Practice Made Perfect?

CONFERENCE PROCEEDINGS AND OUTCOMES

NSW Rural Doctors Network
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1. Overview

1.1. Background

Demographic changes in Australia’s rural medical workforce are expected to contribute significantly to rural GP shortages in the coming years (RDN, 2004). In NSW for instance, of the 1500 rural GPs in practice, 350 GPs are over 55 and approaching retirement while medical school output is not expected to increase GP numbers until 2020 (Matthews, 2005).

The number of women entering general practice is rising with approximately 63% of GP registrars being female. However traditionally women are less likely to work in rural areas and those that do are increasingly choosing to work part-time. Further, both young male and female GPs are wary of what they perceive as heavy medical and business workloads in rural practice (NSWRDN, 2004).

The traditional model for provision of medical services in rural and remote NSW has been:

- The self employed GP seeing patients in a private, community based surgery usually on a fee for service basis. Funded largely by the Health Insurance Commission (HIC) through Medicare, the GP’s income is supplemented by varying levels of private billing. This is often dependent on local issues such as the socio-economic status of the community. Some practices operate on a bulk-billing basis. In remote areas this often reflects a reduced patient capacity to pay.

- The provision of Visiting Medical Officer (VMO) services to the local Hospital remunerated on a fee for service basis in accordance with the Rural Doctors Association – NSW Health agreement - RDA Settlement Package (RDASP). These services comprise inpatient and outpatient services both in and after normal business hours (NSW RDN, 2003).

There is agreement that the traditional model described above fails to address the working conditions valued by the “new generation” medical workforce. The working conditions preferred by GPs in rural and remote towns include:

- Regular holidays, structured time off and reduced (ie: safe) working hours
- Predictable, reasonable income
- Not having to worry about the hassles associated with running their own business
- The ability to concentrate on quality practice of medicine
- Third party provision of real estate infrastructure such as domestic housing and surgery premises
- Not feeling they are deserting their community when they finally choose to leave (NSWRDN, 2003).
In order to attract “new generation” GPs to country areas it is essential that governments and medical service providers continue to look for economically viable alternatives to the traditional GP provided fee-for-service model upon which Australian primary care is currently based (Matthews, 2005).

Since 2000, the RDN has been involved in forming new general practice structures in North West NSW. This has had considerable success in increasing recruitment and retention of GPs, increasing the number and range of GP services and increasing sustainability of health services in some of the State’s more “difficult” areas.

The success of the activity has influenced both State and Commonwealth policies, and has in large part given rise to such initiatives as GP Entity Funding (NSW), the Integrated Primary Care proposal (NSW) and the Rural Medical Infrastructure Funding (Commonwealth).

A number of communities, organisations and practitioners both in NSW and other parts of Australia have also been exploring new ways of providing GP services.

1.2. Purpose

The purpose of the Practice Made Perfect? Conference held in Coffs Harbour on 23rd and 24th February 2005, was to share experiences of organisations that have set up alternative general practice structures, and discuss related issues. A copy of the program is included in Appendix A.

Organised by the RDN, Practice Made Perfect? brought together more than 60 delegates from Government (Commonwealth, State and Local), Divisions of General Practice, Rural Workforce Agencies, state based divisional organisations, practitioners, practice managers, rural consumers, the RACGP, academics and insurance representatives. A list of attendees and presenters is included in Appendix B.

1.3. Key messages

The following key messages resulted from the presentations and discussions at the conference:

1. There is a need for alternative approaches to general practice across NSW and in other states.

2. Sustainable alternative GP structures are achievable as GP entities or integrated primary health care centres (IPC). The GP entity or “practice made perfect” approach can operate as a component of the IPC system or stand alone as a more traditional practice.

3. There are common factors contributing to sustainable general practice in a rural or remote setting. These include:
   - Local management and ownership.
• Addressing the needs of the local community.
• Collaboration amongst local stakeholders ie. Council, Division, Rural Workforce Agencies, health service, academics and local business.
• The existence of an anchor organisation.

4. Where there is adequate infrastructure, governance and management support, alternative GP structures are successful in providing greater flexibility, security and working conditions for GPs.

5. Alternative GP structures can be achieved with current funding levels although start-up funding is necessary.

6. A not-for-profit or “benign corporate model” can work in areas where for profit companies aren’t willing to invest.

7. An independent organisation could fulfil the role of facilitator and support the development of the GP management structure and governance.

1.4. Outcomes and recommendations

A number of outcomes and recommendations were made during the conference and have been summarised as follows:

1. Continue to hold workshops of this nature with a view to:
   • Ensuring continued knowledge sharing.
   • Exploring solutions for primary health care.
   • Finding an agreed direction.

Delegates agreed that the workshop was very beneficial and should be continued either independently or as an adjunct to other conferences. The suggestion of a national forum was mooted as was the notion of opportunistic promotion of discussion in other forums.

It was also suggested that theme-specific workshops (e.g. insurance and structures) with broad representation across states, governments and organisations, be considered. The issue of resourcing these events and ongoing support needs consideration.

2. Encourage web-based information sharing by compiling case studies of practical solutions for rural communities.

The case studies could include:
• Stories from other states and territories.
• Practical check lists to guide others.
• Issues and common questions.
• A list of contacts for those involved in the establishment of GP entities.
• Evaluation techniques to measure outcomes.
• Research opportunities.

3. Conduct research and prepare information about “Primary Health Care” systems for a variety of professional groups.

In particular:
• What is Primary Health Care?
• What is happening in other places?

4. Incorporate key messages from the conference into recruitment and retention strategies.

5. Publish papers and present at a wide range of conferences.

6. Consolidate processes and improve efficiencies across the system.

    Consider strategies such as:
    • Franchising the business model.
    • Data system uniformity.
    • Group buying.
    • Training of staff.
    • Sharing contact lists of organisations involved.

7. Make recommendations to the Department of Transport and Regional Services (DOTARS) on the Rural Medical Infrastructure Funding Program

The Rural Medical Infrastructure Funding Program was discussed at the conference and several recommendations were made by delegates which were compiled by Dr Ian Cameron of the NSW Rural Doctors Network and forwarded to DOTARS (Appendix C). For more information about the RMIF Program Guidelines go to: http://www.regionalpartnerships.gov.au/rmif_guidelines.aspx.
2. Practice Made Perfect? Presentation Summaries

The following section contains summaries of presentations made in Session 1: Sharing experiences from different perspectives.

2.1. Finding solutions in North West NSW: “Easy Entry, Gracious Exit” and the Rural and Remote Medical Services (RARMS) experience

Presented by Dr Ian Cameron, CEO, NSW Rural Doctors Network

Background

The Easy Entry, Gracious Exit approach to recruiting GPs began as a crisis response to chronic doctor shortage and high doctor turnover in North West NSW, rather than as a researched and planned “sustainable model” exercise.

The North West of NSW was identified in late 1999 as being a region chronically short of GPs. In February 2001 the doctor in Brewarrina left at short notice. The NSW Rural Doctors Network (RDN) provided a locum to fill the immediate need but there was no furniture, phone or electricity in the Shire owned house, no entity or equipment to run the surgery or employ practice staff. To enable a doctor to work there, RDN furnished the house and took over management of the practice as a temporary measure.

In October 2001, Lightning Ridge was down from three to nil permanent GPs; Walgett had one permanent GP in private practice and one employed by the Aboriginal Medical Service; Collarenebri had not had a permanent doctor for some time.

The Far West Area Health Service was taking on significant responsibility for recruitment, employment and support of doctors for both hospital and community services including the actual management of general practice. Cost blowouts, poor levels of infrastructure and additional recruitment difficulties catalysed a close planning relationship between RDN and the health service to plan local GP workforce needs.

The Easy Entry, Gracious Exit Model

The role of RDN throughout this time was to facilitate local stakeholder cooperation to achieve more attractive circumstances for recruiting GPs and sustainable general practice. The creation of a walk-in, walk-out environment now referred to as the Easy Entry, Gracious Exit model, was identified as a key initiative to attract more GPs to the area.
Features of the Easy Entry, Gracious Exit model were to:
- Enable GPs to work as clinicians without having to be small business owners and managers.
- Support both the desire of GPs for more predictable and less onerous work commitments and to reduce the need for any significant up front financial investment on their part.
- Have a third party provide domestic and surgery accommodation, and full infrastructure for the general practice and the option for VMO rights and contracts to being negotiated on behalf of the doctor.

Development of Rural and Remote Medical Services Ltd

In 2001, The Rural and Remote Medical Services Ltd (RARMS) was established by the RDN to implement this new approach, initially in Walgett and Lightning Ridge.

The RARMS version of the Easy Entry, Gracious Exit model has metamorphosed several times since its inception. Its current features look like this:

- RARMS leases housing from the Shire Council, which the GP sublets at subsidised but close to market rates.
- RARMS leases the practice buildings (from Shire Council and private owners).
- All furniture for domestic and practice accommodation is provided by RARMS.
- RARMS employs all the practice staff (practice manager, receptionists, practice nurses and cleaners).
- RARMS initially provided a subsidised motor vehicle for some GPs but has re-balanced remuneration structures and doctors now supply their own.
- The GPs contract RARMS to provide the service of managing their practices.
- RARMS has a local finance officer.
- RARMS negotiates with the local Area Health Service and the hospital on behalf of the GPs.
- VMO services have been cashed out to provide predictable VMO incomes. Note: This is an optional element that might not be necessary in less remote areas.
- RARMS handles all practice related financial transactions on behalf of the GP, including VMO payments.
- RARMS provides corporate governance and strategic direction through a Board of Directors comprising a mix of local stakeholders (Division of General Practice, Aboriginal Medical Service, and other more distant management and medical bodies such as RDN and RDA NSW).
Successes of this approach

Experience has shown that this approach, or variations of it, has been very successful in expanding and improving the stability of the general practice workforce in Walgett and Lightning Ridge and also in the nearby communities of Brewarrina and Collarenebri. The successes of this model can be seen as:

- A dramatic increase in the number of doctors, from a low point of three GPs to nine resident GPs in 2003.
- Retention of several doctors beyond originally stated departure dates.
- A significant expansion in Medicare services including greater uptake of Enhanced Primary Care (EPC) items, outreach services to outlying communities and more clinician time to participate in disease prevention and health promotion activities, including formal public health activities.
- The creation of a platform that can be used to provide a wider range of Primary Health Care services.
- A successful partnership of health policy makers, health service organisations, health practitioners, communities and academics. This has formed the basis for raising ad hoc partnerships to formal contractual partnerships.
- Stability in the professional and clinical working environment, resulting in more productive, less stressed clinicians.
- Continuity of practice infrastructure and practice management skills independent of continuity of the medical practitioner.
- Enhanced opportunities to address quality issues in practice. For example, computerised records, good recall systems, chronic disease registers, better information management, greater capacity to engage practice nurses and train (support) staff.
- The continuity of patient records even when there is a high turnover of doctors.
- A better relationship with the local Area Health Service resulting in a more productive and less stressful working environment.
- Elimination of the previously frequent crisis situations that occurred in scrambling to provide hospital and medical cover whenever a doctor was ill, or took a few days off for leave, training or personal reasons.

Lessons Learned

The RARMS experience has shown that:

1. Initially, HIC income generated through bulk billing did not sustain quality general practice and its administration in a remote area. If a separate business entity is established to manage the practice there are also additional corporate governance and financial management responsibilities to be carried and paid for, and issues to deal with including separation of corporate governance from medical performance. For example, Walgett, Brewarrina and Lightning Ridge have had considerable financial support from the Department of Health and Ageing and significant people, time and knowledge support from Royal Flying Doctor Services (RFDS); Collarenebri has had considerable support from the
Far West Area Health Service. In 2005, with increased income through Strengthening Medicare, the practices are financially self sustaining.

This is a central point. In almost all other remote areas in Australia, primary medical services are provided directly with Government infrastructure (District Medical Officers in Northern Territory, Medical Superintendents in Queensland), by organisations with significant Government infrastructure support (especially by Aboriginal Medical Services in Western Australia and Northern Territory, and Royal Flying Doctor Service (RFDS) in areas with no permanent doctor), or more rarely by highly subsidised practices in mining company towns.

2. Private practice in remote NSW is not sustainable in the traditional small business model. In the past it has been subsidised by:
   - Regularly indexed payments (in line with the RDASP) from Area Health Services to doctors for VMO services.
   - The doctor, and sometimes the doctor’s spouse, performing unpaid administrative services after hours. This often creates a secondary problem that when the doctor leaves town, the practice company structure and the practice management is also lost.

3. There is often a serious shortage of people with practice management, management, IT, nursing and financial skills in remote areas. This is a remoteness issue, not peculiar to the health sector, however it dramatically increases practice costs and the difficulties of delivering quality practice services. There is limited opportunity, because of remoteness, to share human resources, and this problem is compounded by the increasing complexity of medical practice management and small business management.

4. Maintaining a sustainable community based bulk billing practice is challenging due to the difficulties associated with achieving the correct fee, billing and contract structures to account for “opportunity” costs such as those arising from the absence of a GP from the practice whilst undertaking VMO, public health and other activities.

5. Stakeholder consultation was vital for the successful implementation of RARMS. The establishment of the Walgett Shire Health Forum provided an opportunity for ongoing public discussion, planning of initiatives, joint action by relevant parties and regular reporting back on progress against commitments made.
Now

Today GP services in North West NSW are sustainable and RARMS as an entity is sustainable. There are more doctors than ever before in the towns of Walgett, Lightning Ridge, Brewarrina and Collarenebri producing a higher volume of Medicare activity and better health outcomes particularly in chronic disease management. VMOs are now being paid a daily rate rather than fee for service.

This success is in part due to the responsiveness of governments. Changes to Medicare such as increased rates of bulk billing and new item numbers have had a positive impact. So too, increased funding such as NSW Health’s $2million funding boost for rural medical grants and The Commonwealth Department of Transport and Regional Services commitment of $3million over three years for the Rural Medical Infrastructure Fund, has made a substantial difference to the sustainability of these practices.
2.2. From the horse’s mouth: A GP’s perspective on sustainable general practice in a remote setting.

Presented by Dr Vlad Matic, Walgett Medical Practice.

The concept of general practice as a cottage industry is gone

Rural doctors have typically lived in the town, owned their house and surgery and managed the medical practice as a small business. They have been responsible for ensuring the practice has appropriate resources including staff and equipment, and for all aspects of the business management. Where the doctor was also working as a Visiting Medical Officer (VMO) this required a close working relationship with the local hospital.

Doctors are increasingly reluctant to invest in a small remote town by purchasing a house or practice, for fear of feeling financially trapped and due to the perceived poor rate of capital growth and/or financial return.

The poor return on capital investment and business risk does not justify the involvement or the financial outlay. Greater return exists on non medical investments with much less risk. The concept of “goodwill” for medical practices is no longer existent and premises can no longer be seen as superannuation.

Making it work in Walgett

I came to Walgett in response to medical need. At the time there was no GP in town willing to commit on a permanent basis. Working as a GP in a community where need is great due to poor overall health status, is a great challenge and a reward in itself.

However I soon realised that one doctor working full time could only reactively manage medical problems in an ever less profitable environment. What was needed in Walgett was a multiplier that would enhance and increase the effectiveness of my efforts every day.

That multiplier consisted of:

• An allied health service team.
• Technology in the form of practice and medical hardware and software.
• Practice management apparatus that could analyse and enhance my business potential and medical impact.

This required a considerable investment of monies, larger premises, greater business risk and the hiring of many more staff.
Elements of this approach included:

- Establishing ownership of the structure in a neutral entity, removing the profit motive.
- Securing the community’s medical service delivery into the future. Historically the medical records left town with each departing GP and I wanted a system where the accumulated health data remained in trust for the local community.

The result was the establishment of RARMS which Dr Cameron discussed in depth in the previous presentation.

**Key observations**

Some of my key observations are:

- You need an investment to get a return.
- If there is assistance from local government it is important to distinguish between supply of infrastructure and the supply of medical services. Shires have a long standing obligation to provide doctor housing and medical premises but should not attempt to run surgeries or directly employ doctors. Communities are too small and the potential for conflict of interest is too great.
- Better health outcomes is the primary motivating factor to getting the balance right. RARMS has increased health outcomes in Walgett. It has been a team-based approach to general practice with a unified vision of better health outcomes.
- Better medicine in a team setting with unlimited patient access is more profitable medicine for the practitioner, delivers better health outcomes for the patient and increases the breadth of services available. For example, Pap smears, wound care and immunisation, asthma education, diabetes management, recalls, transport and cultural safety.
- Greater ethical return on the GP. Unethical returns are possible but RARMS has proven that better health outcomes and profit are complimentary and not mutually exclusive.
- A need to change community expectations in terms of practitioner availability. Not all health care has to be delivered directly by the GP but needs to be within the stewardship and responsibility of the GP.
- Commonwealth health priorities need to be implemented.
- Cashed out hospital payments removing the tension between the more profitable hospital RDA Package remuneration and the income from bulk billed Medicare income.

**Non negotiables**

The following are a set of principles and practical aspects of general practice that I personally believe are “non negotiables” when implementing alternative GP structures in rural and remote communities.

**Principles:**
• I would not support any structure that does not result in increased health outcomes.
• I would not support any structure that does not realise a reasonable income for a medical practitioner.
• I would not support any structure that limits patient access to medical services on a financial basis.

Practical aspects:
• Care planning.
• Mental health three steps.
• Nice equipment and a nice work environment.
• Quality in workplace.
• Occupational Health and Safety standards.
• Practice nurses.
• Aboriginal Health Worker - cultural safety and community linkages.
• Computerisation.
• IT services on call 24 hours, 7 days a week.
• Transport from Aboriginal communities to the surgery.
• Practice Manager.
• Receptionists with suitable training and in adequate supply to cover leave and holidays.

The importance of stakeholder involvement in establishing alternative GP structures

The following is a list of those that should not INDIVIDUALLY run a General Practice, yet have a role and a contribution to make to a successful general practice team.

1. The Shire.
2. The local community.
3. Academics.
4. The local Division of General Practice.
5. The Rural Doctors Network
6. GPs.
7. State Government.
10. IT Professionals.
11. Allied Health Professionals.

All are required to ensure the practice is:
• Locally responsive.
• Incorporating of national priorities.
• Able to self assess and analyse quality and performance.
• Appropriately resourced with infrastructure.
• Profitable.
• Team based.
• Well managed.
• Attractive to new personnel.
• Linked to other health delivery structures.
• Delivering better health outcomes in a not for profit setting without limiting patient access.

I believe an ideal structure is embodied within RARMS which brings all these players to the table at either board level or else consults with them at the Community Health Forums or at meetings with respective organisations.

The overall management and leadership however needs to be vested within general practice, which is appropriate in view of the fact that the ultimate responsibility for medical practice and outcomes rests with the general practitioner.

Where to from here?

There is still the need for greater investment and this should be done in the not-for-profit model. RARMS has been a successful example where a clinician-driven service has successfully operated to deliver benefits to patients without restricting access to those who need it the most.
2.3. Rural practice: What works for female GPs?

Presented by Dr Lyndal Parker-Newlyn, Member of the National Rural Female GP Network Steering Committee.

Background

The National Rural Female GP Network Steering Committee (GRFNET) was funded eighteen months ago to address issues affecting female GPs in rural areas and develop a transition strategy for solutions.

Demographics

The number of women in the medical workforce is growing rapidly with up to 55% of medical graduates being female however currently only around 25% of the rural medical workforce is female. Many women are not attracted to rural practice the way it is currently structured, and as older male GPs retire, the question needs to be asked, “Who will replace them if women won’t?”

What works for female GPs?

As part of its consultation process GRFNET has been gathering information on key elements of successful rural practice amongst female GPs. This information has come from a variety of sources:

- Published research by authors such as Helen Tolhurst (Newcastle University), Jo Wainer (Monash University), Kirsty McEwin (RDN), Anna Nichols (ACRRM), Sue Doyle (ARRWAG).
- Stakeholder groups such as GRFNET and WIRP (Women in Rural Practice – ACRRM).
- The “horse’s mouth”.

One of the key observations has been that “women who are successful, contented and committed to rural general practice, are so because they have already implemented strategies that contribute significantly to satisfaction with rural practice.”

“Doctors who are content with life as a rural doctor intend to stay longer in rural medicine, and the factors that contribute to their contentment can be identified. The variables that contribute to this contentment and satisfaction are DIFFERENT for men and women.” (Wainer, 2004)
Key factors for women in general practice

1. Avoiding stereotypes

For example:
- Doctors have wives at home to look after them, work till they drop, never get stressed and are superheroes.
- Female doctors won’t work after hours.
- Female doctors all work part time.
- Female doctors want to be employees.
- Female doctors all are married with kids.
- Female doctors just do “tears and smears”.

2. Flexibility and respect

- Allow all GPs (especially women) the flexibility to tailor their work practices to reflect the way they want to work, train and study.
- Recognise differences in practice styles as healthy and encourage colleagues and practice managers to do the same.

3. Practice models

Alternative models like “walk-in, walk-out” models are very effective especially in remote areas. Some of the Rural and Remote Medical Association areas in the Northern Territory have a significant proportion of female GPs. It is important to think outside the square and tailor practices to suit the individual. Job sharing, partnerships and locums are other options that could work well depending on the individual’s needs.

4. Provide networking opportunities

- Facilitate networking with other female doctors (or other professionals) in the town, region or Division.
- Assist the new GP to “make the community their own”.

5. Family support

- Welcome partners whoever they are
- Consider spouse employment, networking & support
- Childcare (including after hours care) and schooling are key issues. Note: While men and women both contribute towards caring for children, studies have shown that a female GPs clinical hours decrease by 20% while there is no great effect on a male GPs clinical hours. For female GPs with children under 10 years of age, family and clinical work combined account for an average of 91 hours of work per week.
6. Leadership & Education

- Leadership opportunities and support for women
- Educational opportunities must be flexible and meaningful

So in conclusion, does practice, family and rural life work? It works for me so it can work for you!
The following section contains summaries of presentations made in Session 2: Case studies of alternative GP structures: issues, barriers and solutions.

2.4. Hay Medical Services

Presented by Mr Keith Fletcher, CEO, Murrumbidgee Division of General Practice.

Background

In 2000, a series of “unfortunate events” with newly recruited GPs, and the local Area Health Service lead to a rapid departure of two thirds of the local General Practice workforce. In partnership with the Hay Shire Council, the Murrumbidgee Division of General Practice (MDGP) undertook to operate Hay Medical Services, with the blessing of the remaining solo GP. The goal was to maintain the service with potential recruits as locums with a “no risk, try before you buy” operation. (There was no cost to the incumbent).

Over the ensuing two years, 19 locums were trialled with eight commitments to start. Unfortunately none of these commitments reached agreement.

Over this time period, an additional three practices had been temporarily managed by the MDGP with the same concept. Each was unique in its case, but fundamentally the Division did not want to manage General Practice services. It was considered appropriate for the Division to act as care-taker while a “temporary resident” made their way through to permanent residency or simply a permanent placement was found.

In 2002, Hay Shire Council approached the MDGP to take on a permanent management role for Hay Medical Services. The operation itself was close to breaking even, but the cost of management between both Hay Shire and the MDGP was in excess of $60,000 per year. With discussion and commitment from the Board of Directors and extensive risk assessment, the MDGP entered into agreement with the Hay Shire Council to manage and operate Hay Surgery.

The business entity of Hay Surgery is registered with the Department of Fair Trading as the "Murrumbidgee Division of General Practice t/a Hay Surgery". The MDGP is a not-for-profit health promotion charity and is therefore able to provide staff with the benefits of its status.

GPs are contracted on independently negotiated terms. There are currently two GPs in the facility and each GP receives a fixed annual stipend. In addition, bonuses are
provided for exceeding agreed targets. Invoicing is undertaken by the GP either fortnightly or monthly.

As the GPs are contractors they are responsible for their own professional indemnity. As Hay Surgery itself is a wholly owned trading arm of the MDGP, the MDGP is responsible for:

- Nurse Indemnity
- Public Liability
- Vicarious Liability
- Workers Compensation

Hay itself is located 180km west of Leeton, the head office of the MDGP. As one could appreciate, the distance is considerable and presents issues from time to time. The operation of a business, let alone General Practice, requires strong systems and procedures to ensure its viability and sustainability. To reach this end, systems (policy & procedure) surrounding accounts, assets & fixtures, auditing, banking, GP contracts, risk, payroll, petty cash and purchasing are critical. While Hay is considered remote (RRMA 7) it is extremely lucky to have received broadband access relatively early. It has provided the MDGP with the opportunity to set up a VPN (Virtual Private Network) that has allowed many procedures to be undertaken remotely.

**Mentorship and supervision**

The two GPs currently working in Hay are not vocationally registered. One of the GPs has successfully made his way through the AMC process and is currently on the five year program. The other GP is currently in her second year of the Remote Vocational Training Scheme (RVTS).

Each GP requires a varying degree of mentorship and/or supervision. This is provided by two GPs in Griffith who are paid on agreed terms for their efforts. This, in turn, is reflected in Hay Surgery's chart of accounts as cost of operating the business.

**Recruitment**

Every GP recruited to Hay has been engaged in partnership with the NSW RDN. In fact, every GP recruited to our region utilises the expertise of the NSW RDN. The process of selection and quality assurance is an important component of our risk assessment.

Hay Surgery continues to progress well. To date the surgery offers two Full-Time Equivalent GPs to the community of Hay. Having both a male and female GP has been well supported. In addition allied health support is provided at the surgery in the form of optometry, psychology, women’s health, podiatry and diabetes education as allied health support to the GPs.
Information Technology

The practice has been linked to HIC online, and a VPN (Virtual Private Network) has been introduced. There has been in excess of $100,000 invested in the community in the form of IT equipment upgrades and new medical equipment.

Most importantly, Hay has been provided with the opportunity for a viable and sustainable General Practice.
2.5. Cessnock Uni-Clinic

Presented by Dr Chris Matthews, 
Cessnock Uni-Clinic.

Background

Cessnock is the heart of the Hunter Valley coalfields area. It has a history of socio-economic deprivation and poor health status. It has also been affected by the GP shortage with a patient to GP ratio of 1:2800 compared with the NSW average ratio of 1:1900.

In 2000, the community perceived a threat to health services at Cessnock Hospital and in response NSW Health committed funds to build a “clinic”. In 2002 the University of Newcastle’s Pro-Vice Chancellor for Health Professor John Marley proposed collaboration between the University of Newcastle and Hunter Area Health Service to support the clinic. In 2004 the building was completed.

The Cessnock Uni-Clinic was designed to showcase a new primary care approach. One in which nurses, dieticians and other allied health care professionals work alongside GPs to provide chronic disease management.

Under this structure it was envisaged that there would be a working ratio of one GP to two non-GP health care workers. The clinic would maximise the use of Medicare items and bulk-bill all services ensuring access for the socio-economically disadvantaged.

Major milestones

Between 2000 and September 2004 a number of milestones were achieved prior to the clinic becoming fully operational:

- Project officer completes preliminary planning.
- GP team leader arrives.
- The University of Newcastle provides start-up salary grant.
- Hunter Area Health Service provides funding for clinic fit-out.
- Hunter Uni-Clinic Pty Ltd established as a trust company by The University of Newcastle.
- Practice manager recruited.
- Women’s health nurse and practice nurse recruited.
- Administration assistants and dietician recruited.
Early experiences

The Clinic was officially opened on the 25th October 2004 on the grounds of Cessnock Hospital. Following a local media campaign there was a rapid uptake of services. Human resources were increased to meet the demand with practice nurses increased to 1.2FTE and a dietician employed as a .6FTE. The clinic currently has two GPs and one advanced GP trainee seeing between 350 and 400 patients per week. The number of receptionists has increased to 3 FTE’s and a nurse with mental health experience has been employed .6FTE.

Ups and downs

Significant successes to date include:
- The ready acceptance of non-medical providers by patients.
- The clinic becoming economically self-sustaining within three months.
- Great team spirit.

Challenges to be overcome include:
- Difficulty satisfying all stakeholders.
- Lots of ‘supervision’ disruptions to GPs.
- Worry about over-servicing (80:20 rule).

The way forward

Much has been achieved, with further improvements to be made. The Cessnock Uni-Clinic plans to more fully utilise extended primary care items, and is also looking to extend its premises to allow more nurse consulting services.
The role of local government in rural health

Rural health is a vital ingredient in our communities and one in which local government has to be involved to achieve well resourced and sustainable rural health programs.

There is much that local government can provide in terms of rural health. This includes:

- General administrative assistance.
- Organisational skills to co-ordinate grant submissions, corporate involvement and donations.
- Professional advice.
- Engineering and construction work advice and work (e.g. provision of road and car parking facilities in any capital project).
- Political lobbying to other levels of government.
- Direct cash contributions.

Effective lobbying is the most critical aspect for local government. The willingness and ability of individual councils to articulate the concerns of their communities and just as importantly, to champion and progress solutions, is vital.

So how can local government improve rural health services?

Firstly and most importantly:

- Be aware of your community’s genuine needs as opposed to the wants!
- Audit existing health assets and identify short falls.
- Identify potential partners, both local (local GP’s, community leaders, individuals etc.) and regional (Local, State and Federal members, regional health organisations, Area Health Service board etc) and others.
- Become involved in solutions. Be positive and inclusive!
- Use the local media and engender public involvement. Develop a sense of “it’s our health service”. Be part of its continuing sustainability and relevance.
Gunnedah Council’s rural health initiatives

Gunnedah Council has an ongoing, demonstrable commitment to financially support initiatives aimed at improving rural health services locally. It has provided the following:

- Direct cash assistance through the purchase of 2 x 2 bedrooms fully furnished modern duplex units (with assistance from the local Divisions of GP).
- An executive fully furnished four bedroom residence for the sole purpose of accommodating doctors and other allied health professionals.
- Rent subsidies.
- Funding of $3,000 per annum to the RDN/CWA Bush Bursary program supporting local medical undergraduates.
- In 2003, the Gunnedah Community Scholarship Fund was established to support local student’s tertiary studies. The funding for these scholarships is sourced entirely from individuals, business-owners, GP’s and fund-raising in the local community. Council has distributed $43,300 over the past three years.

Summary of the estimated value of Council assistance in attracting and keeping GP’s in Gunnedah.

<table>
<thead>
<tr>
<th>Assistance provided</th>
<th>Estimated Value ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>House (61 Lincoln Street)</td>
<td>250,000</td>
</tr>
<tr>
<td>2 Flats (1/6 &amp; 2/6 Davis Avenue)</td>
<td>150,000 *</td>
</tr>
<tr>
<td>Furnishings</td>
<td>30,000</td>
</tr>
<tr>
<td>Forgone rent each year</td>
<td>15,000</td>
</tr>
<tr>
<td>Bush Bursary (1999-2003)</td>
<td>10,000</td>
</tr>
<tr>
<td>Community Scholarships (since 2003)</td>
<td>20,000</td>
</tr>
<tr>
<td>NEAH Service – Gunnedah Medical Centre Project</td>
<td>30,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>503,000</strong></td>
</tr>
</tbody>
</table>

* Note: Grant of $95,000 provided under commonwealth program progressed through Australian Rural and Remote Workforce Agencies Group.
Gunnedah Community Scholarship Fund Disbursements

<table>
<thead>
<tr>
<th>Year</th>
<th>Allied Health</th>
<th>Total Funds</th>
<th>Allied Health as a total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>$5,900</td>
<td>$12,300</td>
<td>48%</td>
</tr>
<tr>
<td>2004</td>
<td>$7,000</td>
<td>$13,500</td>
<td>52%</td>
</tr>
<tr>
<td>2005</td>
<td>$8,000</td>
<td>$17,500</td>
<td>46%</td>
</tr>
</tbody>
</table>

Other incentives and assistance include:

- Flights for medical families to Gunnedah to see the community first-hand.
- Looking for employment opportunities for spouses.
- Assistance with integration following relocation.
- Listening and assisting in meeting individual requirements wherever possible.

Councillors and staff members have also taken an active role in rural health initiatives. For example:

- The General Manager and one other Council employee are Board Members on the Gunnedah Health Service Advisory Committee.
- A former councillor was Chairman and Board Member on North East Area Health Service.
- Several councillors are leaders of community organisations eg. GreyPower, Rotary, Miners Support Group.
- Council delegates are appointed to the Gunnedah Nursing Home and Alkira Hostel.
- The local hospital is redeveloping the ‘disused’ nurses’ quarters into a well-equipped up-to-date medical centre. Council has provided significant support in creating the initial submission, as well as contributing financially to the road works for the project.

Council continues to act as a conduit to bring together government representatives, health workers and the community to ensure the provision of quality medical services.
2.7. Wentworth Medical Practice

Demographics

Wentworth is situated in the southern part of NSW at the junction of the Darling and Murray Rivers. The Wentworth Shire is a hub of industry, based on intensive horticulture, significant grazing holdings and tourism.

The Shire covers an area in excess of 26,000 square kilometres with a population of approximately 7,200 spread over the townships of Wentworth, Dareton, Gol Gol Buronga and Pooncarie with smaller towns of Curlwaa, Pomona, Monak and Ellerslie.

The indigenous population of approximately 400 people or eight percent is based around Dareton. Approximately 87% of residents are Australian born with other small ethnic groups from Italy, United Kingdom, New Zealand, Germany, Greece, Philippines and the Netherlands.

History of the medical practice

The Wentworth Medical Practice was established in July 1998 by the Mallee Division of General Practice because of a lack of general practitioners in the area and a growing need for this service. The Practice was run by two GPs of South African origin and a Practice Manager/Receptionist.

In October 1998, the doctors moved to the greener pastures of Broken Hill.

In 1999 the Mallee Division of General Practice employed another GP, however a review undertaken by the board identified that this was not a core activity of the Division. A significant amount of pressure was placed on the practice by the board and other medical practitioners to look at other options or to sell off the business.

At this stage the Wentworth Council was encouraged to take over the management of the practice as a community service as there was a real possibility of losing the practice altogether.

The practice was not profitable at this time and questions were raised whether it was of benefit to ratepayers of the Shire or a financial drain.

The Council agreed to take over the Practice on a trial basis in 2000 and officially took over in 2001. Part of the takeover was to review practices and become accredited to
qualify for Practice Incentives Program (PIP) payments and to improve the financial position of the practice.

During this time a significant amount of help was given by the Mallee Division of General Practice to ensure the correct amount of training and development was passed on to the employees.

In 2001 a new practice manager and full-time receptionist were employed and responsibilities were clarified.

In 2002 the practice was accredited and qualified for the PIP program. A practice nurse was also employed.

Health education sessions for patients commenced. A spirometer was purchased, an asthma 3+ program was implemented and the Wound Management Clinic began.

At this time the GP signed an employment contract with the Shire.

Negotiations with Far West Area Health Service began to enable the GP VMO rights to Wentworth and District Hospital.

Prior to this, GPs from Victoria were the only ones able to access the Wentworth Hospital.

Current situation

In 2004 the GP was accepted as a Fellow with the Royal College of General Practitioners.

The Council is currently running two fully accredited medical practices, one in Wentworth and one in Dareton.

Changes on billing practices impacted positively on the profit margin. The practice went from a deficit budget of $20,000 in 2002 to a surplus of $87,000 in 2004 and is currently operating in a surplus position.

The Practice Manager is responsible for ensuring confidentiality, up-to-date training, health education, patient invoicing and reconciling, purchasing of medical requirements and all other general administration relating to the practice.

Council supports the practice by offering in-house IT services as required, takes an active role in staff selection, administers payroll, pays all invoices as well as providing detailed financial reports on a monthly basis.

The Director keeps in touch with all issues with managers through regular fortnightly meetings or immediate liaison on specific issues as they arise. Communication between Council and the Practice is excellent.
Recently the VMO contract was signed with Far West Area Health Service with huge benefits to the community allowing for follow up treatment to occur locally. This has also contributed to increased revenue.

Council has employed highly qualified and quality staff eg. Practice Manager holds a Bachelor of Arts in Humanities, Bachelor of Nursing, Family Therapist, Graduate Diploma in Management, Certificate IV in Assessment and Workplace Training and the Practice Nurse has Certificates in Wound Management, Immunisation and Counselling. The Receptionist has a First Aid Certificate.

The Medical Practice offers additional services that the community needs. These include:

- Counselling services.
- Pathology collection.
- Extended opening hours.
- An emergency clinic.
- Health education.
- A medical library.

The GP is supported in every way possible including help with filling in personal forms such as Visa applications, providing medical insurance and registration fees.

The practice nurse assists with minor procedures, ordering of medical supplies, immunisations, wound management and triage.

**Why the practice works?**

- It has adequate human resources to meet the community’s needs.
- Staff have identified what customers want and have a flexible approach to meeting their needs.
- The Practice is in a visible position and is often used by visitors to the area or through word of mouth.
- Staff are informed and up-to-date with training on the latest procedures.
- Individual services are reviewed on a regular basis and financial performance is monitored regularly.
- Highly professional, dedicated and caring staff have been employed.
- Practice staff deliver beyond what is considered to be reasonable and have a “make it happen” attitude.
Summary

The Wentworth Medical Practice is currently a viable business and has had a huge turnaround from previous years and will continue to thrive.

It is essential that the rural doctors are fully supported particularly in all administrative matters so that they can concentrate on the medical aspects of the business.

As in any other business, the success depends on the employees running the business, therefore it is absolutely essential that the right employees are selected in the first place.

There will always be difficulties in sourcing GPs for rural areas but when they are sourced, support should be paramount to make life as easy and as comfortable as it can be for them so that we can keep them happy and encourage them to stay as long as possible.
2.8. Cloncurry and Diamantina Shire, Queensland.

Ms Kristine Battye
Consultant,
Health Workforce Queensland.

Background

In 2003, Health Workforce Queensland (HWQ) undertook a project to identify the key factors contributing to the current medical workforce shortage and how it impacts on communities and health professionals.

The purpose of the research was to:

- Understand why rural and remote Australia’s medical workforce shortage.
- How the shortage impacts on communities and health professionals.
- Examine existing models and identify adaptations to improve sustainability.
- Describe two case studies.

Much of this presentation has been drawn from the paper Solutions to the provision of primary care to rural and remote communities in Queensland www.healthworkforce.com.au by Col White, Sheilagh Cronin, Nigel Bond, Chris Mitchell and Kristine Battye.

The rural medical crisis in Queensland

The trigger for the rural crisis was a result of the convergence of federal government policies in the early 1990s that sought to address the oversupply of general practitioners (GPs) in metropolitan areas through restricting medical student intake, reducing GP training places, applying provider number restrictions to overseas trained doctors, and limiting the issue of provider numbers to doctors participating in or completed a vocational training program.

However, the restriction of supply has been further compounded by a range of other factors:

- Ageing GP workforce.
- Increased participation of women.
- Changes in work patterns (80% urban Qld GPs work less than one Full-Time Equivalent (FTE) position).
- Lifestyle factors.
- Changing attitudes to owning and managing practice.
- Poor image of general practice and rural practice.

HWQ has also examined existing models and identified adaptations that would improve sustainability by addressing the risk factors for the poor health of rural practice.
Over the past 12 to 18 months, HWQ has sought to apply these adaptations to rural communities currently in or near workforce crisis.

By developing sustainable rural practice, it is possible to develop safe practice where safety is not only about patient care but safety of the health professional at a professional and personal level.

**Professional and personal barriers contributing to GP shortages**

In particular, the GP shortage has been exacerbated in rural areas because of these professional and personal barriers, which are now pretty well understood and apply to doctors, nurses and allied health professionals.

**Professional**
- Long working hours.
- Difficulty in accessing leave/locums.
- Lack of part-time or job share opportunities.
- Travel costs for training.
- Professional isolation.

**Personal/family**
- Cultural and lifestyle limitations.
- Lack of employment opportunities for spouse.
- Lack of educational opportunities for children.
- Isolation from extended family and friends.

**Impact of GP shortages**

Medical practitioner shortages in rural areas impact on individual patients and clients, the community as a whole and on the doctors themselves. The shortages have contributed to:

**At the community level;**
- Decline of rural communities.
- Poorer health status of people living in rural and remote areas (independent of indigenous factors).
- Heavy reliance on Temporary Resident Doctors (19% [200 Drs] Qld RRMA 4-7).
- High mobility of workforce.
- Impediment to continuity of care, preventive medicine, access.

**At the health professional level;**
- Lack of orientation to culture and rural/remote practice.
- Negative impact on training.
- Loss of procedural skills/services.
- Locums – size of the pool, quality.
- Retention of nurses and allied health professionals.
Principles underpinning new models of sustainable primary care

The research has helped HWQ to define the principles we need to follow to develop new models of sustainable primary care:

- Minimum level of service benchmarked, what’s needed (skill mix) and enough of them to provide safe service both clinically and personal safety.
- Multidisciplinary team approach -moving toward primary health care.
- Community participation in planning and monitoring.
- Services match need and remoteness.
- Quality of personnel, professional development, accredited facilities.
- Culturally appropriate.
- Retention issues such as remuneration, accommodation and safe working hours.

Development of sustainable primary care in rural and remote Queensland requires sorting out the interface, or lack of it, between public and private services resulting from the different funding streams.

By developing an effective interface between the public and private providers there is the opportunity to establish:

- Shared after hours arrangements to reduce on call burden.
- Maintain a critical mass of doctors to support continued provision of procedural services, and increase numbers for small communities.
- It provides the opportunity to use hospital nurses for triage and after hours management and for working in general practice.
- And it opens up opportunities for making better use ambulance officers and health workers to bring them into the health team.

These strategies not only underpin mechanisms to improve recruitment and retention, but also they provide for safe hours of practice.

However, sustainable practice also has to be financially viable. Therefore, we need to add other dimensions to a sustainable model that addresses:

- Practice ownership.
- Practice management and support.
- Other health professionals to enable team based care and shared workload.
- Adequate and appropriate housing.
- Family and personal support structures where communities, Divisions and Rural Workforce Agencies have a role.
Overcoming the barriers

In order to achieve sustainable rural practice some of the barriers that need to be overcome are:

- Chronicity - long term entrenched shortages. It’s not just the population that is chronically ill, it is also the workforce. In some of these communities we aren’t talking about one doctor we can be talking about two, three or four.
- Systemic barriers.
- Acceptance of sub-optimal numbers of health professionals.
- Inertia of bureaucracy compounded by turnover.
- State/Commonwealth barriers.
- Focus on part rather than whole.
- Crisis management planning (5 year program).
- Relationships take time.
- HRM Issues (eg. Housing).
- Place specific.

Application of models to the “real” world

HWQ is working with communities, local Divisions and Queensland Health Districts at a number of sites to see how current models can be adapted to improve sustainability. These include:

- Cloncurry – general practice/ hospital.
- Diamantina Shire – Remote nursing.
- Roma – general practice, hospital and procedural.
- Charleville – general practice/hospital.

The experiences in Cloncurry and the Diamantina Shire are described below.

Case Study 1: Cloncurry

Cloncurry is a town in North West Queensland with a population of 4,000. It has a 20 bed hospital and is serviced by two doctors under contract to Queensland Health with Right to Private Practice (RPP).

Medical services in Cloncurry have continued to be provided by overseas trained doctors, most of whom have been on the five year program, but have little capacity to invest in private practice, and often limited experience in managing private practices.

There has continued to be a high turnover of doctors in Cloncurry, with the problem coming to a head in late 2003 with resignation of the Medical Superintendent with Right to Private Practice (MSRPP) without a replacement, and the second doctor resigning soon after. At the time the Mt Isa Health Service District and the local Division (North West Queensland Primary Health Care) entered into a collaboration to continue to operate the practice using medical staff from the Mt Isa Hospital on a rotational basis.
In 2004, North West Queensland Primary Health Care, Health Workforce Queensland, Mt Isa Health Service District and the Mt Isa Centre for Rural and Remote Health convened a planning meeting and undertook an analysis of health services in the Cloncurry Shire. The outcome of the meeting was a range of strategies to support the immediate provision of medical services, together with a commitment and plan to develop a longer-term solution.

The analysis identified that the current two doctor model was unsustainable, with doctors seeing 35-40 patients per day in the practice as well as having 3-4 hours of hospital based work each day. However, the current practice building provided no scope for increasing the number of doctors. The after-hours commitment was also burdensome at one in two.

The analysis identified that the local mine wanted to ensure the continued provision of a quality medical service for its workers and their families, and that contract work with the mine was an additional source of income to the general practice.

Following the meeting, HWQ developed and costed two models for provision of medical services to Cloncurry. These models included:

- Assessment of the number of doctors required to service the community
- Identification of funding streams
- Strategies for the provision of after hours
- Strategies to support the solo doctor in the nearby town

The Cloncurry Solution

HWQ has negotiated with a corporate general practice organisation, with focus on workplace health and safety services, to undertake the management of the group general practice, contracting an experienced GP as the Medical Director, and Practice Manager to run and operate this practice, and several others in the region. A building is being refurbished and will be leased by the corporate entity.

The current doctors working as MSRPP and Medical Officer with Right to Private Practice (MORPP) will provide general practice services from the new facility. The group practice has applied for and become a training practice and now has a registrar. After-hours and on-call will initially be a three-in-one, moving to a one-in-four when the Registrar is placed.

In summary the key elements of success have been:

- The interface. Successful partnerships between the Division, Queensland Health, Health Workforce Queensland, Xstrata, Mt Isa Centre for Rural and Remote Health.
- Management and ownership. Corporate general practice/ Practice management and leasing and refurbishment of the facility.
- Increasing critical mass. With an additional doctor, training practice/ registrar (now 4 doctors) and practice nurses (now 1FTE).
Key characteristics of the new model

- Privately owned medical practice.
- Three Queensland Health doctors with the right to private practice.
- One Full-time equivalent GP Supervisor (possibly shared position with three part-time GP supervisors).
- Three Queensland Health doctors cover hospital with GP Supervisor acting as back up and senior.

Supporting partners

- Queensland Health funding extra MORPP position.
- Cloncurry Shire providing extra housing for doctors and medical students.
- Xstrata funding via Gemini.
- MICRRH (James Cook University) providing back up to GP Supervisor.
- Tropical Medical Training (TMT), HWQ and the Commonwealth.

Advantages

- One in three roster average equates to safe work practices.
- MORPPs/GP Registrars have time recognised for GP training.
- MORPPs working in ‘walk in walk out’ scenario.
- Hospital able to look after patients needing more complex medical care.

Important issues

- Good practice management.
- Strong academic underpinning of Practice with JCU, MICRRH, TMT.
- Integration of Practice with Allied Health services and Blue Care, Community Health.
- Links with Health Workforce Qld for locum provision and educational training.

But there are casualties!

It’s taken 14 months to get to this stage, and the incumbent MSRPP has burnt out. So we’re on the hunt for a new one. However, going into a more supported environment should mean that retention will be better in the future.

Lessons learned

- Rural positions can be made attractive to young doctors.
- Support and education is vital for ongoing satisfaction amongst young doctors.
- High quality practice management essential.
- Practices need strong academic links.

Case Study 2: Diamantina Shire

The Diamantina Shire is in outback Queensland. Within the Diamantina Shire there are two communities separated by 200km of dirt road. Birdsville has a population of 160 and Bedourie has a population of 120. Indigenous Australians represent 40% of
the Shire’s population. These communities experience a large influx of tourists during the winter months, with over 50,000 visitors passing through Birdsville each year.

The current health service within the Diamantina Shire is based on two primary health care clinics staffed by a remote area nurse in each of Birdsville and Bedourie, operated by a non-government organization. The Birdsville clinic is designated as a two nurse clinic but difficulty in recruitment and retention over recent years has resulted in it often being staffed by only one nurse. The factors contributing to poor retention include prolonged periods of service without relief, difficulty in providing backfill for annual leave and study leave. The high turnover of nursing staff has impeded the development of effective systems within the clinic and development and implementation of health prevention and promotion programs.

The Diamantina Shire Council has invested in health at a local level through the contribution of takings from the Birdsville races toward a second nursing position in Birdsville, and through provision of maintenance to the Bedourie clinic. However, the operation of the clinics appears to have been chronically under-resourced in comparison with operating costs of similar clinics in the region operated by Queensland Health.

The Diamantina Solution

In 2003 the Shire Council successfully obtained funding to build a new clinic in Birdsville and two houses for nursing staff through the Commonwealth Regional Health Strategy and Regional Solutions Program respectively. The Shire and Qld Health also committed funding to the capital works.

But a health service is more than a building! The Diamantina Shire Council were concerned with the continued provision of primary care nursing services within the Shire and approached HWQ for assistance in developing alternative solutions.

Health Workforce Queensland has worked with the Diamantina Shire and the Central West Health Service District to develop a new model for the delivery of primary health care services to the communities of Birdsville and Bedourie.

Representatives from the three organisations collaborated to formulate a discussion paper outlining a model of service for the provision of primary health care based on the input from the community.

The key differences in the new model to the previous model are that the two sites will be treated as one entity with sufficient nursing personnel (3.5 FTE) to provide internal relief, resource allocation for backfill for annual leave and professional development, a designated team leader located within the Shire (rather than being managed from a distance), and process for community engagement in the operation of the service ie negotiation of hours of operation, after hours response, flexibility in where services are provided.
The Diamantina Shire, represented by the Mayor, Councillor and CEO, in conjunction with Health Workforce Queensland, presented the model and discussion paper to the commonwealth and state health departments in October last year and are awaiting an outcome regarding funding opportunities.

**Lessons Learned**

- Change and restructure are possible but slow.
- Systemic barriers
  - Acceptance of sub-optimal service
  - Inertia of bureaucracy
  - State/Commonwealth barriers
  - Crisis management planning (5 year program).
- Solutions tailored for individual community(s).
- Only possible through partnerships (vary dependent on community).
- Other agencies can facilitate but need a local driver.
2.9. New Government Initiatives

2.9.1. Rural Medical Infrastructure Fund

Mr Des Harris
Regional Partnership Operations,
Department of Transport and Regional Services.

In October 2004 the Government announced $15 million over 3 years for the establishment of a Rural Medical Infrastructure Fund (RMIF) to fund the establishment and maintenance of premises and equipment to assist rural and regional councils to establish community medical facilities.

The Department of Transport and Regional Services (DOTARS) representative Mr Des Harris presented the following key elements of the Fund and sought feedback from delegates of the conference as part of its broad consultative process.

There was discussion during his presentation, and in the final session the delegates suggested that their feedback on the principles and administration of RMIF, be provided to DOTARS.

Appendix C contains a synopsis of recommendations made at the Practice Made Perfect? Conference.

Objectives

The Rural Medical Infrastructure Fund will help achieve effective outcomes for the community by:

- Being flexible to suit local circumstances.
- Allowing an integrated approach.
- Not replicating or replacing existing services.
- Increase regional community sustainability and resilience.
- Increase the ability of regional areas to attract, recruit and retain GPs.
- Contribute to health outcomes at the community level.

DOTARS will be responsible for delivery of funding in conjunction with the Department of Health and Ageing.

Evaluation of the RMIF will involve considering various indicators of success.

Criteria for funding

- Clear outcomes.
- Partnerships with other organisations, including community support.
- Viability and sustainability of the project.
- Ability of the applicant to manage the project.
Points for discussion
1. What are some ways to ensure the most effective use of the RMIF funding?
2. How can we ensure a coordinated and integrated approach to developing and assessing applications.
3. What role could key players have:
   - Health/medical bodies
   - Community groups
   - Local government
   - State and Northern Territory governments
   - Area Consultative Committee (ACCs)
   - Australian Government agencies
   - Other?
4. What would be specific criteria for judging the merits of a project?
5. How do we factor in specific criteria and keep the assessment process simple, minimising red tape?
6. Are there particular regions or population groups that would especially benefit from the RMIF?
7. How to identify partners and leverage other funds to support a project.
2.9.2. NSW Health Integrated Primary Health Care Centres

Mr Warwick Neilley  
Deputy Chief of Staff,  
NSW Minister for Health.

The NSW Government is committed to a strengthening of the primary, community and allied health sectors to provide affordable, accessible and comprehensive care to the NSW community.

NSW Health is seeking to further develop, and form new, collaborative partnerships with general practitioners to provide integrated services based on GP led multidisciplinary care, early diagnosis, prevention, enhanced care planning and stronger coordination with acute and specialist services, particularly for individuals with chronic and complex conditions.

Partnerships could be established in rural towns, regional cities, suburbs in major urban centres or across regions and local government areas, dependent entirely on general practitioners who would like to enter such arrangements.

It is intended that these services also provide a stronger base throughout NSW for enhancing training opportunities and for improving workforce sustainability, along with research into the needs of local communities and solutions to their health problems.
3. Discussion topic summaries

Topic 1: Alternative structures for “new generation” GPs

There are an increasing number of women in GP training programs (65%). Half of the rural women GPs are working part time (i.e. < 35 hrs) and research shows that men are also working fewer hours. What GP practice structures and arrangements are most likely to draw new generation GPs to rural practice and keep them there?

GP structures most likely to draw “new generation” GPs are those which display the following characteristics:

- Have flexible arrangements. Organisations may need a complex agreement to make it work.
- Group like-minded individuals. Finding practitioners that value and respect your work, and also that share similar work views or practices to can make life much easier. Practitioners that will allow you to pursue other areas of interest, and who will serve as a barometer for you are valuable.
- Have a reasonable and safe after-hours load.
- Provide adequate supervision of registrars.
- Have varied and interesting work.
- Encourage job sharing.
- Manage a well-structured appointment system.
- Are accredited and have access to the Practice Incentive Program.
- Use practice nurses and teams.
- Have access to flexible training.
- Provide locum support.
- Provide succession planning.
- Provide spouse employment.
- Are a family friendly practice.
- Provide orientation to the area.

Topic 2: Working with governments

There are many examples of rural organisations looking at new GP structures. Whilst acknowledging the difference in state health systems, how do we get cohesion across states and nationally, as this movement develops?

Cohesion across states and at a national level could be achieved if:

- **Alternative structures are regionally appropriate and locally driven.** Models need to be regionally appropriate and preferably locally driven but funding needs to be available through coordination with all levels of government.
- **There is better coordination of grants schemes.** Grants need to show evidence of viability and collaboration across government and stakeholders.

- **Good GP representation is sought.** A lot of this knowledge is already out there ready, to be harnessed. GPs tend to be picked ad hoc for committees so better GP representation at a government level would be beneficial. It is acknowledged that the fragmentation of rural GP groups has not helped this in the past.

- **Policy makers are educated.** State health is traditionally hospital focused and needs to foster a better understanding of general practice. Communities also need to understand GP issues and ways to make them work. Unintended dislocation between state and federal governments at times can also be a hindrance.

- **We don’t re-invent the wheel.** Funding needs to be available to expand capacity and increase viability of existing practices rather than just building new services.

**Topic 3: Models of alternative GP structures**

Rural GP practices are moving beyond the small business model to a more organisational base. What could be the structure, governance, funding and ownership of these new structures?

Four possible models include:

**MODEL A: CORPORATISED, FOR PROFIT, SHAREHOLDER-DRIVEN BOARD**
- All staff and GPs are employees or contractors.
- Uniform and efficient support systems.
- Economies of scale, minimised overheads.
- Maximising government income sources.
- Integration with specialists (eg. pathology and radiology).
- May serve niche markets such as mining OH&S.
- May or may not bulk-bill such as in Bourke, Dubbo and Brewarrina.

**MODEL B: REGIONAL FUND-HOLDING ENTITY**
- Remote self-contained entities, viable size such as Far North Queensland.
- Funding and governance. An amalgamation of Local government, Area Health Service, Divisions and Commonwealth Government.
- Assess needs and buy services such as the Disease Burden Index.
- Range of services provided:
  - Primary care
  - Aged
  - Inpatient.
MODEL C (i): SEPARATE PROVIDER OF INFRASTRUCTURE, SERVICES, & MANAGEMENT.

- Being not-for-profit corporate entity (such as consortia, shire or community) that sources funds.
- General practice along with other health care providers conduct their own practices in entity controlled facilities or services.
- Entity receives fee such as a percentage of earnings, or cost of provision from practices.
- GPs have financial incentives plus more time for medicine, family, education etc.
- Emphasis upon continuity of infrastructure, patient records and management which should encourage GPs to stay longer as has been the experience with RARMS in North West NSW and Hay.

MODEL C(ii): PROVIDER OF INFRASTRUCTURE, SERVICES & MANAGEMENT PLUS EMPLOYER/CONTRACTOR

- Being a not-for-profit corporate entity that sources funds (consortia, Council, Aboriginal Medical Service, Area Health Service or University).
- GPs and staff either directly employed or independent contractors.
- Incentive payments for financial and/or health targets.
- Clinical independence (such as in Wentworth and Cessnock).
- Possibly more potential to be inter-disciplinary rather than multi-disciplinary.

ALL MODELS: GOVERNANCE AND INTERNAL MANAGEMENT ISSUES

- Management issues can impinge on GPs such as computerised records and staff selection etc.
- Clinical issues can impinge on management therefore new clinical activities may require more investment.
- Entity may need a high level broker or a manager below the Board and above the Practice Manager.
- Operational boundaries and protocols will evolve with time, personalities and experience.
Topic 4: Making Primary Health Care work

Primary Health Care (PHC) and PHC teams can provide greater efficiency and greater effectiveness in health service delivery. How can the differing ethos of management between hospitals, community health centres and general practice be effectively managed? How do we manage community expectations as there is a move from doctor base to PHC team approval?

Different ethos’ can be managed if:
- From the outset, stakeholders focus on the goal of improving health outcomes.
- The Primary Health Care team structure alters the dynamic of the traditional GP model.
- Clinical autonomy is retained.
- It is acknowledged that problems will arise and take time to resolve. Stay focused on the goal and be patient.
- Staff are prepared to draw upon reserves of goodwill from time-to-time.

When considering how to manage community expectations in moving from a GP base to a primary health care approach there is an assumption that all GPs embrace the new approach.

Some other factors to consider include:
- First set up new health/medical services
- Emphasise that the nurse is not replacing the GP but that they are seen to complement the GP with quality services.
- Advise and remind patients of the changes.
- In-practice promotion of the new approach is important.
- Address privacy issues and facilitate the sharing of patient information amongst medical and health care personnel.
Topic 5: Looking at the issue of management

Local government, State health and the community through various agencies are likely contributors to GP practice infrastructure. How do we reconcile the difference between contribution and ownership of practice structure with day to day management? What form of management is likely to be sustainable over a long-term period?

The difference between contribution and ownership of practice structure and day-to-day management is reconciled if:

- The approach is perceived to be beneficial by the community.
- Owners receive a return on their input (e.g., medical student training, such as the Uni-clinic at Cessnock or area health service insistence on bulk-billing.
- The potential for “auctioning” or “horse-trading” of general practice services is managed.
- There is recognition that the owner-operator model is valid.
- The issue of ownership and responsibility for medical records is managed properly.

Management is likely to be sustainable over a long period when:

- GPs are happy to be involved in practice management.
- There is recognition that practice management is a specialised role and GPs are becoming de-skilled in this area
- Practice management is provided by the GP, Practice Manager, Remote Practice Manager (virtual, divisional or not-for-profit) not the Area Health Service management. There is some concern too over Shires level of expertise in practice management.
- Commonwealth funding is available for IT and administrative staff for rural practice.
- Rural Workforce Agencies act as the safety-net to ensure continuity and consistency of management.
- There is an increasing role of Divisions of General Practice in the future. Divisions were considered to be the best placed organisation to take a role in management rather than ownership as they are trusted.
Topic 6: Moving towards Primary Health Care and Primary Health Care teams.

There is a set of experiences that show different medical practice structures can increase the number of GPs and GP services. There is an increasing focus on Primary Health Care (PHC) and PHC teams. How could new general practice structures become a platform for PHC and PHC teams? How could new general practice structures increase the recruitment of GPs and other health professionals? How could PHC structures become financially sustainable in rural areas?

Developing new general practice structures as a platform for PHC and PHC teams involves the following:
- Re-educating GPs. PHC teams do not have to be GP-centric.
- Investment in infrastructure to co-locate general practice and allied health services.
- Including allied health in the coordination of Divisions of General Practice, NOT Area Health Service.
- Ensuring financial viability and sustainability.
- Flexible employment conditions for allied health professionals.
- Effective coordination which leads to better health outcomes and practice viability (eg. appropriate use of EPC items).
- Clear, concise and simple guidelines for the use of HIC items.

New GP structures have the potential to increase the recruitment of GPs and other health professionals by:
- Providing improved management support.
- Providing access to allied health.
- Providing peer support for rural GPs.
- Reducing financial commitment and expected length of stay.
- Offering greater continuity of care from a team of professionals.
- Improving locum access if coordinated across a number of practices.
- Providing opportunities for “job sharing” eg. Tasmania and Northern Territory GP share model.

PHC structures could become financially sustainable in rural areas if:
- FFS Medicare item numbers are linked to the CPI.
- There was an increased range of remuneration:
  - Capitation for chronic disease management.
  - EPC (Clear, concise and simple guidelines).
  - PIP (as above).
  - Infrastructure grants to establish co-located rural PHC teams.
- Appropriate practice management (such as infrastructure depreciation) is in place.
- The practice is operated by experienced staff in an efficient manner.
4. Appendices

APPENDIX A

Program

Wednesday 23 February

9.30am – 11.00am  Registration & Information Booths

11.00am – 12.30pm  Welcome and Review of Workshop Program
  Dr Ian Cameron

  Session 1: Sharing Experiences from different perspectives
  ▪ Drs Ian Cameron and Paul Collett – RDN
  ▪ Dr Vlad Matic – Walgett GP
  ▪ Dr Lyndal Parker-Newlyn – GPRFNET

12.30pm – 1.30pm  LUNCH – Charlie’s Restaurant

1.30pm – 3.00pm  Session 2: Different GP Structures – Issues, barriers and solutions
  ▪ Mr Des Harris – Department of Transport and Regional Services
  ▪ Mr Keith Fletcher – Murrumbidgee Division of General Practice
  ▪ Dr Chris Matthews – Cessnock Uni Clinic
  ▪ Cllr Gae Swain – Gunnedah Shire Council
  ▪ Ms Terri Maguire – Wentworth Shire Council

3.00pm – 3.30pm  AFTERNOON TEA

3.30pm – 5.30pm  Session 3: Working through the issues
  Delegates have been broken up into three groups according to the coloured dot on your name badge. Topics will be handed out to delegates prior to this session
  Marina Room  -  Blue = Group 1 facilitated by Ms Kirsty McEwin
  Boardroom 2  -  Green = Group 2 facilitated by Mr Mark Lynch
  Crystal Room  -  Red = Group 3 facilitated by Dr Grahame Deane

5.30pm – 7.30pm  FREE TIME

7.30pm – 11.30pm  Conference Dinner – Jetty Room
Thursday 24 February

8.30 – 10.00am  Session 4: Groups reporting  
Facilitated by Dr Cathy Marshall

10.00 – 10.30am  MORNING TEA

10.30 – 12.30pm  Session 5: Expert panel discussion  
Facilitated by Dr Robin Williams
- Dr Chris Matthews – Cessnock Uni Clinic
- Mr Warwick Neilley – Deputy Chief of Staff, NSW Minister for Health
- Cllr Gae Swain – Gunnedah Shire Council
- Ms Caroline Holland – Mediprotect
- Mr Mike Sullivan – Mediprotect
- Mr Keith Fletcher – Murrumbidgee Division of General Practice
- Dr Ian Cameron – RDN
- Dr Paul Collett – RDN
- Dr Lyndal Parker-Newlyn – GPRFNET
- Mr Des Harris – Department of Transport and Regional Services
- Ms Terri Maguire – Wentworth Shire Council
- Dr Vlad Matic – Walgett GP

12.30 – 1.30pm  LUNCH – Charlie’s Restaurant

1.30 – 3.00pm  Session 6: Where to from here?  
Facilitated by Dr Ian Cameron

3.00pm  Conference Closes
List of Delegates

Dr Ian Adair  
Alliance of NSW Divisions

Sally Armitage  
New England Division of General Practice

Peter Barns  
Tasmania General Practice Division

Dr Kris Battye  
Kris Battye Consulting

Dr Roslyn Bayliss  
Border Division of General Practice

John Bowmer  
Department of Transport & Regional Services

Bernadette Brady  
ACT Division of General Practice

Dr Ian Cameron  
RDN

Mr Darren Carr  
Hawkesbury Division of General Practice

Dr George Cerchez  
Tasmanian Department of Health

Sandra Christensen  
NSW Central West Division of General Practice

Ms Jill Coombe  
Bridge Clinic

Dr Grahame Deane  
RDN Board

Mr Lawrence Donaldson  
Tasmania General Practice Divisions

Dr Janet Dunbabin  
RDN

Ms Catherin Duncan  
Health Workforce QLD

Ms Megan Elliott  
RDN

Dr Peter Finlayson  
Hunter New England Area Health Service

Keith Fletcher  
Murrumbidgee Division of General Practice

Dr Jane Greacen  
Rural Workforce Agency Victoria

Jodie Griffin  
South East NSW Division of General Practice

Dr Miriam Grotowski  
Marius Street Practice

Des Harris  
Regional Partnership Operations - DOTARS

Caroline Holland  
Mediprotect

Ms Sharon Kosmina  
Rural Workforce Agency Victoria

Dr John Kramer

Ms Sharon Kosmina  
Rural Workforce Agency Victoria

Mr Emir Krupic  
RDN

Mrs Marie Lally  
RDN

Richard Lawrance  
RACGP National Rural Faculty

Cr Lynette Lawry  
Great Lakes Council

Dr Faye Lowe  
RDN

Mr Mark Lynch  
RDN
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<td>Terri Maguire</td>
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<td>Wentworth Shire Council</td>
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<td>Department of Health &amp; Ageing</td>
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<td>RDN Board</td>
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<td>Dr Biljana Nikolova-Trask</td>
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<td>Ms Nancey Piercy</td>
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<td>Riverina Division of General Practice and Primary Health</td>
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<td>Young District Medical Centre</td>
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<td>Ms Margaret Smith</td>
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<td>RDN</td>
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<td>Annelies Strietman</td>
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<td>Mid-Western Regional Council</td>
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<td>Dr Karen Sumner</td>
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<td>Rural Doctors Workforce Agency</td>
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<td>Jim Thurley</td>
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<td>General Practice &amp; Primary Health Care NT</td>
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APPENDIX C

Recommendations to the Department of Transport and Regional Services for the Rural Medical Infrastructure Fund

The suggestions outlined in this document are a synopsis of recommendations made at the Practice Made Perfect? Conference and were submitted to Commonwealth Department of Transport and Regional Services DOTARS as part of their consultation process for the Rural Medical Infrastructure Grants.

Mr Des Harris from DOTARS presented an outline of the Rural Medical Infrastructure Fund (RMIF). There was discussion during his presentation, and in the final session the delegates suggested that the assembled suggestions from the workshop, on the principles and administration of RMIF, be provided to DOTARS.

Principles

- The grants should be directed to increasing community ownership of rural General Practice infrastructure.
- The grants should be made available across all rural areas, including rural RRMA 3-7 and “Areas of Consideration”.
- Processes should be administratively efficiently for DOTARS and all parties involved, including uncomplicated application forms.
- Assessment of grant applications should:
  - Include health organisations such as Rural Workforce Agencies and local Divisions of General Practice.
  - Be prioritised across each State and Territory, or nationally, rather than assessed regionally. An example given for this process was the highly successful ACCOG program that provided funds for community ownership of accommodation for medical registrars and students in rural areas. This program was administered through the Rural Workforce Agency Victoria.
  - Include strong support or active involvement of local health organisations, medical practitioners, local government and local community in the planning and proposed implementation of the grants.
- Prioritisation of Grant Applications should include:
  - Remoteness
  - Involvement of GPs, Local Government, local Division of General Practice and local community
  - Evidence that grant will facilitate increased recruitment and sustainability of GP services
  - Evidence that grant will lead to increased primary health care team approach
  - Sound project administration
- The Program should be evaluated after two years, with a progress review each year
Delegates to the workshop suggested that the NSW Rural Doctors Network should take on an anchor role in promoting different GP practice structures. RDN should advise communities seeking to move to new structures and assist communities to overcome difficulties.

The workshop welcomed the introduction of Rural Medical Infrastructure Grants, but strongly advised that the funding available should be dramatically increased.
5. References

