

# Easy entry—gracious exit: testing new models for doctor recruitment and retention in chronically underserved rural communities

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## INTRODUCTION

This is a brief account of:

- why and how the NSW Rural Doctors Network (RDN) became directly involved in the development of medical services in North West NSW
- the circumstances and events in each of four communities (Collarenebri, Walgett, Brewarrina and Lightning Ridge) that have led to varying models of medical practice.

Some observations are made on the outcomes, perceived success factors and on some of the more significant issues that may be relevant to medical service delivery in other areas.

## BECOMING ENGAGED

Late in 1999, RDN asked the rural Divisions of General Practice in NSW to nominate towns that experienced chronic undersupply or consistently high turnover of doctors. The responses held few surprises. Most of the nominated towns were remote (RRMA 7). A few individual towns had particular structural problems and issues that impeded doctor recruitment. In the State's north-west all of the towns in the Walgett and Brewarrina Shires – Walgett, Lightning Ridge, Collarenebri, Brewarrina and Goodooga – fell into the chronically difficult category. The RDN view was that medical services in this cluster of towns should be addressed on both a regional and individual basis.

The Far West Area Health Service (FWAHS) is responsible for medical services at hospitals and for public health across the vast, thinly populated west and north-west area comprising one third of NSW. The Commonwealth Government funds Medicare services through the Health Insurance Commission (HIC). Both the Commonwealth Department of Health and Ageing (DoHA) and the NSW Department of Health (DOH) contract RDN to provide grants and services to rural doctors to help recruit and support them. In NSW, general medical services are provided by General Practitioners (GPs) in private medical practices. Many rural GPs are also appointed as Visiting Medical Officers (VMOs) by their Area Health Service and, in that capacity, provide the medical services in the local hospital. Aboriginal medical and health services are important providers to both Aboriginal and non-Aboriginal people, and sometimes also employ doctors directly. Shire Councils and the Area Health Service sometimes supply infrastructure such as doctor housing, surgery buildings, motor



vehicles or other assistance. The Royal Flying Doctor Service (RFDS) provides emergency evacuation and medical support services. The Outback Division of General Practice (ODGP) with one employee provides services to doctors across a vast area. Other NSW and Commonwealth agencies have programs through which communities and stakeholders can seek resources and assistance – if they know about them, can prepare compelling applications, and have the capacity to implement projects.

The Walgett, Brewarrina and Bourke Shires are large areas often with the harsh climatic conditions of extreme temperatures, floods or the current severe drought. Walgett Shire ranks as having the highest level of socio-economic disadvantage in NSW, closely followed by Brewarrina Shire.<sup>1</sup> Brewarrina Shire ranks as having the highest proportion of people in NSW reporting as having poor or fair health, Walgett having the second highest.<sup>2</sup>

Clearly these communities were receiving an inadequate level of health and medical services. Many agencies and stakeholders had partial responsibility – no one had total responsibility. Chronic doctor shortage was a significant factor. It was also clear that to recruit and support doctors successfully would require a collective and co-ordinated effort.

Given the low health status of north-west communities, the RDN Board authorised that special effort be made to investigate the barriers to GP recruitment and retention and identify what was needed to overcome them. In doing so, RDN drew upon the spirit of the framework adopted in 1999 by the Australian Health Ministers Conference for improving the health of rural Australians, the first goal of which is – “Improve Highest Priorities First”.<sup>3</sup>

RDN became involved more directly than usual – initially as a facilitator able to bring the stakeholders to the table and offer some expertise and some limited resources for doctor recruitment. At first there was no plan other than to bring people together. We felt it was important to have everyone understand what was going on, to discuss what was needed and what steps could be realistically taken together and separately to obtain a sufficient and stable level of medical services in the area.

## BACKGROUND AND CONTEXT

The nearest Base Hospital to the towns in North West NSW is at Dubbo 300 to 450 kilometres by road to the south-east. The FWAHS is based at Broken Hill 600 to 800 kilometres by road to the south-west.

It has been chronically difficult to recruit and retain GPs for these towns over many years. When rare periods of stability and adequate basic services do occur, residents tend not to enjoy a strong sense of security. They know from experience that such stability can be fragile and easily broken. They know that all too often there will be no doctor in town; that frequently there will be scrambling at short notice to find locums or other ways of covering medical and emergency services at the hospitals – for a weekend, a week or longer periods; that, unless the matter is urgent, a doctor’s appointment will often entail a long wait. Were it not for several resident doctors who have endured heavy workloads and demanding conditions for long periods, the situation would have been even more desperate.



Financial assistance and other support designed to attract doctors to the area and encourage them to stay, have been provided from many sources in recent years. The local Shires, the Commonwealth Government and the FWAHS have contributed to the provision of doctor housing. RDN has provided grants (relocation, training, and various financial support grants) and assisted with locums and recruitment services. Substantial (Commonwealth) retention grants are available for doctors who remain longer than a minimum period in remote locations. At considerable expense, the FWAHS has sometimes succeeded in finding doctors who, while unwilling to run a private practice, have been willing to be directly employed to provide both hospital and general practice services.

## FIRST STEPS

Early in 2000, RDN initiated a meeting of all the significant stakeholders. Those with broad regional involvement (Shires, FWAHS, Aboriginal and Torres Strait Islander Commission, the University Department of Rural Health in Broken Hill, the RFDS, and ODGP) were invited. This was intended to expand everyone's knowledge base by sharing perspectives, plans and ideas. It was hoped this would also build commitment to parties working more closely together to provide more coherent, relevant and flexible responses to issues requiring attention.

RDN also held community level meetings – initially in Collarenebri, Walgett and Brewarrina. These involved Shire councillors and staff, hospital staff, Aboriginal health service representatives and doctors, ODGP and community members usually drawn from hospital advisory committees. Again, participants shared perspectives, plans and aspirations.

RDN was able to provide accurate and realistic information on the difficult doctor supply situation and the competition from the scores of less remote rural NSW communities that were also trying to recruit doctors. Participants were able to make clear what resources each could bring to the table and how partnerships could be developed to expand those resources. Communities were encouraged to see themselves less as islands and more as having opportunities to work collectively to improve the chances of improving overall medical and health services in the area. RDN also maintained communications with the Rural Doctors Association (NSW) to ensure that initiatives did not undermine the RDA Settlement Package that determines VMO payment arrangements in most NSW rural hospitals and has been an important factor in maintaining services.

Those attending responded very positively to the sharing of information and the better understanding that came from the meetings. Walgett and Collarenebri agreed to ongoing joint meetings. Known as the Colli/Walli Health Forum, it was chaired by Dr Ian Cameron (RDN) and met quarterly. When Lightning Ridge representatives later joined in, it became known as the Walgett Shire Health Forum. Subsequent meetings have been attended at various times by senior representatives of Commonwealth and NSW Government departments and private sector agencies. The meetings have provided for ongoing public discussion, planning of initiatives, joint action by relevant parties, and regular reporting back on progress against commitments made.

As the traditional strategies were not delivering doctors to the area, a strategy of walk-in/walk-out arrangements was initiated to overcome many of the barriers known to



deter doctors – capital investment and/or lease commitments, the effort involved in establishing practices and running a business, and the fear of being trapped because of exit difficulties down the track. The concept of “Easy Entry – Gracious Exit” underpinned much of what subsequently developed.

The Walgett Shire Health Forum continues to meet. Following attendance by Brewarrina observers at a Forum meeting early in 2002, a Brewarrina/Bourke Health Forum was established in mid- 2002 with similar intentions.

## TOWNS AND MODELS OF MEDICAL SERVICE DELIVERY

The stories of medical services in each of the north-west towns from the beginning of 2000 illustrate both general and particular difficulties of doctor recruitment in remote communities and how they have been addressed in each case. Significant changes have taken place in each town over the past 2½ years and several different models of medical practice have emerged. While the overall situation is much improved, it remains fluid and there is still a long way to go before it can be confidently claimed that enduring solutions have been found.

### Collarenebri 2000–2002

Collarenebri is 77 km north of Walgett, the nearest town and the nearest District Hospital. Lightning Ridge is 123 km to the north-west and Moree is 140 kilometres to the east. An old hospital on the banks of the Barwon River has 14 acute beds. Base hospitals at Tamworth and Dubbo are both about 400 kilometres away.

The town and catchment population, of which 25% are Aboriginal, is about 1000 – marginal for supporting a sustainable private medical practice, even with a VMO appointment to the hospital. In early 2000, there was no resident doctor. The locum (an Australian doctor in his 70s, resident in the UK) supplied by the RDN was about to leave. There had been no resident doctor for over a year and locums had not always been available. At such times, residents had to choose between going to Walgett or Lightning Ridge, both of which had less doctors than needed, or going to the more distant but larger centre of Moree where it could take up to 3 weeks to get an appointment. With no public transport, patients had to have access to a vehicle and funds for fuel. The infirm and young also needed a driver.

At the first community meeting RDN held, residents were anxious and vocal about having no permanent doctor. A series of locums had attended the town for short periods. Community appreciation for these locum services was accompanied by concern at the associated discontinuities in treatment for chronic illnesses and the elderly and concern or distress at the changes in medication that, upon occasions, had been associated with changes in locums. The Hospital Services Manager emphasised that with no resident doctor it was more difficult to recruit nurses and the hospital was increasingly reliant upon expensive short-term agency staff. Prospective nurses wanted assurance that a resident doctor was available – not the responsibility of handling emergencies without one.

The meeting reluctantly acknowledged the reality of Collarenebri being in competition for doctors with larger, wealthier, more accessible towns. While first preference was



for a resident doctor, it was recognised other options also had to be considered. The options and the order of preference that emerged over time were:

- That the FWAHS employ a GP/VMO resident in Collarenebri in the same way it had employed locums in the recent past. The hospital had a house and rooms for the doctor to conduct a practice. The two main obstacles perceived with this option were the difficulty of finding a doctor willing to come and (for the FWAHS) the likely net cost.
- That a GP/VMO resident be recruited to run a private practice in the town, with house and surgery rooms provided. To be financially viable, the GP might provide medical services in town for several days of the week and augment services in Walgett or Lightning Ridge or be funded to undertake part-time activities such as public health programs. The town wanted the security of a doctor being in the town overnight for emergencies.
- Regular provision of medical services by a resident doctor from Walgett (or Lightning Ridge) for several sessions per week, with emergency on-call being provided by phone (and attendance if necessary) by the Walgett doctor(s). This offered greater continuity of care than locums. If patients needed to attend Walgett for treatment at other times, it was a possibility they might see the same doctor and their records could be available at the medical practice in Walgett.
- Carry on with locums as at present, with the hope that sooner or later a resident doctor might be recruited.

The first 3 options were also seen as preferable because they promised greater continuity of care and allowed GP participation in nurse training at the hospital on a regular basis.

### *What happened*

Collarenebri endorsed a submission prepared by FWAHS in collaboration with ODGP and RDN, which sought funding under the Commonwealth Regional Health Services Program for a public health doctor, and additional nurses and Aboriginal health workers in the Walgett Shire. Such funding would enhance public health services in the Shire and, if some funds were available for the Collarenebri area, could improve prospects of doctor recruitment by making medical practice more financially viable.

Collarenebri joined with Walgett (and later Lightning Ridge) to form the Walgett Shire Health Forum. This provided regular access to broader information and participation in the discussion and planning of health and medical services in the Shire as a whole.

Locums continued to visit Collarenebri until 2001 when the FWAHS engaged a female doctor from Adelaide to work there for 6 months. The doctor and the community already knew each other as she had previously worked there as a locum. Flexible working arrangements were available, consistent with her family circumstances. This worked so well for all concerned that she returned after a short break for a further 6 months and has since further extended arrangements to the end of 2003.

Once a known and respected GP was resident in Collarenebri, several things happened. Firstly a backlog of chronically ill patients was treated and stabilised on appropriate treatment plans. Secondly, more people began attending the surgery, in



the knowledge continuity of treatment was available. Thirdly, the doctor undertook some outreach visits and made contact with farm residents and workers who needed but had not sought medical attention. Finally, more outlying residents again began seeking medical attention in Collarenebri – local shopkeepers were delighted to see a return of trade that had been lost when people sought treatment elsewhere. Some patients even travelled almost 200 km from Brewarrina, perhaps because they wanted to see a woman doctor or because Brewarrina was itself being serviced by locums at the time.

In 2002, the Collarenebri Hospital Advisory Council surveyed residents as to their preferences for medical services in the community – the outcome basically endorsed the preferences previously developed. The old hospital is being replaced by a Multi-Purpose Service facility. New nurse housing has just been completed. Present arrangements provide a very satisfactory medical service.

### *Current situation*

While the current arrangement is likely to be slightly costly for the FWAHS than if a privately practising GP/VMO was available, it is probably more cost effective than engaging a continuous stream of locums for several significant reasons:

- the higher costs of recruitment, transport, administration and fees
- the considerable workload and uncertainty associated with locum recruitment when supply is insufficient
- the discontinuity of patient care and gaps in service between locums
- avoidance of the political pressures from community and parliamentary representatives whenever there is no doctor available.

A new Multi-Purpose Service and new nurse accommodation, completed early 2003, has improved Collarenebri health facilities.

### **Walgett 2000–2002**

The town is 305 road kilometres north-west of Dubbo Base Hospital, 220 and 120 road kilometres east of Bourke and Brewarrina respectively, 100 km south of Lightning Ridge and 215 km south-west of Moree. The catchment population of around 3600 includes almost 2000 in town and a significant Aboriginal population of almost 30%.

The Walgett Aboriginal Medical Service (WAMS) is well established and provides a diverse range of services both locally and through outreach to communities over a large area including, in some cases, south-west Queensland. It has usually employed a doctor, and provides medical services in Walgett to both Aboriginal and non-Aboriginal patients. For periods when there has been no private GP in town, WAMS has been the only available medical service provider. A female Australian doctor was employed at WAMS from 1999.

The only privately practising GP in Walgett in early 2000 was an Australian doctor who had practised in the town for about 4 years and was the only VMO providing hospital services. The practice workload was onerous. The number of patients coming through the door left little opportunity to provide the range of additional medical



services being encouraged by the HIC. The District Hospital workloads were also heavy, with many patients unable to see a doctor at WAMS or the practice, presenting at the hospital instead. They were then seen by the VMO at the end of the day, unless it was an emergency requiring earlier attendance. It would not be unusual for the GP to see 40 patients at the practice and find another 15 waiting at the hospital at 6.00 pm. Whenever the private GP was out of town, either a locum had to be found or the RFDS provided emergency backup.

The Walgett District Hospital is a modern facility with 16 acute beds, designated to provide hospital services for Walgett, the surrounding area and more distant communities such as Lightning Ridge where there are no overnight or acute beds available. It has a well-equipped operating theatre and anaesthetics facilities. With only one VMO in town, albeit with anaesthetics training, the theatre was rarely used as there was rarely a second doctor available to take part. There was no obstetric service for routine deliveries in a community with one of the highest birth rates in NSW. Patients were frequently evacuated to Dubbo 300 km away at great cost and inconvenience.

Ideally, to meet FWAHS service objectives, Walgett required at least a GP/obstetrician, a GP/anaesthetist, a WAMS doctor and a doctor willing and able to undertake public health activities if the Regional Health Services proposal was successful. It was also the case that, if Collarenebri could not attract a resident doctor, then the capacity to provide an outreach service from Walgett would be desirable. With sufficient VMO appointments to share the after hours load and allow doctors to take reasonable time out for holidays and further training, the town would offer interesting and rewarding medical work plus a manageable workload. It would also be possible to expand the range of medical services and look at providing outreach medical clinics to outlying communities.

Doctor housing was an issue if more doctors were to be recruited. The WAMS doctor and the private GP occupied Shire houses, one being of very good and one of reasonable standard. A third Shire-owned doctor house was in poor condition and unlikely to appeal to prospective doctors. Quality rental housing was unavailable.

Surgery space was available for a second doctor at WAMS and potentially available at the private practice although the latter, built by the Shire in the 1970s, needed improvements as a pre-requisite for obtaining accreditation under the RACGP Standards for General Practice.

### *What happened*

The first Walgett meeting also endorsed the application for Regional Health Services funding for public health personnel. Also during 2000:

- the Walgett Shire and ODGP jointly applied to the Commonwealth Regional Solutions Program for funding to repair and build new doctor housing
- ODGP sought separate housing funds to accommodate a Medical Registrar
- WAMS sought staff housing funds from a third source



Significant milestones in **2001** included:

- June – RDN agreed to establish a non-profit company, Rural and Remote Medical Services Ltd (RARMS) to help establish walk-in/walk-out arrangements for doctors, to improve prospects for recruitment and retention<sup>4</sup>.
- June – Commonwealth funding was obtained by RDN to provide practice equipment and furniture in doctors' housing in Walgett and other north west towns for implementation of the walk in-walk out concept.
- June – FWAHS recruited a conditionally-registered GP Obstetrician from Cyprus for 4 months to November, to augment GP and VMO services in Walgett.
- July – RARMS agreed to take over employment of the GP Obstetrician from FWAHS, provide housing and vehicle. Walgett AMS agreed to provide him practice room and services.
- September – RDN employed a GP from Scotland to work in the Walgett private practice for 6 months under the Targeted Inland Recruitment Scheme.
- On September 11 2001, following a meeting of all medical service stakeholders, FWAHS agreed to contract RARMS to provide VMO services (GP core, anaesthetics and obstetrics) to the Hospital on a temporary basis at fixed daily rates, while it advertised formal tenders to provide such services long term. Over the next few months RARMS engaged 3 resident doctors to supply VMO services plus one part-time (1 in 6) fly-in doctor, with another available for back-up if needed.
- The Commonwealth Regional Health Services public health project was approved albeit with less funding than sought – the equivalent of 50% of a public health doctor salary instead of 100%. The WAMS doctor was keen to take on this role but WAMS first wanted a replacement for her, which proved difficult.
- In December, the Walgett private medical practice received accreditation. The University of New England commenced a project funded through RDN to provide practice management assistance to north west practices.

Among noteworthy developments in **2002**:

- In January, RARMS assumed responsibility for the private practice, engaging the resident doctor to work there after a period of leave.
- In February, the GP Obstetrician returned from Cyprus and was engaged to work in the RARMS practice until he left for a period in April. The medical indemnity crisis in June resulted in his supervisor (for Medical Board purposes) withdrawing from that role. No replacement supervisor could be found and he was unable to return for several months, until supervision could be re-established.
- In March, at the end of his 6 months RDN contract, RARMS engaged the Scottish doctor to remain in the Walgett private practice.
- April – A long-term Agreement signed by RARMS to provide VMO services to Walgett District Hospital.



- Mid-2002, the female doctor at WAMS departed Walgett and WAMS was supported by a series of locums or short-term appointments until late 2002
- Mid-2002 the medical indemnity crisis forced a change in the way RARMS engaged GPs and in the nature of RARMS as an entity. To ensure RARMS VMOs had access to medical indemnity under the NSW Treasury Managed Fund, the long-term VMO contract with FWAHS was amended. RARMS no longer provided the VMO services but managed doctor recruitment as an agent of FWAHS and managed arrangements for the services supplied by doctors engaged by RARMS.
- July – the GP Obstetrician returned from Cyprus under re-instated supervision arrangements, remaining until October, when he left unhappy about several matters, particularly the failure to have an operational obstetrics service established at the District Hospital by that time.
- Other notable events in 2002 include
  - RARMS negotiated extra surgery space, and the Shire and RARMS undertook building improvements
  - Practice nursing staff were engaged at the Walgett Doctors Surgery
  - Walgett RARMS doctors were able to provide some short-term relief to Lightning Ridge, Brewarrina and Wee Waa
  - For a brief period, the capacity was available to provide outreach services to outlying communities
  - A small amount of Regional Solutions funding plus Medical Registrar housing funding was eventually received and agreement reached to combine the grants to upgrade one doctor's house and provide semi-detached registrar accommodation
  - WAMS received funding for an additional staff house
  - RDN installed satellite internet services and upgraded IT equipment in the practice. RARMS contracted local IT support
  - RARMS leased an area of the District Hospital to provide medical services to non in-patients, usually out of hours.



### *Current situation*

By early 2003, the GP workforce was stable in Walgett with 2 resident GP/VMOs at RARMS (plus a fly-in GP/VMO for 2 months pa), and a resident GP at WAMS. One of the GP/VMOs was also undertaking public health activity for FWAHS under the Regional Health Services project. A GP/Obstetrician was no longer available.

### **Brewarrina 2000–2002**

Brewarrina is 100 km east of Bourke, 135 km west of Walgett and about 415 km from Dubbo Base Hospital. The catchment population of approximately 1600 is around 60% Aboriginal. Town population is around 1100. The old hospital is being replaced. A



new Multi-Purpose Service and new nurse accommodation is due for completion by February 2003.

In early 2000, when RDN began direct involvement in the North West area, the resident doctor was leaving. RDN was able to recruit an Australian doctor to replace him.

In early 2001, the replacement doctor departed unexpectedly. To facilitate the placement of locums until another replacement could be recruited, RDN assumed responsibility for the surgery building and doctor's house (both owned by Brewarrina Shire) and employed the medical receptionist.

There followed a period of 20 months during which 22 locums provided medical and VMO cover, with gaps in cover generally being quite short. Much time and energy was devoted by RDN and FWAHS to providing locums and throughout this period the community, the hospital and the medical receptionist experienced a high degree of change and uncertainty. Commonwealth grant funds were used to improve practice equipment and to furnish the doctor's house for locum and replacement doctors. An Australia-wide advertising of the vacancy by FWAHS failed to deliver an appointment.

In mid-2002, two New Zealand doctors in Bourke established Australian Outback Medical Services (trading as Australian Outback Locums, AOL) and were able to recruit two South African trained doctors from New Zealand to work in Brewarrina at the RDN practice. Although a for-profit company, AOL drew in part upon the initiatives and experience of RARMS over the previous 12 months in Walgett and Lightning Ridge. After several months of getting to know each other, the community was very pleased with the medical services being provided and the doctors were happy to make a long-term commitment to the town. In October 2002, AOL signed a long-term Agreement with FWAHS to provide VMO services to the Hospital, and RDN transferred responsibility for the medical practice, patient records and housing to AOL. A tripartite exchange of letters between RDN, AOL and the Shire ensures continued availability of patient records into the future.

A Commonwealth Regional Health Service public health project covering Bourke and Brewarrina Shires had also been developed by FWAHS, the Outback Division and RDN at the same time as the Walgett Shire proposal. It was successful in obtaining funds for a public health doctor and some of those funds are being used to support the provision of outreach services to outlying communities in the Brewarrina Shire. Without access to these funds, it would have been difficult to attract and financially sustain two GPs in Brewarrina.

### *Current situation*

As at early 2003, Brewarrina is in a very sound position with two long-term resident GP/VMOs, a new MPS facility about to be commissioned and medical outreach services being provided to remote settlements. As the doctors are married, the one doctor's house has been sufficient.



## Lightning Ridge 2000–2002

Lightning Ridge is almost 80 km north of Walgett and in the same Shire. While the official postcode population is close to 3500 with almost 2000 in town, there are strong indications it experiences a transient and seasonally fluctuating population which is difficult to measure but estimated to bring total catchment numbers to between 6000 in summer and 8500 in winter. The town has an Accident and Emergency (A&E) Centre but no hospital. Serious cases are transferred to Walgett District Hospital or further afield depending upon the circumstances.

In the late 1990s, the town had a stable workforce of 3 GPs until one died in an air crash. A second doctor (who now supports Walgett on a fly-in basis) left around late 2000. In 2001, the one remaining resident GP provided comprehensive general practice services but not VMO services. For many years, two Moree GPs have provided private medical services one day a fortnight on a fly-in basis at the A&E Centre. The FWAHS recruited a second GP for the town for 6 months, to provide VMO services and provide general medical services from vacant practice premises, supported by AHS staff.

When RARMS was established in mid-2001, the initial plan was to concentrate first upon addressing doctor recruitment and associated issues in Walgett and to move on to Lightning Ridge issues in February 2002. Involvement in Lightning Ridge had to be brought forward when in October 2001 the resident GP withdrew from practice for health reasons. It suddenly became very urgent to attract another doctor. Following discussions between RARMS and FWAHS it was agreed that RARMS would supply GP services to the town.

Neither of the existing practice premises would satisfactorily accommodate 2 doctors. New premises were identified (and vacated promptly by the Shire), leased and fitted out. Temporary practice staff were recruited and RARMS took over employment of the FWAHS GP for the remainder of his contract. RARMS entered into a temporary Agreement with FWAHS to provide VMO services for several months – this included a financial incentive to have two GPs providing medical services. Housing was eventually secured for a second RARMS doctor. Medical services were supplied by a series of locums until one doctor agreed to commit to a longer term.

Delay in FWAHS advertising for provision of VMO services on a long-term basis meant that RARMS was unable to make firm long-term financial commitments to doctors potentially interested in becoming resident GPs. An Agreement signed in February 2003 is expected to change that and RARMS is more confident of recruitment success in 2003.

During 2002, the Lightning Ridge Doctors Surgery was physically expanded to accommodate practice nursing and is hosting an outreach midwifery clinic provided by Walgett AMS. The practice assessed for accreditation.

The A&E Centre is due to be replaced by April 2003. A new Multi-Purpose Centre with 4 acute beds, 2 holding beds and a 25 bed aged care facility will improve locally available health services and is expected to increase VMO workloads. Subject to the availability of housing and other considerations, it may be advisable to try to recruit a third GP.



### *Current situation*

With 2 GP/VMOs, the previously frequent difficulties experienced in maintaining emergency cover have largely disappeared. The GP workforce of one resident and a locum remains less established than is desirable. The prospects for recruitment have improved now that long-term VMO arrangements are finalised.

Planning may need to take into account that an elderly long-serving GP provides medical services at Goodooga (population around 400, almost entirely Aboriginal, and surrounding population) and VMO services at the small hospital there. Located 100 km from Lightning Ridge and 123 km from Brewarrina, in which Shire it is located, this practice is not financially viable in the longer term without subsidy. If, as seems probable, it proves difficult to find a successor to the present doctor when he retires, it may have to be supported by outreach services from Lightning Ridge or elsewhere.

## POINTS TO PONDER—OUTCOMES, SUCCESS FACTORS AND ISSUES

### Outcomes

There are **more doctors** in the North West. Currently 8 GPs in the 4 towns (7 resident and 1 locum) compared with 4 (3 resident and 1 locum) two years ago.

The volume and range of **medical services have expanded**. GPs in Walgett and Brewarrina now undertake public health activity. In the first 9 months of RARMS operating, HIC recorded activity in Walgett and Lightning Ridge as rising by 40%. Outreach and public health services are taking place in Brewarrina.

There is **greater reliability** of general practice and VMO services and less community anxiety about whether medical attention will be available when required.

The new arrangements have **boosted local employment**— particularly practice nurses in Walgett, Lightning Ridge and Brewarrina.

The positive doctor recruitment results arising from activities undertaken in the North West, has influenced a recent initiative by the NSW Department of Health. The **new \$2m grant program** is designed to improve the prospects for recruiting doctors by supporting the establishment of up to 10 new General Practice Employment Entities in rural NSW.

Commonwealth funding has been provided to RARMS to prepare and publish a Guidelines document. Based largely upon experience in the North West, this will canvass the issues to consider if rural communities, organisations or individuals are contemplating new models of medical service delivery in the hope of improving their prospects of attracting and retaining doctors. RDN has also received short-term funding to expand its capacity to provide **advice on alternative models of rural general practice**. Inquiries are being received from Shires, rural Divisions of General Practice, Area Health Services and individuals.



## Success factors

The **involvement of stakeholders and community representatives** through the Walgett Shire Health Forum (and more recently the Bourke-Brewarrina Health Forum) has helped to maintain momentum and accountability by service providers, helped identify practical solutions, and generated a better collective understanding and awareness of health service and doctor recruitment issues. The meetings were at times an effective vehicle for demonstrating to attending Commonwealth or State officials, the strength and legitimacy of health disadvantage, the need for funds and that there is a community-based mechanism for maintaining interest in project implementation. It was also helpful that the Chair, Dr Cameron, had lived and practiced medicine in the North West for many years, and had strong links in the communities.

All four towns now have doctors engaged on the basis of **walk-in/walk-out arrangements** that do not require capital investment or long-term leases for housing and practice accommodation. The medical practices supply staff, computers, most medical equipment and many business services.

Reaching agreement with FWAHS on **financial arrangements for VMO services** on a long-term “cashed out” rather than “fee for service” basis (in consultation with the NSW Rural Doctors Association) has enabled RARMS and AOL to be much more specific in indicating likely income levels to prospective doctors, many of whom are from interstate and overseas, and unfamiliar with NSW arrangements. For resident GP/VMOs, knowing in advance what their VMO income will be for a given number of on-duty days, weeks or months assists their financial planning.

In negotiating VMO and practice fees, RARMS has sought to ensure **GP remuneration** is to be competitive in attracting and retaining resident doctors, while ensuring adequate funds are available to provide a high standard of practice services.

A critical success factor was the willingness of the Dept of Health and Ageing to provide **initial grant funds** for practice equipment and to furnish doctor housing, thereby underwriting up-front costs that could not have been met by RARMS. The grant also provided the incidental benefit of assisting cash flow in the early months before revenue streams rose to workable levels.

An important factor in Walgett was the **commitment** of the one resident GPO/VMO, Dr Vlad Matic, to the “easy entry – gracious exit” concept and his willingness to transfer control of the practice to RARMS. The same doctor has been an important influence in drawing upon his extensive experience in the area to guide the RARMS’ approach to many issues.

Throughout the period discussed, RARMS has had the support of an experienced rural doctor, Dr Paul Collett, as **Medical Advisor**. He has carried much of the negotiations with prospective doctors, with hospital and FWAHS staff on clinical issues and played a prominent role in developing arrangements and resolving matters within practices as they evolved and as doctors and staff changed. That he also undertook short locum stints in RARMS practices, improved his capacity to understand and advise on such matters.

The **service development and company establishment role** played by health planner Margo Anderson, initially made available by FWAHS and subsequently employed by



RARMS to the end of 2002, was very important. There were many issues to be resolved between health services and RARMS, and many tasks that could not have been undertaken by practice staff who did not have the experience and authority to operate at the level required, let alone the time to do so.

Without **doctors willing to come** to the North West, and without RARMS (and Brewarrina) **practice staff being prepared to commit themselves** to working under sometimes trying circumstances, particularly in the early months of establishment, the progress made to date would not have been possible.

The **moral and practical support** provided by RDN, and by RARMS Directors, has been substantial and significant, including the services provided by RDN accounting staff for RARMS in the first difficult year of operation.

## Issues

Direct involvement in medical service delivery in these remote areas has proven to be much more challenging and time consuming than even a well-informed organisation like RDN had anticipated. Examples include lack of locally available skills, difficulties associated with distance and technology, and the complexities of achieving change when responsibilities are so diffused.

### *Skills shortage*

**Practice Nurses.** An enormous effort has been required to engage registered nurses as practice nurses. In Lightning Ridge the best that could be achieved for much of 2002 was 1 day per week supplied by each of three different nurses. In Walgett, the Hospital, the Walgett AMS and the Walgett Doctors Surgery were all seeking nurses and consciously avoiding the ultimately unproductive temptation to recruit from each other.

**Practice Staff.** On occasions it has not been possible to obtain experienced or qualified people to fill positions.

**IT Skills.** These are also in short supply. When the only available person in Walgett was talking of moving east, RARMS retained his services in the area by guaranteeing a certain level of work for the following 12 months. He has therefore been available to also assist practices in Bourke and Brewarrina.

**Skills in the community.** For a significant part of the period discussed, most of the Walgett Shire senior personnel were themselves locums supplied on short terms by an agency. High turnover (eg 3 Walgett Shire General Managers during the period discussed) at senior levels slowed progress on several occasions. High turnover characterises the staffing situation of many organisations in the area.

### *Doctor engagement*

For RARMS, a significant issue has been the manner in which doctors are engaged. RARMS took over direct employment of 2 doctors from FWAHS, and for a period engaged doctors as independent contractors. As a result of assessment of medical indemnity, tax, superannuation, worker compensation and incentive issues, RARMS has evolved into an entity that contracts practice infrastructure and services to doctors



who conduct their own practices in RARMS premises, and that contracts with FWAHS to recruit VMO doctors and manage the provision of such services.

### *Responsibility and control*

Doctors engaged by RARMS value their clinical independence and that they do not have to worry about business establishment and management. There are nevertheless points of potential tension that need to be worked through, to strike an optimum balance between practice arrangements that maximise support to the doctors without compromising the financial viability of the company. Also 2 doctors in the one practice may hold differing views on some matters (eg are instruments best autoclaved on site or at the hospital?) and effective mechanisms for resolution are required.

### *Triage*

An issue still being worked through is the establishment of hospital triage arrangements that ensure VMO call out on urgent cases, and alternative but appropriate responses to less serious presentations. Excessive call outs can be stressful and detrimental to GP health and to willingness to remain in the town.

### *Medical indemnity*

RARMS was not immune to the medical indemnity crisis and in fact was potentially more exposed than most because the initial VMO Agreement created a situation where RARMS doctors were not eligible for State Treasury cover for their VMO work and there was some uncertainty about commercial cover. The VMO Agreement was modified to address this.

### *Infrastructure*

RDN and RARMS have had to devote considerable effort to resolving infrastructure issues (mainly housing and practice buildings). A basic level of doctor infrastructure is in place but insufficient for expansion e.g. if a third doctor is sought for Lightning Ridge, housing is in short supply and expensive. Housing availability is also problematic in the recruitment of other personnel.

### *Practice services provider vs service development*

Because RARMS received early support to engage an experienced local co-ordinator/planner, it was in a position to be proactive in service development issues involving AHS and AMS. It is now closer to being purely a provider of practice services and manager of VMO services, and only receives ongoing revenue in connection with those activities. A service development role is being maintained by the Medical Advisor over next few months. This aspect requires further consideration.

## **CONCLUSION**

The “Easy Entry – Gracious Exit” initiatives in the NSW North West have, with much work and effort by many parties, achieved significant initial success in doctor recruitment. Further recruitment action is needed for Lightning Ridge and possibly Walgett. The next challenges include further development of practice staff, and further refinement and improvement in medical practice service provision.



A great deal more remains to be done by health providers and others, before the unsatisfactory health conditions in the NSW North West are rectified.

## REFERENCES

1. *A Social Atlas of Australia. Volume 2: New South Wales.* Public Health Information Unit, University of Adelaide, South Australia. December 1999. Page 76
2. Ibid, Page 114.
3. *Healthy Horizons 1999–2003, A Framework for Improving the health of Rural, Regional and Remote Australians,* National Rural Health Policy Forum, March 1999.
4. The RARMS Board is chaired by an RDN Director, and comprises 2 other RDN nominees, plus 1 nominee each from the Rural Doctors' Association (NSW), the Outback Division of General Practice, and the Walgett Aboriginal Medical Service.

## PRESENTER

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