support – continued to operate and develop further before, during and after the merger; and we also contributed strongly to NT and national policy, as well as managing a range of programs. Some highlights are outlined below.

WORKFORCE PROGRAMS

GPPHCNT facilitated a workshop of key stakeholders in Darwin in November 2004 to address remote recruitment and retention issues in the NT. The workshop resulted in the "Darwin Statement and Actions Arising", a key document outlining directions for achieving sustainable General Practice and Primary Health Care across the NT. We are working actively with our partners to address the recommendations from the workshop.

Nevertheless, recruitment and retention of GPs to remote areas remains very difficult and challenging. We are facing a national and international medical workforce shortage, and we are competing for doctors with other locations across Australia and overseas. While the NT offers great medical experience, exposure to Aboriginal health and culture, and wonderful lifestyle opportunities, some GP positions also carry hardships and challenges, and with the many other options available for doctors, several of our vacancies in the NT are proving hard to fill. We are continually exploring new ways of attracting GPs to the NT, both from within Australia and from overseas; and we are also focused on what we can do to keep them here once they come. This is core business for our organisation and remains our strong focus.

Our activity in this area over the past year has encompassed attracting GPs and locums to the NT through our website, conferences, marketing campaigns, and overseas recruitment drives; working with employers to fill positions and ensure they are viable and well supported; managing a very much "in demand" locum program to ensure existing GPs can take leave, and that where possible locums can act as "stop gaps" where positions are vacant for a period of time; working closely with the NT Medical Board on OTD assessment and supervision issues; providing new support programs to OTDs in the NT; funding the NT Divisions to provide access to continuing professional development for rural and remote doctors, and to bring GPs' families into town for Divisional events; providing the first in a series of remote emergency skills training courses; providing a program of rural high school visits to attract young people to health careers in the NT; and expanding and enhancing the housing program in communities, for students and GP registrars.

The single largest workforce program we currently manage is the RAG program. This program provides subsidy to health services to support GP positions. An external review of the RAG program was undertaken in early 2005, and this review recommended that the program be restructured to free up funds to better target assistance, and to enable new positions and those most in need of access to subsidy. The review led to some small changes to the administration of RAGs in 2005-06, including small reductions in the size of each grant. Further and more extensive changes are likely in 2006-07.

DIVISIONAL SUPPORT

A major focus over the past year has been rebuilding and refocusing our Divisional support functions, and enhancing our relationships with the two NT Divisions. We have made considerable progress in this area, and from a limited base, now have a strong working relationship with the two Divisions across a range of levels and programs.

The Federal Government's response to the review of Divisions has led to a number of national reforms, including the development and implementation of a challenging new planning and reporting framework for the Divisions network. GPPHCNT has provided leadership and advocacy for the NT Divisions in this process, co-ordinating NT input into this framework and supporting the NT Divisions to introduce systems to deal with the new requirements. This has been a very intensive process, but also a very important one.

GPPHCNT has also led the NT Divisions in preparing for organisational accreditation, which is a requirement of the new planning and reporting framework. Following investigation of options by our staff and presentations to Divisions, GPPHCNT, Top End Division of General Practice (TEDGP) and Central Australian Division of Primary Health Care (CADPHC) have together decided to register for accreditation using the ISO 9001 standards, through SAI Global. SAI Global is an Adelaide-based company with considerable experience in ISO accreditation, including with NT-based companies. Not only are they an impressive company, but all SA Divisions have registered with SAI Global and we can achieve economies of scale and collaboration such as attending training workshops along with the SA Divisions. By registering before 30 June 2005, our three organisations all became eligible for an incentive payment. GPPHCNT aims to be accredited within the 2005-06 financial year and to support the NT Divisions to also achieve accreditation within this timeframe.

GPPHCNT has represented the NT Divisions at quarterly meetings of the Coalition of state based organisations and Australian Divisions of General Practice (ADGP); and organised participation and displays at the 2004 National Divisions Forum in Adelaide, and at the South Australia/Northern Territory Divisions Forum in Adelaide in May 2005.

In addition, GPPHCNT's divisional support program encompasses specific program activities in primary mental health care, immunisation, access to broadband technology, aged care, and nursing in general practice. GPPHCNT also led the NT Divisions to develop a successful proposal for an NT primary care collaborative, as part of the National Primary Care Collaboratives (NPCC) program, and to implement this in a consortium framework.

Waterlilly - NTTC

POLICY AND ADVOCACY

One of the key aims of the merger was to free up staff and Board capacity to undertake more policy and advocacy work. With the completion of the merger this became a reality. Based on strategic discussion by the Board, and drafting work by staff, GPPHCNT developed and released several significant policy papers over 2004-05: a position statement on issues relating to recruitment of and support for overseas trained doctors, for advocacy for improvements to assessment and support; a definition of primary health care, to influence the national debate over primary health care policy and the role of GPs in this; and a submission to the national review of the Rural, Remote, and Metropolitan Areas (RRMA) classification system.

GPPHCNT has also provided input on behalf of the sector to a number of NT government policy processes and program reviews, including the development of a renal strategy, a review of the Sexually Transmitted Infections/Blood Borne Virus strategy, and management of the Medical Specialist Outreach Assistance Program, to name a few. We have re-engaged with the NT Chronic Disease Network, and with the Primary Health Care Research, Evaluation and Development program managed by the Centre for Remote Health (CRH).

PROJECTS

Participation in and management of specific projects has the potential to add to the quality and breadth of our work, as well as diversifying the financial base of the organisation.

During 2004-05 GPPHCNT managed two stand-alone projects, in addition to the NT primary care collaborative mentioned above. The first was a feasibility study into the establishment of an Aboriginal Health Worker (AHW) Association for the NT, commissioned by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) on behalf of the NT Aboriginal Health Forum. We engaged a short term project officer who successfully undertook very extensive consultations across the Territory in late 2004, and a report including a costed plan for the establishment of an AHW Association was completed and disseminated in early 2005. At this stage, we are not aware of any agreement from governments to fund the proposed Association. The other project was a consultation exercise on after hours primary medical care needs in the NT, which found that these needs could most adequately be addressed in Darwin/Palmerston. Given this finding, GPPHCNT identified TEDGP as the appropriate body to develop any further proposals.

GPPHCNT Medical Adviser Dr Jim Thurley was seconded from July to October 2004, to implement a neonatal resuscitation train-the-trainer pilot in rural and remote South Africa, in conjunction with the University of Witwatersrand and Rural Workforce Agency Victoria (RWAV). The outcomes of the pilot were presented at the National Rural Health Conference in Alice Springs in March 2005, and included a demonstrated potential for the training program to save babies' lives in these communities.

LOOKING FORWARD

Following the consolidation achieved in 2004-05, and our improved financial position, we are in a position to work on new initiatives and seek to effect more fundamental improvements to General Practice and Primary Health Care in the Territory in 2005-06.

These new initiatives are likely to include new approaches to recruitment and retention, including recruiting partnerships with other bodies, international recruitment drives, and possibly the development of a practice management service for services or practices in crisis. We need to develop a stronger relationship with the NT Government so that we can work together more effectively on primary health care reform in the Territory, and break down the barriers between our programs. I believe we also need to strengthen our communication with GPs, other primary health care professionals, and health services, to ensure that our major stakeholders have a real say in how we do our business. As just one part of this, we are planning to establish a quarterly newsletter to help ensure the sector in the NT has a profile and that everyone is kept up to date with developments.

We are likely to be affected over the coming year, for better or worse, by the national

policy context including further implementation of the national reform of the Divisions network, the review of the Rural and Remote General Practice Program, the possible development of a national primary health care policy, and a range of health workforce initiatives including those targeting OTDs, practice nurses (PNs), and nurse practitioners (NPs). We are now in a good position to provide a strong, well informed response to these national initiatives. There should also be further discussion of structural efficiencies on the agenda for the NT over the coming year.

At a business level, our management systems are likely to be greatly improved over the coming year with the move to accreditation. We are hopeful also that the move of our Alice Springs office to the planned Remote Health Precinct will be achieved in early 2006: this will represent a great improvement to the conditions under which our Central Australian staff work, and enhance our partnerships with other co-located organisations.

Overall, it promises to be another busy year!

A WORD OF THANKS...

I would like to take this opportunity to thank the Board and staff for their support and continued commitment over a very busy, and at times challenging, year. Previous GPPHCNT Chair Dr Peter Tait, and current Chair Dr Sarah Giles, have both provided strong leadership and strategic direction to the Board, myself and staff, and I have greatly appreciated their guidance.

Over the past year, we have also developed a very strong, talented and professional staff contingent. Our team leaders and medical advisers have been central to the consolidation and strategic development of the organisation; our contract accountant, and past and present members of our corporate services and finance team have been critical in achieving the merger, financial sustainability, and a continuous improvement culture; and each of our project and policy staff has demonstrated their commitment, and made a tangible difference to the fields they work in. I would like to sincerely thank every staff member who has worked for GPPHCNT over 2004-05 for the important contribution you have made to our organisation, and to the future of General Practice and Primary Health Care in the Territory.

Kathy Bell
Chief Executive Officer

"Over the past year, we have also developed a very strong, talented and professional staff contingent."

Ubirr at sunset - Sandie Dean

staff listing


Kathy Bell


Jim Thurley


Stewart Potten


Carita Davis


Sandie Dean


Matthew Davis


Tina McLean


Fiona Hofmeyer


Gae Allcock


Paul Giacometti


Agata Pukiewicz


Vanessa Burke


Richard Potter


Kim Ellis

GPPHCNT STAFF / CONTRACTORS AT 30 JUNE 2005

Chief Executive Officer
Ms Kathy Bell

Medical Adviser
Dr Jim Thurley

Medical Adviser (P/T)
Dr Leonie Katekar

Workforce Programs Branch

Workforce Program Manager
Mr Stewart Potten

Senior Program Officer
Ms Carita Davis

Program Officer
Ms Sandie Dean

Program Officer
Mr Matthew Davis

Program Support Officer
Ms Tina McLean

Divisional Support and Policy

Divisional Liaison Officer
Ms Fiona Hofmeyer

Practice Nurse Program Co-ordinator
Ms Gae Allcock

Broadband Project Officer (P/T)
Mr Paul Giacometti

Senior Policy Officer
Ms Agata Pukiewicz

Collaborative Program Manager
Ms Therese Turner

Immunisation Co-ordinators (P/T)
Ms Marie Kirkwood/Ms Jackie Richardson

Corporate Services Branch

Corporate Services Manager
Ms Vanessa Burke (incoming)

Senior Project Officer
Ms Melinda Smith (outgoing)

Senior Finance Officer
Mr Richard Potter

Corporate Services Assistant
Ms Kim Ellis

Contract Accountant (P/T)
Ms Mary Fathers

OTHER STAFF EMPLOYED BY GPPHCNT DURING 2004-05:

Senior Policy Officer
Mr Martin Blaszczyk

AHW Association Project Officer
Ms Nichola Krey

Workforce Program Officer
Ms Nicole Lamb

Mental Health DLO
Ms Lesley McBride

Senior Finance Officer
Ms Marcia Pidgeon

Personal Assistant to CEO
Ms Jan Schut

workforce programs

"I would like to take this opportunity to thank the Board and staff for their support and continued commitment over a very busy, and at times challenging, year."

Kathy Bell
Chief Executive Officer

The Workforce Programs Team has worked solidly over the past twelve months to develop realistic strategies to respond to the GP workforce shortage that is significantly impacting on health service delivery in rural and remote NT.

Some notable achievements were made in 2004-05. These include the Darwin workshop in November 2004 on recruitment and retention of GPs to Aboriginal primary health care teams in remote NT, successful lobbying of the Commonwealth government for increased support for OTDs, and delivering, in collaboration with partners, a Rural Emergency Skills Training course specifically tailored for remote GPs.

The core programs and support services were maintained. However, strong emphasis was given to raising the NT profile with GPs interstate, through displays at national GP conferences, and the provision of accessible and useful information to GPs nationally and internationally via the revamped website www.gpphcnt.org.au.

This has been achieved against the backdrop of a chronic national and international shortage of doctors, increased levels of competition between the states to attract GPs, and changing doctor preferences in terms of work, family and recreation. These factors have significantly exacerbated the difficulties of attracting and recruiting GPs to the NT. GPPHCNT continues to undertake policy and advocacy work, both individually and through the national peak body for rural workforce agencies, ARRWAG, (on the Board of which GPPHCNT is represented), to influence national and NT government policy to help to address remote workforce issues.

Dr Glynis Johns and friend at Maningrida - GPPHCNT

"It is important to have an ongoing presence and to raise and maintain an NT profile at showcase national events and conferences."

DARWIN WORKSHOP – NOVEMBER 2004

The GPPHCNT workforce team convened a stakeholder workshop in Darwin in November 2004, to develop an agreed approach to recruitment and retention of GPs to Aboriginal primary health care teams in the NT, particularly in remote areas.

This "Darwin Workshop" was attended by representatives of Australian Government Department of Health and Ageing (AGDHA) NT Office, NT Department of Health and Community Services (NTDHCS), Aboriginal Medical Services Alliance NT (AMSANT), NTGPE, TEDGP and CADPHC.

Darwin Statement on Sustainable General Practice in Aboriginal Primary Health Care in the Northern Territory

The workshop generated a "Darwin Statement on Sustainable General Practice in Aboriginal Primary Health Care in the Northern Territory". This Statement is intended to set out a blueprint for the future of general practice in Aboriginal primary health care in the Northern Territory.

Following considerable consultation with workshop participants and GPPHCNT member organisations, the Darwin Statement was finalised in the months following the workshop, along with an agreed set of actions arising from the statement. While the partners to the statement accept that not all of its elements can be implemented immediately, all have made a commitment to work towards its implementation over time, and to develop and deliver policies and programs that align with the vision of this statement.

Actions Arising from Darwin Workshop

Several of the identified actions arising from the statement are already being implemented, including a "Hot Spots" working group convened by GPPHCNT and including representatives of AGDHA, NTDHCS, NTGPE and AMSANT. The group has met monthly since February 2005, to examine how areas of immediate or potential GP workforce crisis can be addressed. A separate meeting of these stakeholders has evolved to jointly assist councils in applying for Rural Medical Infrastructure Fund grants.

MARKETING & ATTRACTION OF GENERAL PRACTITIONERS TO THE NORTHERN TERRITORY

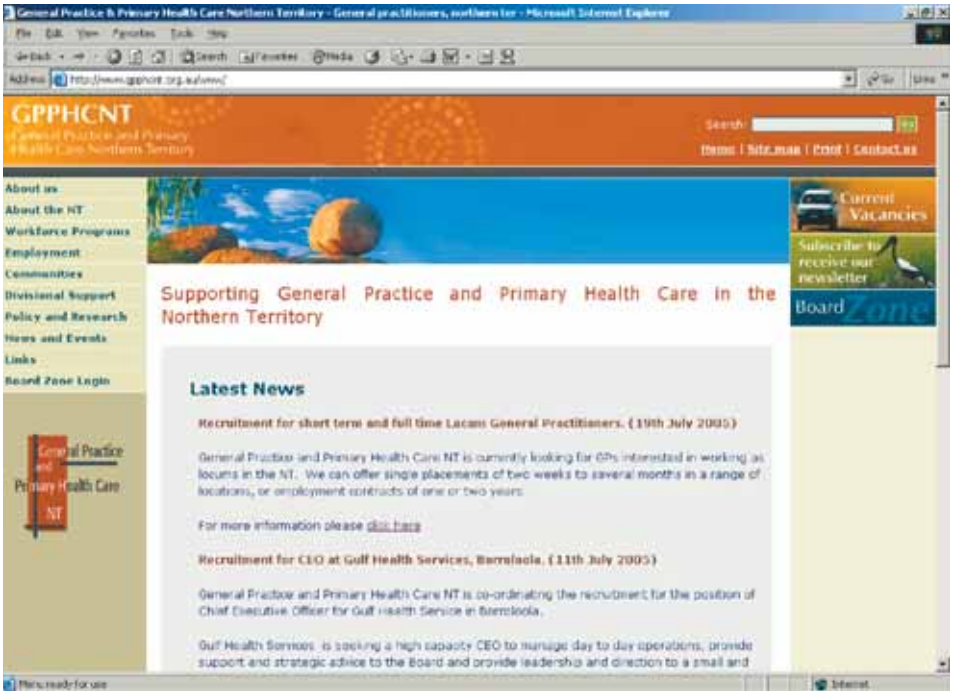
Conferences

GPPHCNT developed new NT recruitment materials for inclusion in packages at a Skilled Migration Exhibition in London in March 2005 and for use at the General Practice Conference and Exhibition (GPCE) and other conferences. Web based and medical journal advertising was also used to promote a UK visit by Medical Adviser Dr Jim Thurley in June/July 2005 to conduct recruitment interviews and consultations with GPs interested in working in the NT.

General Practice Conference and Exhibition

GPPHCNT, as part of its drive to attract GPs to the Northern Territory, attended the GPCE, in Melbourne in November 2004, and in Sydney in May 2005. This provided a significant opportunity to actively promote NT General Practice vacancies and locum GP opportunities to over 1,000 GP delegates attending each of the conferences. It is envisaged that this strategy will be a long term cost effective response, particularly in attracting new locums to the NT. It was developed partly in recognition of the high cost (between $3,500 to $6,000 per recruitment) for communities and health services to advertise GP vacancies in the national papers and prominent doctor magazines.

At the Melbourne conference, 35 doctors and in Sydney 45 doctors registered interest in coming to the Northern Territory for a locum placement with a longer term view to considering working in the Northern Territory. GPs that either have recently departed (Dr Hung Nguyen, Dr David Peiris) and those currently working in the NT (Dr Glynis Johns, Dr Greg Hayes) accompanied Dr Jim Thurley and Carita Davis from the Workforce Team to promote the professional benefits and lifestyle opportunities of working in the NT to other GPs. GPPHCNT holds a long term view that recruitment booths at conferences such as these provide opportunities for doctors to talk to doctors. It is important to have an ongoing presence and to raise and maintain an NT profile at showcase national events and conferences.



National Rural Health Conference (NRHC) Alice Springs 11-13 March 2005

GPPHCNT attended this conference with the aim of increasing its profile and recruiting General Practitioners to the Northern Territory. At the NRHC, GPPHCNT, in collaboration with the two NT Divisions and NTGPE, staffed a very successful booth and had the opportunity to talk to many visiting doctors and network with staff of other Rural Workforce Agencies. GPPHCNT assisted with and participated in ARRWAG's national policy forum, held alongside the NRHC, including identifying a remote NT GP to speak at the conference; and hosted a workshop of RWA staff alongside the conference, to work on issues of common interest.

Website

The revamped GPPHCNT website has been a highly effective tool for promoting NT general practice and locum vacancies. It provides accessible up to date information about the range of workforce programs, vacancy information, locum opportunities and information about remote communities to general practitioners in a timely and effective manner.

The website offers a CV lodgement function that allows GPs to apply on-line for NT vacancies together with an enhanced capability to allow employers and health services to post vacancies directly to the site.

Since the redevelopment of the site, the levels of activity and the number of visits to the site have grown steadily. Over the past twelve months the website recorded, on average, 6,000 hits per month. Of these, 900 seperate hits per month were made by people specifically and intentionally visiting the GPPHCNT website.

RECRUITMENT & GP SUPPORT

NT GP Locum Program

Over the 2004-05 financial year there was a significant increase in the demand for Locum GP services from GPPHCNT across remote NT. Comparing the period of 1 July 2004 to 30 June 2005 with the previous year, 1694 days of locum placement were provided, representing an increase of 215 days on the 2003-04 figures; and the program contracted 45 locums in 2004-05, a rise of 16 on 2003-04 figures.

The increase of Stop Gap requests should be noted as these are directly related to the critical GP workforce shortage in the NT and the increased number of vacancies in established GP positions in remote areas. These positions are often taking between nine and twelve months to fill, and in some cases longer.

The program provides subsidised affordable locum relief for each remote GP position in rural and remote areas across the NT.

Ability to Respond 2004-05

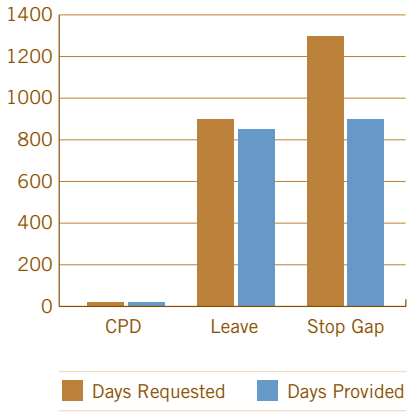


Figure 1: Days Requested and Days Provided

The graph above indicates the days of locum support requested and days of support provided in 2004-05.

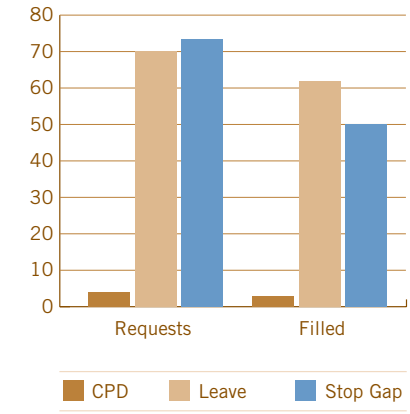


Figure 2: Types of requests made and requests filled for locum support

This graph indicates that GPPHCNT met 90% of leave requests made and 69% of stop gap requests were met. 20% of all requests could not be met, which totalled 595 days.


Children of Milingimbi - GPPHCNT

The program is acknowledged by GPs and medical services as the single most important service provided by GPPHCNT to support incumbent GPs.

By providing the opportunity for rural and remote GPs to take regular leave, the program plays a significant role in retaining GPs, assists in attracting GPs to take up practice in rural and remote areas, and ensures that communities have continuing high quality medical care during the necessary absences of resident GPs.

GPPHCNT also produced a user guide: *'NT GP Locum Program: A Practical Guide'*, which was published in March 2005. The publication provides a practical guide to all aspects of the NT GP Locum Program and is specifically targeted at incumbent GPs, practice/clinic managers, health board staff and locum GPs.

As the GP Locum Program continues to expand in the NT, the workforce team is looking at innovative and different ways of attracting and retaining regular locum GPs for rural and remote communities. New initiatives currently identified for 2005-06 are:

- Expanding the GP locum pool by offering competitive salaries and a targeted national recruitment process to attract two or three full time locums, as this will provide greater flexibility to cover the increased requests.
- Different strategies to attract GPs to the Territory, using the unique lifestyle and the challenges of Indigenous health in the Territory as focus points.
- Covering the cost of GP spouse travel over peak periods, i.e. mid year school holidays, Easter and Christmas, to enable travelling GP locums to maintain contact with their families and provide some support and respite from solo travel and placements.
- Exploring opportunities to develop ongoing relationships between regular locum GPs and specific health services as a means of providing continuity of health delivery and quality care and improving GP job satisfaction.

GP Recruitment and Retention

During the 2004-05 financial year, GPPHCNT successfully recruited six GPs in Rural, Remote and Metropolitan Areas classification (RRMA) 6 or 7 GP positions with two of the recruits being OTDs.

These doctors took up positions at:

Central Australian Aboriginal Congress, Yuendumu	(1)
Central Australian Aboriginal Congress, Alice Springs	(1)
Kakadu Health Service – Jabiru	(1)
Pintubi Homelands Health Service, Kintore	(1)
Miwatj Health Service, Nhulunbuy	(1)
Kunbarllanjnja Community Government Council, Oenpelli	(1)

Throughout the year GPPHCNT assessed 570 GP applications/CVs which included 43 specific vacancy applications. Of these, 374 were from OTDs. An additional 15 doctors were referred to the NT DHCS for hospital employment. GPPHCNT submitted 19 applicant CVs for preliminary assessment by the NT Medical Board.

During the reporting period GPPHCNT has been actively assisting Communities/Local Government Councils to recruit to vacant GP positions in the following areas: Alice Springs, Alyangula, Borroloola, Galiwinku, Katherine, Katherine East, Mutitjulu, Nhulunbuy (Gove) Numbulwar and Tennant Creek.

Exploring Sustainable GP Models – Tennant Creek Working Party

GPPHCNT together with the Tennant Creek Town Council in March 2005 established a working party to examine a variety of models that would ensure sustainable GP services to Tennant Creek. This initiative followed the re-location of the incumbent GP to Darwin at the beginning of 2005.

Western NSW has faced similar crises in recent years and new private practice models have been devised ("Easy Entry, Gracious Exit" recruitment and retention models) in which consortia involving town councils and other groups have bought or secured otherwise unsustainable clinics and managed them, enabling GPs to come and go without requiring their long term financial investment. GPPHCNT assisted the Tennant Creek Town Council to convene the working party, with a view to exploring whether similar models might be appropriate for Tennant Creek.

The working party was comprised of the NT DHCS Services, AGDHA, Tennant Creek Council, GPPHCNT, CADPHC as well as valuable input from the Royal Flying Doctor Service SA/NT.

Expert advice was sought from the NSW Rural Doctors Network (NSWRDN) and GPPHCNT brought Mr Mark Lynch to the Northern Territory to assist the working party and to utilise NSWRDN expertise in the development of managed general practice models suitable for the NT. The working party has identified a model for a sustainable General Practice for Tennant Creek and is in negotiations with potential service providers.

GP SUPPORT GRANTS

GPPHCNT provides financial and other support to GPs during the recruitment and relocation process, including funding site visits and ongoing support including RAGs to sustain remote GP positions.

Remote Area Grants

During the 2004-05 year 17 RAGs were issued totalling $578,500. RAGs are provided to support GP positions in remote locations.

Review of Remote Area Grants Program

In early 2005, Human Capital Alliance, an external consultancy firm with extensive experience in health service evaluation, was contracted by GPPHCNT to undertake a review of the RAG program. The review involved extensive consultation with key stakeholders, including twelve of the fourteen services currently in receipt of a RAG in the Northern Territory. The review was completed in May 2005, and the findings were presented to the Board of GPPHCNT.

Key findings from the review highlighted that the use of RAGs has shifted significantly from their original intention. The original purpose of RAGs was to provide "seeding grants" that would assist new GP positions to be established, and to offset a proportion of the salary cost of employing GPs in remote locations in the Northern Territory. For various reasons RAGs have tended to become seen as an ongoing source of recurrent annual funding or "safety net" for services, which was not the intention of the program. As all available grant funds have been continually committed to existing recipients, this has prevented GPPHCNT from offering grants for new GP positions or to areas which have not previously received funding. Anecdotal information collected during the review also suggests that reliance on RAGs may in some cases have acted as an unintended disincentive for some services to maximise Medicare income.

The GPPHCNT Board considered the findings of the report, and made several important decisions in relation to the future direction of the RAG program. The aim of these changes is to ensure that the grant allocation system is responsive and flexible, and that grants are targeted to the areas of highest relative need, including new GP positions and areas which have not previously received grants. GPPHCNT will assess relative need by examining the financial situation of grant recipients, along with population figures and population/practitioner ratios. Areas with higher income from all sources per person in the catchment population will be considered to have lower relative need than those which are less well funded per capita; at the same time services will be encouraged and supported to maximise their Medicare income, so as to reduce reliance on recurrent funding grants such as RAGs. Over the longer term, grants will be refocused on seeding new positions and on dealing with areas of potential or actual crisis.

"The aim of these changes is to ensure that the grant allocation system is responsive and flexible, and that grants are target to the areas of highest relative need..."

Relocation Grants

Six Relocation Grants, of a total value of $34,344 were approved this financial year.

Relocation grants are provided in order to remove barriers to GPs taking positions in rural and remote NT. As the costs involved in relocating to rural and remote NT can be significant, these grants cover the costs associated with moving the GP, the GP's family and their belongings to a new position.

Orientation & Training Grants

Six Orientation and Training Grants totalling $15,727 and two Site Visit Grants totalling $4,366 were allocated during the period.

The purpose of an Orientation and Training Grant is to ensure that a GP taking up a new position in the NT is appropriately orientated to the practice and has the clinical skills to meet the needs of the community. Site visits allow GPs to assess the feasibility of living and working in a specific location they are considering.

Continuing Professional Development (CPD)

GPPHCNT provided significant financial support to the two NT Divisions of General Practice, to assist with providing equitable access to continuing professional development for practitioners from rural and remote areas, and to enable the Divisions to fund family support activities alongside major CPD events.

TRAINING AND SUPPORT ACTIVITIES

Rural Emergency Skills Training Program (REST)

GPPHCNT in partnership with CADPHC and the RWAV conducted a REST workshop in Alice Springs on 5th – 6th March 2005 at the Centre for Remote Health, for 15 remote practicing GPs.

REST is an accredited two day emergency medicine life support course developed by the RWAV designed for rural GPs and delivered by rural GPs and other specialist instructors.

The REST program teaches participants a standardised approach to the management of a comprehensive range of paediatric, trauma, medical and psychiatric emergencies. The program aims to enhance the confidence and skills of GPs in the initial assessment and stabilisation of emergency presentations through the use of skill stations and scenarios.

Overseas Trained Doctors 5-year Scheme

At 30 June 2005 there were 21 doctors accepted for the 5-year scheme in the NT. There are currently eight OTDs who are active on the scheme that have achieved fellowship with Royal Australian College of General Practitioners (RACGP).

In the Northern Territory, GPPHCNT administers the scheme and applications are assessed by a panel consisting of representatives from RACGP, Australian College of Rural and Remote Medicine (ACRRM), NT DHCS and the GPPHCNT Medical Adviser.

This scheme was introduced by the AGDHA to help address problems of general practice workforce shortages in rural and remote Australia.

Support for Overseas Trained Doctors in the NT

GPPHCNT successfully secured funding from the Commonwealth to assist OTDs on the 5 year OTD scheme to achieve Fellowship of the Royal Australian College of General Practitioners (FRACGP).

GPPHCNT is contracted to provide case management support to eligible OTDs and engage appropriately skilled Medical Educators to develop individual learning plans for each doctor. GPPHCNT is working with specialist GP training providers to provide individually tailored training and revision courses to meet each doctor's needs. Capped funding is being provided to improve OTD access to relevant learning materials, tutoring and courses.

It is envisaged that individual support and personalised training aspects of this initiative will better equip OTDs to successfully complete and achieve fellowship.

Rural Retention Program: Flexible Payments System

The Rural Retention Program is a Commonwealth Health Insurance Commission (HIC) initiative which provides GPs with financial incentives to continue working in rural and remote areas.

Kata Juta - GPPHCNT

During the financial year to 30 June 2005, GPPHCNT received and assessed approximately 25 applications for flexible payments which were submitted to the HIC.

ABORIGINAL HEALTH WORKER ASSOCIATION NT FEASIBILITY STUDY

In September 2004, GPPHCNT, with the support of the Northern Territory Aboriginal Health Forum's Workforce Issues Committee, was contracted by the OATSIH, to undertake a feasibility study into the establishment of an Aboriginal Health Worker Association (AHWA) for the Northern Territory.

The goal of the study was to develop recommendations on the purpose, objectives, membership, governance structure, funding needs and funding options for an AHWA for the NT; as well as to propose next steps in the development of such an association, and to identify priority issues to be addressed as future outputs.

Under the guidance of a Steering Committee made up of representatives of the partners to the NT Aboriginal Health Forum, GPPHCNT engaged a Project Officer to undertake consultations with AHWs and other key stakeholders across the NT. These consultations took place between October and December 2004. The final report of the feasibility study was based on stakeholder views expressed in the consultations, on documentary research, and on input provided by steering committee members.

The report was unequivocal in its key recommendation that an NT AHWA be established immediately in recognition of the need to support and enhance the AHW profession in the Northern Territory. The report called on the Australian and NT governments to provide funding for the Association over the initial two year establishment period with a view to identifying additional sources of income.

RURAL HIGH SCHOOL VISITS PROGRAM

The Rural High School Visits Program (RHSVP) is a health careers initiative which was introduced as a pilot program to the NT by the NTRHWA in 2002. The aim of the program is to raise awareness about health career options to both Indigenous and non Indigenous secondary students who would not normally receive the opportunity for direct exposure to this type of information.

To ensure that the multi disciplinary aspects of health careers receive adequate focus in the program, ten interstate medical and allied health students are brought to the NT in order to successfully deliver the program. Undergraduate nurse applicants if suitable are selected from within the NT from courses presently available.

"The report was unequivocal in its key recommendation that an NT Aboriginal Health Worker Association be established immediately in recognition of the need to support and enhance the AHW profession in the Northern Territory."

Warakurna Community - GPPHCNT

"...some students as a result of their experience in the NT have been inspired to return to rural and remote areas to work upon graduation"

By collaborating closely with the local rural health club, Central Australian Remote and Aboriginal Health (CARAH) Club, GPPHCNT in 2003 and 2004 expanded the program and achieved higher participation rates of Indigenous students and schools throughout the NT in each of the years the program has run. In 2004, the program expanded to include 17 workshops with 20 participating schools and 451 students in total.

In July 2004, GPPHCNT was contracted by OATSIH to deliver the first RHSVP in the Top End of the NT. The Top End program was conducted from 25th – 31st July and involved visits and workshops at 9 schools involving GPPHCNT personnel and undergraduate health students from across Australia. The schools visited were: Darwin High School, Kormilda College, Taminmin High School, Palmerston High School, Jabiru Area School with students from Gunbalanya Community Education Centre also attending, Katherine High School, Yirrkala Community Education Centre and Nhulunbuy High School.

The promotion of health professions to rural secondary students is a strategy used by the National Rural Health Network (NRHN) to aid in the recruitment and retention of rural health professionals. Additionally, the undergraduate medical and health science students involved are exposed to primary health delivery and unique Indigenous health issues in rural and remote settings. Anecdotal information suggests that some students as a result of their experience in the NT have been encouraged and inspired to return to rural and remote areas to work upon graduation from university.

Unfortunately, the program has not received ongoing Australian Government funding to continue. However, GPPHCNT believes this innovative program has long term benefits in terms of growing Australia's medical and health workforce, and has earmarked resources to invest and to deliver this successful program in 2005-06.

SOUTH AFRICAN NEONATAL RESUSCITATION PROJECT

This project had its genesis at the World Organisation of Family Doctors (WONCA) Conference in Spain in September 2003 following discussions between Professor Ian Couper, Professor of Rural Health, Witwatersrand University, Johannesburg, South Africa and Dr Jane Greacen, CEO RWAV. Professor Couper expressed the view that neonatal resuscitation skills could be improved in the rural areas of South Africa and the neonatal mortality/morbidity would thereby be improved.

Following various discussions it was agreed that a partnership involving GPPHCNT, RWAV and the Department of Rural Health, South Africa would develop a training program to teach the remote doctors and midwives neonatal resuscitation skills and that

GPPHCNT Medical Adviser Dr Jim Thurley was eminently qualified and experienced to deliver the program in South Africa. This project was also identified as an opportunity under the terms of the Melbourne Manifesto to give something back to South Africa in recognition of the number of doctors that Australia had recruited from that area.

The program was conducted by Dr Jim Thurley in South Africa from July to October 2004, to coincide with the Southern African Resuscitation Society's Annual Scientific Update. The program contained two components, a Neonatal Resuscitation Program and a Train-the-Trainer Program. The Neonatal Resuscitation course consisted of a pre-course multiple choice question paper, a series of lecture presentations, skill stations, scenarios and a post-course multiple choice question paper. Using elements of Train-the-Trainer Manual for General Practitioners developed by RWAV and lectures prepared by Dr David Campbell, Medical Educator, RWAV a 'Train-the-Trainer' course was also developed.

Thirty seven courses were held in 28 different sites in eight of the nine South African Provinces. A total of 415 people were trained, comprising of 293 females and 122 males, of which 215 were nurses, 192 were doctors and 8 were paramedics. Three medical students took part as observers.

Ninety two percent of all people who did the course and 98% of people in their evaluation said that after the course they were more confident in neonatal resuscitation.

Twelve Train-the-Trainer Courses were held for 97 people. These trainers have continued to conduct neonatal resuscitation courses and there are currently plans to undertake a formal evaluation of the project and to gauge its impact on neonatal mortality in the regions where the course was conducted. GPPHCNT is pleased to have had the opportunity to contribute to saving babies' lives in disadvantaged communities in South Africa.

divisional support and policy activities

The role of the Divisional Support and Policy team is to build the capacity of Divisions to achieve expected outcomes and to link with State Governments and other agencies to achieve health integration at the state level. This role includes identifying and promoting best practice and knowledge sharing at the state and territory level and supporting individual Divisions in performance and quality improvement. The team also brings together key players in the non-government primary health care sector and takes a leadership role in policy development and advocacy in priority areas. Lobbying for Territory issues and differences to be considered and included in national policy and funding is a key part of the team's role. In addition to broad support and advocacy for NT Divisions, and a range of policy work, the specific programs currently covered by the team include Mental Health, Immunisation, Broadband for Health, Practice Nursing, Aged Care and National Primary Care Collaboratives (see individual reports) as well as Chronic Disease, and Lifestyle Prescriptions.

"...identifying and promoting best practice and knowledge sharing at the state and territory level and supporting individual Divisions in performance and quality improvement"

CURRENT ACTIVITIES

The Divisional Support and Policy team has worked actively on developing closer relationships with the two Divisions, TEDGP and CADPHC, adopting a triumvirate approach to major tasks and issues currently facing the Divisions network. GPPHCNT established an inclusive process on organisational requirements such as the new Planning and Reporting Framework where we worked in concert to ensure our plans reflected a united front on program delivery and employed a three way educational approach to ensure all three organisations were clear on departmental requirements and expectations. We have also researched providers for organisational accreditation, and driven the decision making process which has resulted in cost and time savings for the three organisations and a clear understanding of the process and the commitment required.

The team is also developing and enhancing closer working relationships with external agencies and local primary health care services including: National Asthma Council (NAC), Healthy Living NT, Menzies School of Health Research, Council of Remote Area Nurses of Australia (CRANA), CRH, and the Centre for Disease Control (CDC); and will continue to develop cross-agency ties.

We advocate strongly and consistently for NT and Indigenous issues at every opportunity and in all arenas, and also lobby for changes to funding models and for all national government initiatives in General Practice and Primary Health Care to include and acknowledge the Territory perspective. This includes continual reinforcement and education on geographical isolation, sparse population, travel costs, Indigenous issues and cultural differences, environmental challenges, social deprivation and loneliness, diverse standards of living, overwhelming presence of chronic disease and dealing with high instances of substance abuse and physical violence. Understanding and appreciation of these factors does appear to be improving on some fronts and we will continue to foster this growing awareness at all levels.

MENTAL HEALTH

The Mental Health Program continued with many achievements over the past year, with a new Development and Liaison Officer (DLO) joining the organization in June 2004 and remaining in the position until March 2005. Major accomplishments included the completion of a paper around "Remote / Rural Mental Health Issues in the Northern Territory – Strategies for Improvement". The paper discusses issues which contribute to health service difficulties in the NT, such

as access, the lack of multi-disciplinary approach to mental health service delivery and coordination, the need for more collaboration and integration between funding bodies and further training for staff working in remote communities around Indigenous, culturally and linguistically diverse and refugee consumers. It also talks about the importance of Indigenous health workers (including traditional healers), who are an under-acknowledged group requiring more advocacy for recognition, career structure and a registration process for their work. Other suggestions to improve the delivery of mental health services in the NT include an identified integrated youth specific mental health service (particularly in Darwin and remote / rural areas), a step-down unit/strategy from the hospital ward before the person is discharged, improved information technology services and the development of a broad based mental health resource kit to support staff in remote areas.

Ongoing DLO involvement also continues with the Better Outcomes in Mental Health Care Initiative and as secretariat and chair of the NT Mental Health Intersectorial Reference Group (NTMHIRG), along with representation at many other forums, including the NT Government's Co-existing Disorders Project Steering Committee.

Following the DLO's departure in March 2005, GPPHCNT worked on redefining the mental health project via the development of a scoping paper. This includes a background paper providing general information about the history of the mental health programs and initiatives in the NT and Australia wide, with particular focus on the work of the two NT Divisions, the SBO and other NT stakeholders. The second major focus of the scoping paper is a future directions paper with suggestions for the Mental Health Project and the role of the DLO within GPPHCNT, in order to better forward the mental health initiatives of the Commonwealth and NT governments and non-government organisations. It also focuses on researching pilot projects and national and local mental health initiatives with the view to linking them up to Division's current programs and initiatives. Examples include resources gained from Western Australia's HEALTH RIGHT initiative which addresses the recent findings regarding physical health of people with mental illness and the Perinatal and Infant Mental Health in the Community Project (PIMHIC) which currently operates in urban SA, with an Indigenous version being developed for piloting early next year in rural SA.

TEDGP continues to deliver robust programs including their nationally recognised Aboriginal Mental Health Worker Program, the Tamarind Centre Program and new initiatives such as the National Alcohol and Mental Health Co-morbidity Project. CADPHC recently employed a new mental health program manager and is in the process of applying for funding under the Access to Allied Health Initiative. GPPHCNT intends to focus on providing maximum assistance to CADPHC in order to obtain funding and progress new mental health programs.

IMMUNISATION

The GPPHCNT Immunisation Coordinator role in the Northern Territory is part of a network of State-Based Organisation Immunisation Coordinator (SBOIC) positions across Australia. In the NT, this role is currently sub-contracted by GPPHCNT to the two NT Divisions and is shared equally on a part-time basis between the two NT Divisional Immunisation Project Officers.

Funding for this position has come from the General Practice Immunisation Incentives (GPII) Scheme, which was implemented in July 1998 as a part of the national Seven Point Plan for Immunisation.

The GPPHCNT Immunisation program strives to improve immunisation coverage rates and the quality of vaccination services in the Northern Territory. The major aim is to encourage at least 90% of practices to have at least 90% of children aged seven years and under who attend their practice fully immunised, through participation in the GPII Scheme.

Key Activities in 2004-05:

Childhood immunisation rates according to GPII figures are at their highest levels ever, with both Divisions achieving over the targeted 90% coverage in the most recent recalculated statistics, February 2005. Increased engagement of the Australian Childhood Immunisation Register (ACIR) Field Officer has assisted in achieving this milestone.

Community Pool - GPPHCNT

The provision of immunisation resources has been one focus this year. Our biggest accomplishment was to assist the TEDGP to gain funding and print a 2nd edition of the *'Immunisation For All'* resource for use in the Top End. This resource is useful as a practitioner's guide, with client education and promotion components. Other resources provided to Divisions were coloured cold chain graphs, paper based chart labels and consumer promotional materials.

Ensuring adequate representation of NT issues at a national level was another focus. Through our SBOIC network, we were able to advocate for issues regarding purpose built vaccine fridge problems and the need for national data; Remote Area Nurses (RANs) being allowed access to Practice Nurse scholarships for immunisation courses; and improvements to the National Indigenous Pneumococcal and Influenza Immunisation (NIPII) Program.

Further advocacy and collaborative roles were also developed within the NT. Highlights included assisting the NT CDC with the implementation of the NIPII program this year, and ensuring that for the first time, AMSANT was included in this process. Data from Divisions about problems with purpose-built vaccine fridges was also provided to CDC for compilation of NT-wide data. GPPHCNT also continues to facilitate the quarterly NT Immunisation Interagency meeting for the 5th year.

Future Directions

Strategic involvement in Influenza Pandemic planning has already begun in collaboration with CDC and the NT Divisions. Other interagency issues on the agenda relate to vaccine fridge problem solving; participation in a national vaccine fridge survey; issues regarding the administration of the vaccine providers course; and continued administration of the NIPII program. We are also looking forward to assisting Divisions in the areas of HIC On-line.

BROADBAND FOR HEALTH

Broadband internet access offers significant advantages for clinics, particularly those in remote locations, including streamlined business processes and access to online databases and decision support tools. Broadband For Health (BFH) is a $32 million Commonwealth initiative to provide subsidised broadband connections to GP clinics and Aboriginal Community Controlled Health Services (ACCHS). It has demonstrated a successful collaboration between the Divisions of General Practice network and AGDHA. BFH officers were contracted through each State Based Organisation (SBO) except the ACT, forming an effective network to investigate and support the rollout of broadband to clinics.

Uptake in the NT has been high, with 52% of the 121 eligible sites subsidised overall. ACCHSs have been the highest adopters, with 45 of 71 clinics subsidised. Top End urban clinics remain the lowest uptake demographic, with private GP uptake across the NT being 14%.

From 1999 to 2003 a network of Information Management / Information Technology (IM/IT) support capacity was developed at the Division level through a Chronic Disease Management initiative, which greatly assisted the computerisation of General Practice in Australia, now around 90% of clinics. In the absence of a functional IM/IT capacity in most Divisions, the SBO officers endeavoured to ensure that the plans available under the initiative were appropriate for use in clinics, and to monitor their uptake. Information on how to apply for the initiative and appropriate security for general practice was supplied through Division newsletters, information sessions, clinic visits and cold calling. Over 90% of eligible clinics were contacted in the first year.

The core of BFH is a market of qualified plans, whereby internet service providers contract to provide a service meeting a set of conditions. Eligible clinics taking up one of these plans can apply for the subsidy, which in the first year was set by the cheapest available plan, however has now shifted to a capped maximum set by a measurement of the remoteness of the clinic under RRMA classification system. The officers worked actively to identify and resolve issues with these plans that affected the security and useability for clinics. Successes in the NT included one satellite provider agreeing to supply a device with their service to allow the connection to be shared by all users of the local clinic network, and the decision by AGDHA to fund ISDN connections if requested by clinics, that were otherwise outside the scope of the initiative.

The ACCHSs have demonstrated many complex eligibility issues and requirements, with around 10% of all NT clinics being owned by NT DHCS, which is a criterion for ineligibility, and many services needing to link up multiple sites to a central clinical database. In response AGDHA initiated a study to show the utility of the plans for providing clinical information systems over wide areas. The report "PIRS Systems Over Satellite Mediated Wide Area Networks" has shown the value of managed networks, which provide end to end support for clinic's systems. These developments are being actively pursued by many in the sector, and it is hoped that outcomes delivering improved sustainability for remote clinic IT systems will be directly found from this work.

Secure broadband connections in clinics are an essential building block both for secure messaging (eg. electronic referrals and discharge summaries) which GPs identify as the most pressing requirement, and for broader initiatives. HealthConnect is a federal project to create a national electronic health record, and recent comments from Federal Health Minister Tony Abbott indicate a national agenda to achieve results in this area within the next 12 months. Emerging technologies, such as Voice Over Internet Protocol (VOIP) which enables businesses to make cheap or free telephone calls, and is now available in rapidly maturing consumer focussed products, will continue to drive broadband takeup into the future.

"Secure broadband connections in clinics are an essential building block both for secure messaging and for broader initiatives."

Darwin sunset - NTTC

In addition to increased funding in remote areas, another major development is the Security Awareness and Conformance Report. Based on the General Practice Computing Group's IT security checklist, the report will help identify security requirements, and address them with a $1,000 incentive payment.

BFH has been an opportunity for the Divisions network to show its capacity to engage the sector. For example, when AGDHA requested feedback on the proposed form of the second year of the initiative, it took the SBO BFH team only around 2 weeks to survey 130 responses, of which 62% were from GP clinics and 4 responses were from ACCHSs. Most interestingly, it showed that the key application GPs want from broadband is secure electronic messaging, rather than emerging technologies like videoconferencing. This has helped shift the focus of the second year onto securing quality connections for broadband adopting clinics, rather than focussing on emerging value added products.

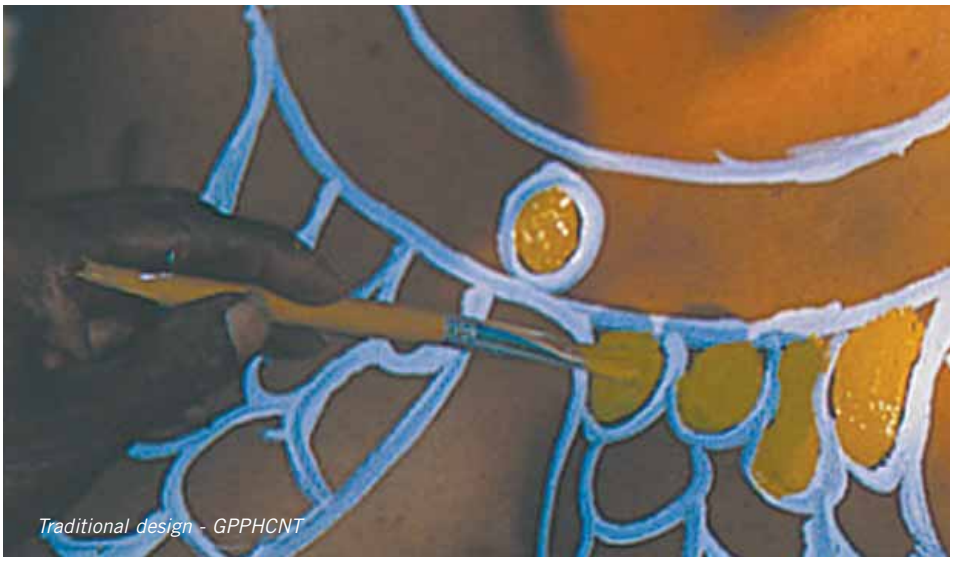
NURSING IN GENERAL PRACTICE

The aim of this Project is to build the capacity in Divisions to increase support services for practice nursing in the Northern Territory. This is to be accomplished by assisting Divisions to extend the development of programs and maintain support services for practice nurses by coordinating and funding training opportunities for practice nurses across the NT.

The Project

The Practice Nurse Program Coordinator (PNPC) commenced with GPPHCNT in May 2005, and this is a new position within the organisation. Having a dedicated PNPC ensures NT responds to the needs and priorities of local general practices and nurses, tailoring programs to meet these needs.

"...the role of the nurse is becoming increasingly recognised as an integral part of primary health care"



Traditional design - GPPHCNT

As Nursing in General Practice is further advanced in the specialisation of general practice with well documented role description, competency standards, career and educational pathways and professional organisational support, the role of the nurse is becoming increasingly recognised as an integral part of primary health care. Working collaboratively with Divisions, it is expected to reduce duplication, address cross border issues, broker training partnerships and improve training opportunities across the Territory. It is hoped that the project funding will be extended beyond its current end date of December 2005 to enable the long term visions for this project to be realised. It is envisaged that as GPs and Nurses embrace the opportunities of increased responsibility, continued flexibility and increased specialisation, practices will be in a better position to meet their targets and extend the range of services offered to the patient.

Achievements and Outcomes

- Completing a needs assessment and plan for each Division in the Territory including a 6 month strategy and a three year plan.
- Assessing training and education requirements of practice nurses in NT taking into account:
  - local general practice needs
  - current Government priorities
  - available courses, trainers and costs of delivering training
  - distance education opportunities
  - nursing in general practice competency standards
- Coordinating and directing the project in conjunction with the ADGP.
- Coordinating the Demonstration Divisions role in providing mentoring, advice and materials to assist the SBO and Divisions in meeting the project objectives.
- Establishing collaborative relationships with other training agencies including CRANA, Australian Practice Nurses Association (APNA) Remote Health and Workforce Development and NT DHCS.

AGED CARE

Residential Aged Care Facilities (RACFs) have been finding it increasingly difficult to keep the services of GPs who can provide regular consultations for residents. This is especially the case where a resident does not have a regular doctor. Data suggests that services are provided by a small proportion of GPs and that this proportion is shrinking. At the same time, the number of RACFs and residents is increasing as the Australian population ages and there is also evidence that the proportion of these residents with high care needs and complex conditions is increasing. This juxtaposition has led to ineffective management of chronic conditions leading to otherwise avoidable acute episodes and poor access of aged care home residents to appropriate urgent and after hours medical care.

To address this situation, the Australian Government introduced the Aged Care GP Panels Initiative, effective July 2004 and its aim is to improve access to primary medical care for residents of RACFs and to enable

GPs to work with RACFs to assist with quality improvement strategies for the care of all residents. GPs who participate in the Panel can receive funding in addition to accessing relevant Medicare items for any services provided directly to the residents.

Activities

Fully operational GP Panels, with defined agendas for action, have been established in both NT Divisions, however staff turnover delayed implementation in Central Australia. Inadequate access to GPs was a priority issue in the Top End but not in Central Australia where the rates of service are comparable to the national average. MBS data shows some increases in the level of GP service provision to RACFs in the NT over the 2004-05 financial year. However without a marked improvement in the GP to population ratios, the incentives for GPs to leave their surgeries to visit RACFS remain limited.

Central Australia's priorities were to provide specialist geriatric training for RACF staff and GPs and to improve RACF on site IT/IM to support GPs integrating medical and medication management between their practice and the RACF. A South Australian geriatrician has since been visiting Central Australia to provide training and also carries out a number of Comprehensive Medical Assessments for residents during his visits. A laptop has been purchased and dial up connections installed which has enhanced good use of GP time and health outcomes for residents by streamlining the consultation and medication process.

Other issues currently being addressed by both panels include medication management processes, RACF visit protocols and access for remote Aboriginal aged care residents

GPPHCNT is represented on the panels of both Divisions and advocates for issues of concern at national level as well exploring common issues and opportunities for resource sharing. A face-to-face meeting with AGDHA, ADGP and all SBOs is being held on 1 July and the issue of PBS acceptance of Medical Charts in RACFs will be raised by the NT. The Aged Care SBO network teleconferences monthly to discuss activities in each state, report to AGDHA, raise hot issues and share information from the Aged Care GP Panels initiative.

NT PRIMARY CARE COLLABORATIVE

The NT Collaborative is managed by the NT Collaborative Consortium involving the three divisional organisations in the Northern Territory – GPPHCNT, TEDGP and CADPHC. These three organisations, with GPPHCNT as lead agency, are all signatories to a Service Level Agreement with Flinders Consulting Pty Ltd which formed the NPCC to implement the Collaborative program for AGDHA. The Department also entered into an agreement with the UK National Primary Care Development team to deliver standard support materials and training on the UK collaborative methodology and processes to the NPCC.

In concert with the NPCC, the goal of the NT Collaborative is to assist general practices in developing their capacity to deliver rapid, sustainable and systematic improvements in the care they provide to patients and their communities, through a sound understanding and effective application of quality improvement methods and skills.

In accordance with the NPCC, the NT Collaborative has three aims for participating practices:

- Better access to primary health care: 90% of patients to have access to primary provider routinely the next working day.
- Better management of diabetes: 50% of patients with diabetes have a HbA1c of 7 or less.
- Better management of coronary heart disease (CHD): 30% reduction in mortality of patients with CHD in 3 years.

The Collaborative program consists of three waves – each wave is of nine months duration and includes a series of three learning workshops with action periods in between and afterwards to deliver real improvements in practice. The workshops allow practices to learn from each other and provide protected time for them to formulate plans for action. One of the great strengths of the workshops is that they provide a safe and supportive environment where peers are able to actively share, debate and learn from each other.

The first wave began in April 2005. NT practices involved in the first wave are: Anyinginyi Health Aboriginal Corporation, Tennant Creek; Central Australian Aboriginal Congress, Alice Springs; Central Clinic, Alice Springs; Cavenagh Medical Centre, Darwin; Fred's Pass Medical Centre, Humpty Doo; and Katherine West Health Board's Kalkaringi Clinic.

PROGRAMS

Chronic Disease

GPPHCNT has been active in a number of areas within the Chronic Disease Management program.

- Attendance at the NT DHCS Renal Strategy 2005-09 information session and input into the draft strategy document. The final document was recently launched by Dr Peter Toyne in Alice Springs.
- Collaboration with NAC, CADPHC and SA Division of General Practice to pool available national funding to deliver Asthma 3+ training to remote SA and WA areas. This model has been nationally commended with additional divisional funding offered and further discussions to implement 3 way model (Asthma, Diabetes, Practice Nursing) are underway at a national level.
- Attendance at and input into workshops on the National Chronic Disease Strategy and National Service Improvement Frameworks, joint Federal Government initiatives to provide a consistent and coordinated approach to chronic disease prevention and management across Australia.
- Member of the Chronic Diseases Network Steering Committee for the 9th Annual Conference.
- Participation in the Service Planning Workshop for Enhancement of the NT DHCS Chronic Pain Services to comment on the draft paper and drive implementation of the service in the NT.

Lifestyle Prescriptions

Funding was recently offered to GPPHCNT for the Lifestyle Prescriptions Initiative, which includes tools for GPs to encourage lifestyles that optimise health. However, particularly in the absence of specific resources relevant to Aboriginal health, the initiative was not identified as a high priority area by the NT Divisions and we were unable to implement the program in its existing form. The team has remained very much in the loop through ADGP, AGDHA, University of NSW and VicFit and options to explore funding for the NT to be utilised in alternative ways are being discussed, including the possibility of working on the inclusion of Indigenous material for the initiative. Some interest in the program has also been shown by two departments within NTDHCS.

Other

The team has also been involved in developing marketing materials, scoping the production of a quarterly GPPHCNT newsletter, liaison with Palliative Care organisations and programs including the Program of Experience in the Palliative Approach (PEPA NT) and the *Standards for Providing Quality Palliative Care for All Australians (2005)*, and participating on the committee for the SA/NT Divisions Forum and producing GPPHCNT's display. In 2005-06, the team looks forward to working as a close-knit unit to enhance the delivery of Primary Health Care in the NT by knowledge sharing and exploring cross-program opportunities to produce effective, economical and meaningful results.

POLICY AND ADVOCACY

The policy section of GPPHCNT is responsible for researching and analysing health service delivery policy and programs, assisting the GPPHCNT Board in developing and drafting proactive policy, and responding to government initiatives in the area of General Practice and Primary Health Care. The role involves developing background and option papers, reports and presentations, as well as working closely with GPPHCNT's clients, government and health sector agencies and Indigenous and community stakeholders.

Pivotal to all policy work is lobbying for the issues specific to the NT, such as remoteness and Indigenous health, to be recognised and included in national policy and funding. GPPHCNT strongly advocates for NT and Indigenous issues at every opportunity and in all arenas.

In all its policy development and advocacy work, GPPHCNT follows its 'Policy and

Procedures for GPPHCNT Policy Development' which were developed in 2004 and reviewed and updated in 2005. This protocol ensures that GPPHCNT's Board and member organisations actively shape its policy positions.

Activities and Achievements

In 2004-05, GPPHCNT:

- In consultation with the two NT Divisions developed and submitted a combined NT submission to the *'Australian Government's Response to the Report on the Review of Divisions of General Practice'*, which set out the Government's vision of the role of Divisions in the reform and delivery of primary health care in Australia.
- Following a consultation process with stakeholders, produced a comprehensive position statement on issues involving the recruitment, training and retention of OTDs, particularly those working in rural and remote NT.
- Held a large multi-stakeholder workshop on recruitment and retention of GPs in rural and remote NT. The resulting 'Darwin Statement on Sustainable General Practice in Aboriginal Primary Health Care in the NT' establishes a set of principles, benchmarks and recommendations in relation to recruitment and retention of doctors in remote areas. The Statement has been endorsed by all major organisations in the NT's primary health care sector.
- Together with TEDGP, engaged in sustained and consistent lobbying which resulted in Darwin being awarded with an 'Area of Consideration' status and increased Medicare bulk-billing incentives. Both these measures are expected to significantly assist in the recruitment and retention of GPs in the Darwin area.
- GPPHCNT had a major role providing policy input which shaped the roll out of the NPCC program. This included providing a paper to the NPCC Consortium discussing issues affecting the implementation of the NPPC program in the NT.

Bogged at Borroloola - GPPHCNT

- In consultation with its stakeholders, developed and submitted a response to the AGDHA review of the RRMA Classification System. GPPHCNT advocated that, alongside the current geographical factors on which the current RRMA system is based, the key indicators of the new or revised system are the level of access to primary health care available to and the health and well being of the community. GPPHCNT also advocated for reclassifying Darwin from a RRMA 1 (attached to all Australian capital cities) to a RRMA 3 status to more appropriately reflect Darwin's reduced access due to its remoteness, lack of infrastructure, difficulties in employing and retaining health workforce professionals and higher burden of disease, especially amongst its Indigenous population.

Other policy input provided by GPPHCNT during 2004-05 includes:

- An NT response to ADGP's discussion paper on the 'Role of the Practice Nurse';
- Development of a Primary Health Care Definition Statement, subsequently endorsed by the two NT Divisions, as input into ADGP's work on a National Primary Health Care Policy framework;
- Participation in consultation process through attendance at the NT wide "National Alcohol Strategy Consultation Forum" held in Darwin on 7 June 2005.

"the team looks forward to working as a close-knit unit to enhance the delivery of Primary Health Care in the NT to produce effective, economical and meaningful results."

corporate services activities

The 2004-05 financial year was a busy one for the Corporate Services Branch, which supports all GPPHCNT staff and programs particularly through financial management, administrative support, and human resource management.

MERGER

Corporate Services Branch played a key role in the operational aspects of the merger of the former remote health workforce agency and state based organisation, to form GPPHCNT. The operational aspects included clarifying and then merging the two previous organisations' finances, and creating new finance systems for GPPHCNT; novation of all government grants from the two previous organisations to GPPHCNT; conversion of all supplier, staff, and grant recipient contracts from the two previous organisations to GPPHCNT; management of the governance aspects of the merger; and compliance work with the NT government and the Australian Taxation Office. The merger was formally completed on 1 October 2004.

FINANCIAL MANAGEMENT

Following clarification of the financial standing of the two previous organisations, late in 2003-04, intensive work was undertaken to ensure that GPPHCNT began operations with as small a liability as possible, and to ensure that the liability was addressed over the remainder of the financial year. This work was undertaken in close liaison with AGDHA and the GPPHCNT Board.

The large liability of the remote health workforce agency was addressed through tighter budgeting and financial controls on operational costs including staffing and travel; generation of additional funds through

Gove Peninsula - GPPHCNT

specific purpose grant management fees; a reduction in RAGs; a moderate increase to the "user pays" charges under the locum program; holding back on new and unfunded program activities; ceasing leases on two units held by the organisation; and efficiencies in legal, accounting and audit, governance and administrative costs, made possible by the merger itself. The efforts enabled GPPHCNT to begin its operations with a manageable liability, as well as enabling this remaining liability to be dealt with completely during the remainder of the 2004-05 financial year, enabling the organisation to begin 2005-06 on a sound financial footing.

The sound financial management of the organisation will be sustained through the development and implementation in 2004-05 of comprehensive new financial management policies and procedures; by governance and financial management training for the GPPHCNT Board; by the continued engagement of qualified staff and contractors with strong financial management and bookkeeping skills; and by the establishment of a Board Finance and Audit Sub-Committee.

HUMAN RESOURCES

Corporate Services Branch has assisted the CEO and team leaders with human resource management, through activities such as assistance with recruitment and selection processes, staff contracts, and payroll; development and implementation of a staff performance review system; assisting with a framework for staff training and development; planning and organisation of a whole-of-staff workshop in November 2004; work on occupational health and safety issues; and the development and continual updating of a staff handbook.

INFORMATION MANAGEMENT AND INFORMATION TECHNOLOGY

GPPHCNT's computer systems and inter-office electronic communications received a much-needed upgrade during 2004-05, with new equipment being purchased and improved networking systems being put in place for remote access. This has enhanced the productivity and efficiency of staff working in Darwin, Alice Springs, and on the road. Shared computer drives were organised and are being well utilised by staff; and a new onsite filing system, and offsite archiving system, for hard copy files were also introduced.

POLICIES AND PROCEDURES

A number of new or revised policies and procedures were introduced this financial year. The new financial management policy ensures there is a philosophy of transparency and complete disclosure of the financial position and activities of the organisation to appropriate stakeholders and the procedures ensure that good internal control and accountability is maintained throughout all financial and accounting transactions.

Work also commenced on a new risk management strategy and register for GPPHCNT; and several operational policies were also developed and incorporated into a new Staff Handbook, which is proving an important induction and reference tool for staff members.

PREPARATION FOR ACCREDITATION

A consultative process was entered into with the TEDGP and CADPHC to decide upon the most appropriate accreditation model to adopt. Regular meetings were held with representatives from the two Divisions, and teleconferences were conducted with a range of accreditation providers and models from around Australia. Discussions were also held with other divisions around Australia on their decision making process, the model they chose and the processes they went through.

The three Divisional network members in the NT decided jointly to undertake accreditation with SAI Global's ISO model. The Northern Territory is linking with 11 South Australian Divisions of General Practice, allowing for interchange of information and ideas, economies of scale, and significant savings. The plan is for GPPHCNT (and the two Divisions) to become accredited within the 2005-06 financial year. This will involve staff training and collaborative work involving all three organisations, on internal systems, including policies and procedures; self-assessment will be followed by external audit. This process will ensure that a culture of continuous improvement is embedded in GPPHCNT.

"GPPHCNT's computer systems and inter-office electronic communications received a much-needed upgrade during 2004-05"

financial report for the nine months ended 30 June 2005

independent audit report to members of GPPHCNT incorporated

"...the Board appreciates the efficiency with which Board business is conducted..."

Dr Sarah Giles, Chair

SCOPE

The financial report and Board of management's responsibility

The financial report is a special purpose financial report and comprises the statement of financial position, statement of income and expenditure and the accompanying notes to the financial statements for the General Practice and Primary Health Care NT Incorporated (the Association), for the period ended 30 June 2005 as set out on pages 36 to 43.

The Association's Board of management is responsible for preparing a financial report that presents fairly the financial position and performance of the Association. This includes responsibility for the maintenance of adequate accounting records and internal controls that are designed to prevent and detect fraud and error, and for the accounting policies and accounting estimates inherent in the financial report. The Board of management has determined that the accounting polices used and described in Note 1 to the financial statements are consistent with the financial reporting requirements of the *Associations Act* and the Association's constitution and are appropriate to meet the needs of the members. These policies do not require the application of all Accounting Standards and other mandatory financial reporting requirements in Australia. No opinion is expressed as to whether the accounting policies used are appropriate to the needs of the members.

The financial report has been prepared for distribution to the members for the purpose of fulfilling the Board of management's financial reporting requirements under the Associations Act and the Association's constitution. We disclaim any assumption of responsibility for any reliance on this report or on the financial report to which it relates to any person other than the members, or for any purpose other than that for which it was prepared.

Mt Conner - GPPHCNT

Audit approach

We conducted an independent audit of the financial report in order to express an opinion on it to the members of the Association. Our audit was conducted in accordance with Australian Auditing Standards in order to provide reasonable assurance as to whether the financial report if free of material misstatement. The nature of an audit is influenced by factors such as the use of professional judgement, selective testing, the inherent limitations of internal control, and the availability of persuasive rather than conclusive evidence. Therefore, an audit cannot guarantee that all material misstatements have been detected.

We performed procedures to assess whether in all material respects the financial report presents fairly, in accordance with the accounting policies in Note 1 to the financial statements, a view which is consistent with our understanding of the Association's financial position, and of its performance as represented by the results of its operations.

We formed our audit opinion on the basis of these procedures, which included:

- examining, on a test basis, information to provide evidence supporting the amounts and disclosures in the financial report, and
- assessing the appropriateness of the accounting policies and disclosures used and the reasonableness of significant accounting estimates made by the Board of management.

While we considered the effectiveness of management's internal controls over financial reporting when determining the nature and extent of our procedures, our audit was not designed to provide assurance on internal controls.

We performed procedures to assess whether the substance of business transactions was accurately reflected in the financial report. These and our other procedures did not include consideration or judgement of the appropriateness or reasonableness of the business plans or strategies adopted by the Board of management of the Association.

Independence

We are independent of the Association, and have met the independence requirements of Australian professional ethical pronouncements.

Audit opinion

In our opinion, the financial report of the General Practice and Primary Health Care NT Incorporated presents fairly, in accordance with the accounting policies described in Note 1 to the financial statements, a view which is consistent with our understanding of the Association's financial position as at 30 June 2005, and of its financial performance as represented by the results of its operations for the period then ended.

Merit Partners

Matthew Kennon, Partner

Darwin 23/8/2005

board of management's certificate for the period ended 30 june 2005

As detailed in Note 1 to the financial statements, the Association is not a reporting entity because in the opinion of the Board there are unlikely to exist users of the financial report who are unable to command the preparation of reports tailored so as to satisfy specifically all of their information needs. Accordingly, this "special purpose financial report" has been prepared to satisfy the Board's reporting requirements under the Northern Territory of Australia Associations Act and the Constitution of the organisation.

We certify that to the best of our knowledge and belief:

a) the financial statements hav been properly drawn up in accordance with the policies of the operations of the Association for the nine months ended 30 June 2005 and the state of the Association's affairs;

b) The statements are in accordance with the accounting and other records of the Association;

c) The Board has reasonable grounds to believe that the Association will be able to pay its debts as and when they fall due.

Chairperson

Treasurer

Darwin 22/8/2005

summary statement of income and expenditure

	Notes	9 months 30 June 2005 $
Total revenue		3,417,967
Total expenditure		(3,237,989)
Surplus for the period	2 (a)	179,978
Extraordinary Item on Start of Business	2 (b)	(142,918)
ACCUMULATED FUNDS AT THE END OF THE PERIOD		**37,060**

Statement of Income and Expenditure should be read in conjunction with the notes to and forming part of the financial statements.

balance sheet at 30 june 2005

	Notes	9 months 30 June 2005 $
CURRENT ASSETS		
Cash and bank	3	992,277
Receivables	4	212,582
Other current assets	5	27,853
		1,232,712
NON CURRENT ASSETS		
Property, plant and equipment	6	37,057
TOTAL ASSETS		**1,269,769**
CURRENT LIABILITIES		
Payables	7	202,943
Provision for employee entitlements	8(a)	134,095
Grants payable	9	190,183
Unexpended grants	10	691,091
		1,218,312
NON CURRENT LIABILITIES		
Provision for employee entitlements	8(b)	14,397
TOTAL LIABILITIES		**1,232,709**
NET ASSETS		**37,060**
EQUITY		
Accumulated funds		37,060

Balance Sheet should be read in conjunction with the notes to and forming part of the financial statements.

notes to and forming part of the financial statements

1. SUMMARY OF ACCOUNTING POLICIES

a) Period of Financial Report

The special purpose financial report is for nine months from 1 October 2004 to 30 June 2005. General Practice and Primary Health Care Northern Territory Incorporated (GPPHCNT) began operations on 1 October 2004. Assets and liabilities were transferred from Northern Territory Remote Health Workforce Agency Incorporated (NTRHWA) and General Practice Divisions Northern Territory (GPDNT) at that date.

b) Financial Reporting Framework

The Association is not a reporting entity because in the opinion of the Board there are unlikely to exist users of the financial report who are unable to command the preparation of reports tailored so as to satisfy specifically all of their information needs. Accordingly, this "special purpose financial report" has been prepared to satisfy the Board's reporting requirements under the Associations Act.

The financial report has been prepared on the basis of historical cost and except where stated, does not take into account changing money values or current valuations of non-current assets. Cost is based on the fair value of the consideration given in exchange for assets.

The Association is not a reporting entity as defined in Statement of Accounting Concepts SAC 1 Definition of Reporting Entity and therefore is not required to prepare a general purpose financial report in accordance with Australian Accounting Standards, however, all applicable accounting standards have been adopted with the exception of the following:

AAS 6	Accounting Policies
AAS 10	Recoverable Amount of Non-Current Assets
AAS 15	Revenue
AAS 22	Related Party Disclosures
AAS 24	Consolidated Financial Reports
AAS 28	Statement of Cash Flows
AAS 33	Presentation and Disclosure of Financial Instruments
AAS 36	Statement of Financial Position
AAS 37	Financial Report Presentation and Disclosures
AASB 1018	Statement of Financial Performance
AASB 1028	Employee Benefits
AASB 1047	Disclosing impact of adopting Australian Equivalents to International Financial Reporting Standards

c) Statement of Cash Flows

The Association does not prepare a statement of cash flows as require by AAS28. The Association believes there is adequate relevant information available from the financial report, and therefore the omission of the statement of cash flows does not adversely affect:

(i) decisions about the allocation of scarce resources made by the users of the financial report, and
(ii) discharge of accountability of management and board.

d) Depreciation of Property, Plant and Equipment

Items of property, plant and equipment are depreciated over their estimated useful lives using the straight line method. The main rates used are:

	30 June 2005
Building improvements (office partition)	1 year
Computer equipment	3 years
Office equipment	1-5 years
Furniture and fixtures	3 years

Higher depreciation rate are used for some items transferred in at 1 October 2004 due to the age and condition of the items. The depreciation rate is based on the useful life of the asset.

e) Consolidated Accounts

Balances and transactions within the entity have not all been eliminated on consolidation. It is believed that the information relating to the internal balances are useful to the users of the special purpose financial report.

f) Employee Benefits

The amount expected to be paid to employees for their pro-rata entitlements to long service and annual leave is accrued annually at current wage rates. Leave provisions include applicable oncosts.

Sick leave is accrued in the payroll system but not provided for in the accounts, sick leave is non-vesting.

The long service leave liability is accrued in respect of employees with greater than five years service.

Annual leave and long service leave in respect of employees with a present entitlement are shown as Current Liabilities. All other long service leave is shown as a non-Current Liability.

g) Goods and Services Tax (GST)

Revenues, expenses and assets are recognised net of the amount of GST. Receivables and payables are recognised inclusive of GST. The net amount of GST recoverable from, or payable to, the taxation authority is included as part of receivables or payables.

h) Government Grants

Grants are recognised as revenue in accordance with the year in which the service to which they relate is performed. Grants receivable for the current year but not received are accrued as a receivable. Grants received or receivable in respect of services that will be provided in future years, are treated as a liability. The portion of grants received in the current year, and unspent at year end, is transferred to current liabilities.

i) Income Tax

The Association is not subject to income tax.

j) Comparative Figures

Comparative figures are not applicable as General Practice and Primary Health Care Northern Territory commenced operations on 1 October 2004.

2. RECONCILIATION OF OPERATING STATEMENTS

a) Reconciliation of operating statements

	30 June 2005
	$
Rural and Remote General Practice Program	527,114
ACCOG	-
Overseas Trained Doctors Scheme	91,040
Rural Locum Relief Program	25,455
OATSIH - Governance and Management	-
Aboriginal Health Workers Assn Study	-
After Hours Primary Medical Care	-
RMFSS - Remote Medical Family Support	9,650
General Practice Divisions Program (SBO)	32,240
National Primary Mental Health Care Initiatives	2,841
Aged Care GP Panels Initiative	-
Access to Broadband for Health	5,678
General Practice Immunisation Incentive Scheme	-
Chronic Disease Management	-
Support Nursing in General Practice	81,025
National Primary Care Collaboratives	15,523
Self Generated Income	48,926
Unexpended grants 2004-05 taken to liability	(675,166)
Add back Capital Expenditure to Balance Sheet	15,652
	179,978

b) Extra Ordinary Item

On 1 October 2004 all the assets and liabilities were transferred from NTRHWA and GPDNT to the Association. These amounted to a net liability of $142,918.

3. CASH AND BANK

Cash on hand	400
General cheque account	991,877
	992,277

4. RECEIVABLES - CURRENT

Receivables	212,582

5. OTHER CURRENT ASSETS

Locum Travel Clearing Account	12,022
Locum Family Travel Clearing Account	4,309
Prepayments	11,522
	27,853

6. PROPERTY, PLANT AND EQUIPMENT

	30 June 2005
	$
Building improvements	6,484
Accumulated depreciation	(4,850)
	1,634
Computer equipment	30,573
Accumulated depreciation	(8,190)
	22,383
Furniture and fittings	7,380
Accumulated depreciation	(1,975)
	5,405
Office equipment	11,279
Accumulated depreciation	(3,644)
	7,635
Total property plant and equipment	**37,057**

7. PAYABLES - CURRENT

Creditors including Australian Taxation Office	151,799
Accruals	51,144
	202,943

8(a) PROVISION FOR EMPLOYEE ENTITLEMENTS - CURRENT

Annual Leave	83,933
Wages Provision	50,162
	134,095

8(b) PROVISION FOR EMPLOYEE ENTITLEMENTS - NON CURRENT

Long service leave	**14,397**

9. GRANTS PAYABLE

Remote area grants contracted to third parties	41,000
ACCOG grants contracted to communities	149,183
	190,183

Grants pledged by the organisation to third parties are recognised as liabiities. The grant liabilities include amounts retained from grants until the Grantees have fulfilled all of their contractual obligations.

10. UNEXPENDED GRANTS

Remote Rural General Practice Program	411,714
Overseas Trained Doctors Assistance Program	91,040
Rural Locum Relief Program	25,455
Remote Medical FSS	9,650
General Practice Divisions Program (SBO)	32,240
National Primary Mental Health Care Initiative	2,841
Access to Broadband for Health	5,678
Support Nursing in General Practice	81,025
National Primary Care Collaboratives	15,523
Unexpended Grants 2004-2005	675,166
Medical Management Review (2002-2004 grant)	15,925
Total Unexpended Grants	**691,091**

The unexpended balances of grants funds at 30 June are transferred to the statement of financial position and recognised as a current liability.

11. GOING CONCERN

The Board of GPPHCNT voted, on 29 July 2004, to accept the transfer of all assets, liabilities, contracts and obligations of NTRHWA and GPDNT. The assets and liabilities were transferred at net book value at 1 October 2004.

During the year the organisation received grants from government departments and other funding bodies, the future operations of GPPHCNT is dependent upon continued funding from these or other funding bodies.

GPPHCNT have funding agreements with the Commonwealth of Australia as represented by the Department of Health and Ageing (the principal funding source) for the balance of the agreement period for Rural and Remote General Practice Program commencing 1 July 2005 and, unless terminated earlier, will continue until 30 June 2007. The agreement is for the sum of $6,035,641 (GST inclusive) paid in equal quarterly instalments, each year, over the agreement period. A funding agreement has been signed for the Divisions of General Practice Program core funding from 1 July 2005 to 30 June 2008, unless terminated earlier. Other schedules and special purpose agreements have also been signed.

12. SUBSEQUENT EVENTS

There are no known subsequent events that affect the financial position of the organisation as at 30 June 2005.

13. SEGMENT REPORTING

General Practice and Primary Health Care Northern Territory operates in the Northern Territory of Australia in the Health Promotion Industry.

14. COMMITMENT - OPERATING LEASE

The following commitment is an operating lease and therefore not included in the financial statements as a liability. The commitment is a note to the accounts only.

	30 June 2005
	$
Motor Vehicle - Corolla Ascent	
Balance from Lease term brought forward from GPDNT 22 months from 1 October 2004 to 10 May 2007	
Payment within one year =	5,294
Payment >one year, <two years	4,853
	10,147

consolidated detailed statement of income and expenditure

	Notes	9 months 30 June 2005
		$
INCOME		
Grant Income		
Dept of Health and Ageing		2,649,505
National Primary Care Collaboratives		77,500
Total Grants Received		**2,727,005**
Grants Payable Brought Forward		38,500
Unexpended Grants Brought Forward		359,204
Unexpended Grants Carried forward		(675,166)
Total Grant Income		**2,449,543**
Non-grant Income		
Australian Division of General Practice - RIC		10,000
Bank Interest Received		30,536
Operational expenses recouped		73,833
Locum Fees Charged		807,334
John Flynn Scholarship Scheme		16,500
Project Management		7,500
Bad and Doubtful Debts Recovered		12,721
Grants Payable Reallocated		10,000
		968,424
TOTAL INCOME		**3,417,967**

EXPENDITURE		
Audit		17,438
Accounting		42,520
Board costs		36,635
Administration costs		136,017
Staff Salaries/Travel/Super/Recruitment/P'roll Tax		851,874
Seminars and Conferences		17,809
Depreciation		28,202
Insurance		19,533
IT Equipment Replacement		9,490
Consultants - Programs		97,649
Remote Area Grants		578,500
RAG Program Review		14,416
Relocation Grants		27,079
Orientation & Training Grants		10,169
GP Recruitment Site Visits		4,366
GP Advertising		690
GP Marketing		15,771
Locum Program		1,025,664
Program Support		33,244
Rent - Darwin and Alice Springs		62,324
Loss on disposal assets		8,705
Top End Medical Advisor		29,049
CPD Funding to Divisions		64,034
Flexible Payments Scheme		8,560
ACCOG		45,455
Grant Funds Repaid to Funding Bodies		52,796
TOTAL EXPENDITURE		**3,237,989**
Operating Surplus	**2(a)**	**179,978**

Road to Ampilatwatja - GPPHCNT

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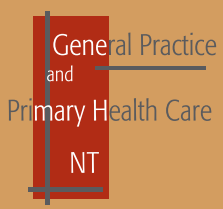

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