THE HEALTHY COMMUNITIES FOUNDATION AUSTRALIA

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Rural and Remote Medical Services

A guide to assist rural communities to design and implement an innovative approach to recruiting doctors and strengthening medical services

healthforall

THE HEALTHY COMMUNITIES FOUNDATION AUSTRALIA

Dhayn ngiyani winangaylanha Australia-ga ganunga-waanda yanaylanha, dhaymaarr ganugu-waanda nhama ngarrangarranmaldanhi.

We respect Aboriginal peoples as the First Peoples and custodians of Australia.

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HEALTH ACCESS Community Care | HEALTH ACCESS Home Care | HEALTH ACCESS Mobile Care | HEALTH ACCESS Mind Care | HEALTH ACCESS Virtual Care | HEALTH ACCESS Integrated Care

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Section 1: Background

1.1 Why a new model?

The traditional model for provision of general 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, and in addition, supplemented by varying levels of private billing dependent on local issues including 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, which is usually remunerated on a fee for service basis according to the Rural Doctors Association – NSW Health agreement - RDA Settlement Package (RDASP). These services comprise in-patient and outpatient services both in and after normal business hours.

It is widely believed that community based general practice is in fact significantly cross subsidised by hospital VMO fees, to the extent that many believe that "bulk billed" practice in rural & remote areas is not financially sustainable in the absence of hospital VMO cross subsidy.

Rural doctors generally live in the town, own their house and surgery and manage the medical practice as a small business. They are responsible for ensuring the practice has appropriate resources including staff and equipment, and are responsible for all aspects of the business management. Where the doctor is a VMO this requires a close working relationship with the local hospital.

Strong anecdotal evidence suggests that 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.

General comments gathered from existing GPs in the remote towns of North West NSW, and particularly from locums, overseas trained doctors and temporary visa doctors who service these towns, agree that the traditional model described above fails to address the themes that are valued by the medical workforce in this region. Many of these themes are common to all rural and remote locations:

- 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 eg domestic housing, surgery premises
- Not feeling they are deserting their community when they finally choose to leave

As a result of the failure to satisfy these themes, it has become increasingly difficult to attract doctors to more remote communities using the traditional model.

1.2 What is the Easy Entry, Gracious Exit Model?

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. However, it has evolved into a model that, with some variation across the four towns involved, is delivering a vastly improved supply of doctors and medical services. Implemented by the NSW Rural Doctors Network (RDN), the Easy Entry, Gracious Exit model or walk-in-walk-out approach, aims to make general practice in these difficult areas more attractive by enabling GPs to work as clinicians without having to be small business owners and managers. The model seeks to 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. The reduced financial commitment allows more freedom to come and go as a doctors circumstances dictate. Domestic and surgery accommodation, and full infrastructure for the general practice is provided by a third party, as well as the option for VMO rights and contracts being negotiated on behalf of the doctor.

The Easy Entry, Gracious Exit model differs from previous recruitment models, in that it involves a third party provider. Ideally a local community entity provides the infrastructure necessary for continuity of the practice. Previous models have concentrated on the continuity of the doctor, rather than the continuity of the practice or practice management structure.

The model was initiated with the hope that by removing many of the previous barriers to recruitment it would be much easier to attract doctors. It was also hoped that once doctors arrived in these towns they would find that while free to leave at any time, the support, financial arrangements and the interesting medicine would be so attractive that they would readily remain for a reasonable period.

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

The RARMS version of the Easy Entry, Gracious Exit model has metamorphosed several times since its inception in June 2001. 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 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 that 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 (RDN and RDA NSW).

1.3 Successes of this model

Experience has shown that this model, 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 3 GPs to 9 current resident GPs with good locum back up (June 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 – eg: 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.

1.4 Lessons Learned

Despite the successes of this model, the process has not been without its problems. The value of this experience is that important lessons have been learned along the way that can be passed on to other parties contemplating adoption of a similar model.

The RARMS experience has shown that:

- Without some form of subsidy, HIC income generated through bulk billing does 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.

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 Superintendants 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.

- 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.
- There is often a serious shortage of people with practice management, management, IT, nursing and financial skills in remote areas. This is a **remote** 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.
- 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.

1.5 Purpose of this Document

The purpose of this document is to provide guidance for communities and other parties interested in designing and implementing a new approach to rural general practice that offers greater success in attracting and retaining doctors. Section 2 will help determine whether the Easy Entry, Gracious Exit model in its entirety is the most appropriate solution for a particular community, or whether only certain aspects are worth adopting. Section 3 provides a checklist and brief discussion of the major issues that need to be considered when implementing the Easy Entry, Gracious Exit model or aspects of it. These issues are expanded upon in Section 4, through a description of the experience of RDN and RARMS in establishing and refining the model in several communities. Section 5 provides a brief summary of several similar models currently being implemented in other rural areas of NSW.

Useful documentation, such as the RARMS Practice Manual and examples of contracts are included in the appendices and will be available on the RDN website www.nswrdn.com.au.

This manual is intended as a guide only, and in no way purports to covering all issues or providing the level of detail that might be required for decision making purposes. However, it does aim to highlight a number of issues that deserve careful consideration. It also aims to bring to the attention of the reader the difficulties, as well as the successes, associated with the Easy Entry, Gracious Exit model as implemented by Rural and Remote Medical Services Ltd.

Section 2: Is the Easy Entry, Gracious Exit model necessary?

This section provides suggestions on three initial steps that any community might take in considering the extent of shortages of medical services in its area. These steps involve bringing together the stakeholders, assessing the problem, and identifying and weighing the available options. The order of the steps may vary, but all are important for success.

It is hoped that the questions raised in this section will inform discussion about whether the walk-in-walk-out model is the most appropriate solution. If it is determined that this model is appropriate, then the issues and questions raised will help to anticipate what needs to be considered and will help to avoid the pitfalls that RARMS and others have encountered while establishing such practices.

2.1 Involving Stakeholders

Involving all stakeholders at the earliest stage possible is essential to the successful implementation of any model of doctor recruitment and retention. A meeting of stakeholders allows a sharing of knowledge and expertise and the development of a common understanding of the issues. Stakeholders' external to the immediate community (e.g. the local Division of General Practice) may be able to provide expertise and point to potential sources of assistance. It may be that some of the perceived obstacles can be overcome quite quickly and easily. Such a meeting can also build wider understanding and commitment to resolving the problem. An interim leadership or coordination mechanism (an individual, a group or an agency such as the council) will need to be identified until strategies, a plan of action and ongoing responsibilities are determined.

RDN, with expertise in doctor recruitment and retention matters, is able to provide advice and may be able to attend a stakeholder meeting if that would help.

Key Stakeholders in a rural community would normally include:

- Local GPs
- Shire Council
- Area Health Service (AHS)
- Local hospital
- Hospital advisory body
- Local Division of General Practice (DGP)
- Aboriginal Medical and Health Services (AMS)
- Community Consultative Groups

Other key stakeholders might include:

- Royal Flying Doctor Service (RFDS) (for remote communities)
- Other health providers - Non Government Organisations (NGOs)
- Other community focus groups, eg: mental health or diabetes support groups
- Local academics
- Employer and service groups (Chamber of Commerce, CWA, Rotary etc.)

The level of stakeholder commitment must be determined once there is agreement on the problem and the course of action. It is important to recognise that if the walk-in-walk-out model is to be adopted, it is likely to involve a serious commitment of time, effort and depending upon the circumstances, money.

In North West NSW, the Commonwealth Government was willing to provide initial financial support to see what could be achieved. Many of the stakeholders committed time, experience and other assistance. Dr Vlad Matic, the sole incumbent GP in Walgett generously contributed time and ideas, as did Dr Phil Lambie. RDN made a large commitment in terms of staff allocated to the establishment and implementation of RARMS and the model. The Far West AHS provided support and managed the Collarenebri medical services. The Outback DGP and the Walgett and Brewarrina Shire Councils were also active. In South West NSW, Wentworth Shire Council independently took on the role of lead agency with help from the Mallee DGP. Details of the Wentworth Shire Council experience can be found in Section 5. A brief account of RARMS stakeholders can be found in Section 4.

2.2 Assessing the Problem

There is a general shortage of GPs in rural NSW with well over 100 vacancies currently being advertised (RDN Vacancy Website, www.nswrdn.com.au/vacancies/vacancies.cfm, June 2003)[1]. Broadly, the difficulties in recruiting doctors tend to be greater the more remote the location. There also tends to be more assistance available for the more remote areas.

Before embarking on a mission to implement a new model of medical service delivery and GP recruitment for a particular community, it is important to determine whether the problem actually requires an entirely new model or just aspects of it. Consider the following points and questions:

- Identify the real medical service problem(s) in the town or region in focus.
- What are the circumstances that have led to the problem and why?
- What is the time frame – is the problem now, soon, some time away?
- Is the problem temporary or ongoing?
- Who owns the problem? Who are the stakeholders who have an interest in ensuring appropriate medical services – the public, the hospital, employers, the council, other doctors and health workers, Aboriginal health or medical services etc.?
- Is the problem only a shortage of general practitioners?
- Are there other factors limiting the prospects of recruiting a doctor, such as no suitable housing, onerous workloads, insufficient income to provide remuneration that is comparable with that available in other towns lacking in doctors?
- Identify the barriers to be overcome when dealing with the problem.
- Are the barriers related to infrastructure, population size, isolation etc?

If the barriers are not too complex, or only temporary, then approaches that are not as extensive as the walk-in-walk-out model may be more appropriate and quite successful. The size and complexity of the barriers will help determine the extent to which the model might be adopted. In some rural towns, the availability of suitable leased housing and surgery facilities alone might be sufficient to attract a doctor. In the RARMS experience, the provision of housing and vehicles was important but not sufficient to overcome the initial disincentives of heavy medical and administrative workloads and isolation. The problems identified in the North West of NSW are detailed in Section 4.1 and illustrate how the walk-in-walk-out model that evolved there was appropriate for that situation.

2.3 Weighing the Options

Once the problem(s) has been clearly identified, the options for solving it need to be identified and canvassed. Apart from interested local stakeholders, there may be internal or external resources that can be tapped to assist - local or nearby doctors, the local Division of General Practice, or RDN.

A cost benefit analysis on all conceivable options is helpful in determining which path to follow. This will require access to current financial information (from the local Division or other informed sources) so that the analysis is realistic. Is the walk-in-walk-out model as it is described here, the most appropriate solution? It is important to involve the relevant stakeholders and weigh up what appears to be the most beneficial and cost effective option. Many options may be raised.

- Set up a new general practice?
- Support an existing general practice?
- Recruit a doctor within the existing general practice structure?
- Seek a regular outreach service from a larger centre?
- If a doctor is to be recruited, what kind of doctor is required?
- Are skills in emergency medicine, anaesthetics or obstetrics required by the hospital?

There may be several options identified that can be prioritised in order of preference and pursued either sequentially or together. If there are doctors still practicing in town, it will be critically important to consider the impact of the options upon them. Will support for an incoming doctor alienate an existing doctor, with counterproductive results? Involve any existing doctors – they may have valuable expertise to offer, and will gain an understanding of what is being done to improve doctor supply.

The financial and logistical viability of the options will help determine the most appropriate. There is no point starting work on a solution that is financially or logistically nonviable for the parties involved unless there are realistic opportunities to draw upon community and external resources to meet any perceived gap.

RARMS required extensive initial funding to get the model up and running and has discovered that the practices do not cover the costs of the complete RARMS structure. The income derived from the doctors in-practice fees broadly supports the running of the actual practices, but does not yet support the cost of the corporate structure (management, financial management and governance). Further details of the RARMS structure and management can be found in Section 4.2. (Despite this financial negative, the positive side is that communities served by RARMS now have a hugely improved quantity, quality and range of much-needed medical services).

Section 3: Checklist of Issues for Implementation of Easy Entry, Gracious Exit

If it is assessed that the Easy Entry, Gracious Exit model in its entirety is justified, then the following checklist of issues provides a helpful starting point. Some of these issues may also be relevant even if it is decided that a lesser degree of intervention will be sufficient. Although these issues have some semblance of order, they are not strictly linear and overlap in some instances.

3.1 Structure and Ownership of the Entity

Once the walk-in-walk-out model has been identified as the most appropriate solution to the problem, a threshold question is 'what kind of entity will work best to implement the model'. It is necessary to have "drivers" or "champions" to lead the creation and management of the entity. The following questions need to be considered:

- Who (which organisation, group or consortium) will drive the model?
- Who will auspice the business entity? Will it be a private individual or group, the council, the Area Health Service, a consortium of stakeholders or some other arrangement?
- Is the entity going to be For-Profit or Not-For-Profit?
- Is it going to be an association, a corporation limited by guarantee or part of an existing organisation?
- Who will supply or control the physical infrastructure (surgery, housing) and equipment?
- Will the doctor be employed, or contracted to work – or will the entity enter into an agreement to provide the doctor with practice management support services for a fee? If a for-profit company employs a doctor, then this company may be deemed a medical company to which special tax rules apply. If it is a not-for-profit company, it may be possible to obtain exemptions from certain taxes (payroll, fringe benefits etc.)
- Is the corporate governing body going to be entirely local or include external expertise?
- Will there be a Board and CEO or Manager?
- Will there be a need for separate management, financial reporting and advice on medical matters?

"Corporate governance describes the arrangements an organisation utilises to plan, direct and control its long-term development and day-to-day operations. It refers primarily to:

- The governing rules that set an organisation's charter (notably Constitution and Board Policies)
- The role and performance of the Board
- The role and performance of the CEO or manager
- The relationship between the Board and the CEO or manager
- The systems and procedures in place to deal with the key dimensions of the organisation's operations including long-term strategic direction, operational planning, relationship with key external stakeholders, risk management, financial planning and budgeting and human resource management" (Corrs, Cambers, Westgarth Lawyers, May 2001)[2].

If the organisational structure requires a Board, it is important to remember that Boards are to set policy, not manage day to day issues like a management group. Legal advice should be sought to determine the legal and ethical obligations of Directors and the entity in regards to status and structure, depending on whether the entity is for-profit or not-for-profit. The governing body or Board of Directors will need some form of financial and management reporting arrangement to inform its decision-making, and appropriate arrangements to ensure effective day-to-day management of entity activities.

RARMS is a non-profit organisation for a variety of reasons, outlined in Section 4.2. A copy of the RARMS structure can also be seen in Section 4.2. For an entity providing medical practice services to one doctor or one practice, a simpler structure than RARMS is possible.

3.2 Key Relationships

It is important for the entity to build allegiances and networks with the AHS, the hospital, the Aboriginal Health or Medical Service, and other health services (e.g. pathology laboratory, radiology service, sterilisation and medical waste disposal services). This is to ensure that they are all working together to improve the health services in the community and are aware of any new opportunities to do so.

Area Health Service (AHS): Particularly in communities with a hospital, the relationship with the local AHS is most important. The AHS is responsible for ensuring there is a doctor (VMO) available at all times for the care of hospital patients and to respond to emergencies. The AHS therefore has a strong interest in having one or more (usually resident) GP(s) available on roster. As the AHS determines VMO appointments, if a new GP is expected to take on VMO services, then it is important that the new recruit be acceptable to the AHS for such appointment.

There are many ways in which good relations between the doctor(s) and the **local hospital** can foster efficient practices and procedures that greatly benefit the quality of medical service to patients at each location. The entity therefore also has a strong interest in supporting such a productive relationship.

Regular meetings and liaison are essential to share information, discuss issues, and encourage open communication. They provide an ongoing forum to discuss issues such as mutual contractual obligations, and improvement in service efficiency and quality.

The following points note areas that would benefit from an early, strong working relationship with the AHS and local hospital:

- Combining and/or utilising services that are already in existence. It is really important to establish a relationship with the AHS so that organisations in the community can work together to make the best use of all the services that are available and to eliminate duplication. Negotiating the shared use of community nurses and Primary Health Care Hubs for example can benefit all parties. Even if formal agreements don't eventuate, relationship building is extremely important to get the services working together or at least thinking about how they might work together in the future.
- Efficient and effective triage practices at the local hospital. Relationships between GP VMOs and hospital staff can benefit from sound, practical triage practices at the local emergency department. Emergency departments in rural hospitals often have a high staff turnover with many (overseas) temporary nurses. It is important to understand the structure of rural medical practice in that often the emergency doctor is also the doctor who has worked all day. By establishing good relations with the AHS and local hospital, the entity can take over non-clinical negotiations with the hospital on behalf of the doctor assisting in the reduction of stress and workloads.
- Establishment of VMO appointments and rosters for new GPs. Good relationships and communication are critical to establishing effective VMO arrangements.

The doctor(s): Clearly the relationship between the doctor(s) and the entity is also critical. The nature of the relationship with the doctor working in the entity's premises will vary depending upon the form of doctor engagement (employment, independent contractor, or the entity providing practice services to the doctor for a fee). Thought needs to be given to how the doctor can communicate effectively with the entity on a regular and an as-needed basis. The relationship between the entity and doctors in other practices in the town may also be very important – good collaboration on VMO, after-hours services, locum arrangements and other activities may well improve medical service delivery in the community and/or reduce doctor stress and workloads.

The local Division of General Practice (DGP); There are 17 rural DGPs in NSW plus 3 Victorian divisions that cover parts of southern NSW. DGPs provide a range of support services to rural doctors and practice personnel, including advice on medical programs, practice management, assistance with locums and with medical professional development. Many are well placed to assist and advise communities on medical practice issues although not all may be sufficiently well resourced to take on a larger role. Working with the local DGP is likely to be helpful in terms of avoiding pitfalls and identifying appropriate contacts on the range of issues associated with medical practice management.

3.3 Medical Indemnity

Medical Indemnity is an important and currently complicated issue and was the cause of some of the problems that RARMS encountered during implementation of the Easy Entry, Gracious Exit model. See Section 4.5.

The method by which the entity engages its doctors will have a bearing upon the degree of medical indemnity risk that may be carried by the entity. Direct employment is likely to carry the highest level of risk. Engaging a doctor as an independent contractor may also involve medical indemnity risks, particularly if the doctor is deemed, at any point, to be a defacto employee. A very much lower level of risk to the GP entity applies when it provides surgery services to one or more doctors that conduct their own practice as practice principals. In the latter case, stationary and signage that displays the GP as the practice principal will reduce vicarious liability. The medical indemnity situation remains fluid in NSW at present (mid-2003) and should be independently verified before an entity takes final decisions on the form of doctor engagement it will negotiate or adopt. The entity should know and understand the form and level of medical indemnity cover acquired and maintained by their doctors. Medical Indemnity insurers may be willing to visit medical practices to provide assessment and advice on managing risks within the practice environment. RDN will continue to monitor and provide up to date information and advice on medical indemnity issues.

3.4 Provision of Infrastructure

The goal of the Easy Entry, Gracious Exit model is to allow a GP to be able to walk in off the street and start practicing immediately. For this to occur, full infrastructure needs to be provided by a third party rather than by the doctor. This includes accommodation (possibly furnished), practice building, medical and practice equipment, practice staff, and fully functioning systems for running a general practice. The ownership of the infrastructure will vary depending upon the sources of funding and the conditions of any grants obtained.

Accommodation

The lack of availability of suitable housing in some towns and the unwillingness of many doctors to buy a house, even when available, means that housing is often a major barrier to doctor recruitment – particularly if other communities are able to offer suitable rental housing.

Although it is suggested that the entity take over provision of housing for the GP, it is not necessary to own the building. It does not matter who owns the house/unit, as long as it is not the doctor. The entity may secure a lease from the shire or other owner, or the owner may agree to reserve a suitable home as a doctor's residence. A key point is that when a suitable doctor is found, a suitable house needs to be available that meets that doctor's needs and circumstances.

The size and nature of the accommodation may be an issue. A young single doctor might prefer a small home or apartment with little cleaning and gardening - which might be quite unsuitable for a doctor with several children. Some modifications might be necessary to make the house safer for small children etc. Having a degree of flexibility in what housing can be offered, can be a competitive advantage in attracting a doctor. If a town has a good stock of quality housing available to rent, the issue of securing housing for a doctor may not be significant. It might be sufficient for the entity to simply assist a prospective doctor to identify a suitable house to rent.

RARMS found that early development of good working relations with the local shire council lead to an agreement in which RARMS leases the doctors houses from the shire, provides all the furniture and household equipment itself, and rents the furnished housing to resident and locum doctors. Wentworth Shire initially provided a rental subsidy but no house, and the doctor subsequently purchased a house in the town.

Having **furnished housing** available is **essential for locum doctors** and is often an advantage in recruiting resident doctors. For doctors who supply their own furnishings, a relocation grant is usually available from RDN to cover all or much of the removal costs within Australia.

An issue to consider in towns with little available housing is whether lease arrangements with the resident doctor might provide for a locum doctor to use the same house if the resident doctor is vacating the house while on leave.

Many shire councils already own houses for a variety of reasons, or they may be convinced of the benefit of purchasing a house for use as an incentive to attract doctors. This kind of agreement can provide a win/win situation for the entity and the council. The council provides a house to the entity at an agreed rate, and they are assured of receiving regular rental payments on a long-term basis. The entity is assured of always having accommodation available when one doctor leaves and another arrives.

In order to keep the doctors happy and to continue attracting new ones, it is important to provide a good quality home. It is also important to have clear mechanisms in place for dealing with requests from the doctor. An unsatisfactory landlord-tenant relationship can quickly sour the positive view of the community that is necessary to encourage a doctor to stay. These mechanisms are also important for ensuring smooth transitions from one doctor moving out to the next one moving in. Such issues to think about include responsibilities for:

- Paying household bills when a doctor is in residence
- Paying household bills when no doctor is in residence
- Taking care of the property and furnishings
- Replacement of broken or damaged household items
- Purchase of additional household items. Who pays for and owns these items?
- Grounds maintenance – will the entity arrange and pay for this and adjust the rent accordingly, or will the doctor be responsible?
- Cleaning and maintenance of house and grounds between resident doctors
- Ensuring the accommodation is suitable to the doctor and their family situation

Vehicle

The provision of a vehicle is an added expense for the entity and may be seen as an incentive rather than an essential item of infrastructure. If a vehicle is going to be provided as part of the contract, it is important to provide a vehicle appropriate to the conditions of the surrounding areas and to the family of the doctor being contracted. Issues to think about include:

- Who is responsible for maintenance costs? Petrol, Insurance, Registration?
- Will the doctor meet or contribute to the costs?
- Will the vehicle be provided on an ongoing basis or only for an initial period?
- Can the vehicle be sourced from the Shire or the AHS?
- What happens if the car is off the road due to an accident?
- Provision of child seats, etc?

Practice Building

It is essential that the surgery is well located, in a quality building with appropriate fittings and layout for a general practice. It is highly desirable to essential that the surgery meets Accreditation standards. Being accredited means that the practice better serves patients by meeting a minimum desirable standard of infrastructure and process/procedures and is able to obtain higher payments from HIC – to the financial benefit of both the doctor and the practice management entity.

The size of the surgery should allow for the expected number of doctors, medical receptionist(s), practice nurse(s). Consider the potential for further expansion if that is likely to be necessary. (The surgeries at Walgett, Lightning Ridge and Brewarrina have all required expansion or upgrading for practice nurses or additional doctors in the past 12 months.)

If there is an existing surgery building, does it meet current needs? In many areas, surgeries have been provided by councils, Area Health Services, Aboriginal Medical Services, pharmacists or other private owners. What are the options available in each community? If expansion or upgrading is needed, are the owners or others willing to contribute the costs in the interest of attracting and retaining medical services?

When looking at Practice buildings, it is worthwhile thinking about:

- The location of the practice – should it be located on or near the main street, near the pharmacy, or in or near the hospital?
- Is there good access – suitable parking; suitable access for elderly, unwell or incapacitated patients; good access for an Ambulance?
- Are there any other services, which might share a location and costs, such as pathology, pharmacy, etc? (Note: Pathology services may need to be on a separate lease.)
- Commercially, and in terms of service users, it may be more viable to be in a central location.
- Think through the ramifications of every action and consult the community and stakeholders before action is finalised.
- Will the building need significant modifications to create a functioning general practice?
- Who will fund these modifications?
- Is there any room to expand or modify the building again, if another service wants to co-locate?
- Will the physical characteristics meet criteria for Accreditation?

Practice Management

If the entity agrees to provide complete practice management infrastructure, then in effect it is agreeing to provide and maintain the premises and equipment of the Medical Practice, as well as carry out all administrative operations and financial management of the practice on behalf of the Practitioner. Such responsibilities would include:

- Organising appointments.
- Providing suitable reception and typing services.
- Providing practice equipment and medical supplies.
- Providing adequate paramedical support for the running of the practice.
- Establishing and maintaining appropriate bookkeeping.
- Billing, banking and collecting professional fees.
- Tracking payments, costs and expenditure.
- Payments of creditors.
- Tracking revenue potential.
- Accounting to the GP for GP payments.
- Determining the Practice or GPs eligibility for any Grant funding.
- Accessing and Monitoring Practice Incentive Program (PIP) payments
- Keeping the practice up to Accreditation standards.
- Tracking payments associated with HIC and Department of Veteran Affairs (DVA).
- Maintaining and forecasting budgets. (In the initial phase this can be difficult if there is little or no historical data available. Even in the longer term, this can be challenging because turnover is dependent upon the work practices of the doctor(s) and a range of other factors).

When looking at the provision of practice management it is important to determine the level of responsibility that the practice manager is going to be given, and to have clear lines of accountability.

Equipment/Supplies

If the entity is going to be supplying the infrastructure, then it will be responsible for supplying all medical and administrative equipment in the practice and in any subsidiary practice. The company would therefore be responsible for repairs and maintenance of this equipment.

Issues to think about include:

- Obtaining informed advice on business and medical systems and equipment - doctors, practice personnel and the local Division of General Practice are good starting points.
- Requests to purchase medical equipment that may be optional rather than essential.
- Whether the organisation or individual doctor will be responsible for purchasing this optional equipment.
- The relative merits of expensive equipment versus lower cost but functional equipment.

Practice Staff

In order to facilitate the Easy Entry, Gracious Exit model, all practice staff must be engaged by the entity to manage the day to day functioning of the general practice(s). Staff might include practice managers, receptionists, practice nurses, other allied health workers and cleaners, etc. See Human Resources in Section 3.6 for more details.

3.5 Forms of Doctor Engagement

There are several different options for engaging doctors. They can either be employed by the entity on a salary, or contracted by the entity as an independent contractor. Alternatively, the entity can provide the practice infrastructure, staffing and resources to the doctor for a fee, in which case the medical practice is the doctor's and the entity is the supplier of practice infrastructure and services. In this situation, the contract between the two parties will define the services and facilities to be provided by the entity and the fees to be paid by the doctor. (This is the model now being used by RARMS).

There are a variety of issues that will affect the decision on which form of engagement is the most appropriate including:

- Medical Indemnity
- Taxation provisions
- The preferences of the prospective doctor and of the entity

RARMS had to alter the way it engaged its doctors several times over a period of 12 months as a result of these issues. See Section 4.5.

Other issues to consider include:

- When a doctor is employed or is an independent contractor, the relative merits of a fixed salary or fixed contract fee versus incentive based remuneration.
- Who takes responsibility for monitoring financial output and professional standards of the GP?
- If a doctor is on a set salary or fee, is there a degree of risk that the doctor may, for poor health or other reasons, not generate sufficient revenue to cover practice costs?
- Are there tax incentives or disincentives for one mode of engagement over another?
- If the entity decides to contract their doctors, who is going to be responsible for monitoring their performance, in both a medical and administrative sense?
- Who will approach the doctor if professional standards issues need to be discussed?
- Will the entity have a designated "medical advisor" for tasks such as this?
- Who will this person be, where will they come from and how will they be paid?
- What will be the informal and formal dispute resolution mechanism?

3.6 Human Resources

Where experienced high quality practice staff is available the challenges of establishing and managing medical practice services will be greatly reduced. It can be very difficult to recruit suitably qualified and skilled staff in remote communities. A shortage of people with management, practice management, IT and financial skills can increase costs through elevated recruitment expenses, salaries and training requirements. There may be little opportunity, because of remoteness, to share human resources. The difficulties are compounded by the increasing complexity of medical practice and small business management.

Practice Managers and Admin/Support Staff

Rural doctors, not infrequently, employ their spouse as the practice manager. In such situations, when the doctor leaves, the town also loses the practice manager. All the knowledge, skills and contacts of the practice manager may be lost, leaving little continuity for the new doctor or for the patients. The Easy Entry, Gracious Exit model may alleviate this potential problem. However, it has little control over the availability of experienced high quality staff. There also may be good reasons for employing the GP spouse in some circumstances.

Managing a General Practice involves specific skills, knowledge and qualifications. It is essential to have a person with a thorough working knowledge and experience of private general practice and its management and funding complexities eg: Medicare, Department of Veterans Affairs, Enhanced Primary Care, Practice Incentives Program etc. Where possible keep local skilled practice managers for continuity of practice management. It is very important that someone understand the systems and structures of the practice to be able to continue its smooth running when new doctors start. The added clinical benefit of maintaining local practice managers and reception staff is that they often have insights into illness patterns and urgency for appointments etc. Moreover, they often provide a historical link between doctors.

If suitably skilled Practice Managers are not available, then arrange training for new Practice Managers as soon as possible. The University of New England Partnerships (UNEP) runs a diploma of practice management and the Royal Australian College of General Practitioners (RACGP) run a number of short courses for practice management.

Once other practice staff members have been employed, their training requirements should be assessed:

- Do they need additional training in First Aid for triage at the front desk and for general emergencies?
- Are they aware of the strict Privacy requirements of working in a medical practice?
- Do they require additional training in general office computer programs or in the Medical Programs being used in the practice?

A Practice Manual is an important tool for practice staff. Many Divisions of General Practice are an excellent local resource and often have electronic pro formas of practice manuals, which could be utilised. The Practice Manual that was developed for the Walgett and Lightning Ridge practices is included in the appendices. The RDN website will also hold a copy of this Practice Manual on the GP Entity Resources section www.nswrdn.com.au

Practice Nurses

Rural communities are often short of nurses. So it can be difficult to recruit a suitably skilled practice nurse. General Practice services may be improved with the introduction of practice nurses, and if managed well can lead to a higher income for the practice. It may be necessary to offer above award rates to attract and retain a quality practice nurse. On the other hand the working hours of practice nurses, particularly if some flexibility is available, may attract former nurses back into the workforce.

Because practices nurses are a relatively new addition to rural general practice, few nurses are completely trained in general practice issues and may not be fully aware of what their role in the practice actually is. It is important to clarify their role at the outset. It is also useful if the practice nurse has knowledge of PIP payments and how these relate to their role. For detailed information on the Commonwealth PIP Practice Nurses Initiative of 2001-2002, visit the Health Insurance Commission (HIC) website: www.hic.gov.au/providers/incentives_allowances/pip/new_incentives/nurse_incentive.htm

The local Division of General Practice may be able to provide support and assistance in the recruitment and training of practice nurses.

It is important for the GP Entity to be aware of the different requirements associated with Enrolled Nurses (ENs) and Registered Nurses (RNs). Professional Indemnity Insurance for Practice Nurses should be checked to ensure that it covers the exact nature of their work. It is also useful for GP entities to have specific goals for practice nurses to achieve certain standards and levels of income generation, for example through EPCs etc, to ensure they generate enough income to cover their costs.

Medical Advisor

Not all entities will require the services of a Medical Advisor. However, depending on the size of the entity and the number of doctors that it intends to engage, it could be worthwhile thinking about engaging one. In the RARMS experience, a local and external Medical Advisor were essential and the fact both Medical Advisors were rural GPs was an important feature. To read about the RARMS Medical Advisors see Section 4.2. Some issues to consider include:

- A medical person can provide guidance for the systems and structures of the entity to ensure they are efficient and logical from a GP's point of view.
- Medical practitioners often feel more comfortable negotiating on medically related issues with another medical practitioner.
- A medical person with rural general practice experience will understand the issues faced by a GP being engaged by the entity.
- A medical person with rural general practice experience is more likely to have knowledge, experience and credibility to help guide discussions with the AHS in regards to VMO services and related issues. This person may also be able to provide guidance on utilising existing AHS structures and systems for the benefit of the practice.

A separate medical advisor may not be required if other people within the entity have the relevant skills, or if the local Division of General Practice can provide the level of advice and assistance required. However, it is useful to think about this role in the planning stages.

3.7 Ownership, Professional and Clinical Independence

In the RARMS model, the doctor is the practice principal and has contracted the entity to supply services to the practice. The doctor does not manage the practice business. The lines of professional and clinical independence and ownership of the practice need to be as clear as possible in such situations. The doctor(s) are purchasing business support and although they no longer have a role in providing their own business support (practice management, etc), they still retain some level of responsibility for the quality of this service, in that they pay for it. Responsibilities are shared between the entity and the doctor(s). The GP has not relinquished either ownership or independence, rather these have been delegated during their tenure, and they are paying for it to be provided at a level with which they need to be comfortable and for which they are jointly responsible. It is the level and understanding of these responsibilities that is the key issue and needs to be as clear as possible at the outset and which may further evolve over time.

It is important to be aware that there may be a transitional period of adjustment where the doctor, if used to managing a practice business and making day-to-day decisions, gets used to the shared responsibilities, the role of the entity and the new role of the GP. Despite this being one of the positive aspects of the model (in that it relieves pressure from the GP to be a small business owner) it may take time to change behaviour developed under the traditional model of the doctor being the business owner and decision-maker.

In order to assist the doctors in moving through this transition period smoothly, it is important to think through the following points:

- Who actually owns the practice and who is in charge of non-clinical matters? In a model where the doctor is an employee of the entity, this point would be very clear. The entity would own the practice and have complete control over all administrative and management decisions.
- The entity needs to be very clear as to whether it owns the practice and contracts the doctor to provide a service, or whether the GP owns the practice and is effectively purchasing the infrastructure and services provided by the entity. This will affect respective responsibilities on a variety of issues.
- If the practice is still seen as the GP's practice with the entity providing services to the GP, what level of involvement does the GP want to have?
- Does the GP just want to practice medicine and have absolutely no involvement in any aspect of the practice management? Or does the GP want to be involved in decisions that will affect the running of the practice, such as hiring/firing staff. The key may be consultation. The GP does not want to physically do the hiring/firing, however, s/he may wish to be consulted, as the decision could have an impact on the day-to-day work in the practice.

In the RARMS experience, the lines of ownership and control, were at times blurred as a result of moving through 3 different methods of GP engagement. See Sections 4.3 and 4.5.

If an entity provides practice services to the GP, as in the current RARMS situation, it would be useful to think through the following points:

- If GPs are told it is their practice and they can run it how they like, what happens when there is more than 1 GP involved? (RARMS has 2-3 practices in the one surgery).
- What happens if 2 or more GPs want to use different billing methods, sterilising systems, etc? (RARMS acknowledges the right of individual GPs to set their practice fees. To date, all GPs have bulk-billed, but that could change. If the changes increase net practice service costs it may be necessary to re-negotiate fees).
- What happens if a GP does not agree with the long term strategic goals of the entity, because it will affect clinical practice?
- Be aware of the possibility of sensitivities arising between doctors and the need for effective mechanisms to ensure issues are dealt with quickly and not allowed to fester e.g. regular liaison between doctors and with practice and entity staff
- An Advisor of some description (Medical or otherwise) can play an important role in regards to alleviating the stress associated with all these issues. The Advisor can help the GPs to keep the communication lines open with each other and with the entity.
- Include the GPs in decision-making processes from the word go. Irrespective of how they are engaged, it is important that the GPs identify strongly with the practice, and feel their important role is valued and acknowledged.

3.8 Financial Viability of General Practice

RARMS has demonstrated that a competitive remuneration package can be put together that can attract doctors to remote areas. The RARMS experience has also to date demonstrated that if a competitive remuneration package is provided to attract a doctor to a remote area, some form of subsidisation is required to ensure a quality bulk-billed general practice is financially viable. It has further demonstrated that, at least in the first year or two, income from Medicare (HIC) payments alone is not sufficient to cover the costs associated with running a quality practice service entity in a remote location. In less remote rural areas, where qualified staff and better amenities may be more readily available, and subsequently where costs may be lower, the equation may be more favourable and financial viability more obtainable. Despite these obstacles, the external subsidy provided by the Commonwealth to RARMS has resulted in many positive outcomes for these communities that have amongst the worst health outcomes in Australia. Some of these outcomes include a 3-fold increase in doctors, a huge increase in the volume and range of Medicare activity, assured levels of VMO availability instead of frequent crises, and expanded public health programs and other medical services.

The primary objective of a rural community would normally be to provide a financially viable, quality medical service for residents, on a basis that provides a competitive and attractive level of remuneration to the doctor(s) sufficient to attract and retain their services for reasonable periods of time.

Potential doctor income can be boosted in a variety of ways that will vary from town to town. Apart from HIC payments for practice consultations (plus a much smaller volume of non-Medicare consultations such as Veteran's Affairs, workers compensation, insurance and employment medicals etc.), the most significant source of income is likely to be VMO income from providing medical services to a local hospital. Depending upon the income profile of the population, charging on a fee-for-service (rather than bulk-billing) basis may increase doctor and practice revenue. Other possible sources could be from undertaking funded public health activities, providing services to the local gaol (if there is one), or undertaking activities on behalf of the local Division of General Practice. It is important to remember that while the doctor is earning income from these other activities outside the practice, s/he is not earning income for the practice. This would be the case unless there is some arrangement in place for covering the opportunity costs incurred by the practice during the absence of the doctor or if there is sufficient doctor capacity in the community to allow the practice to operate unabated.

Doctors in rural and remote communities are also eligible for Commonwealth Retention Grants. These are paid on a sliding scale, with the highest grants paid to the most remote doctors.

It should be borne in mind that if the entity is successful in obtaining grants or other external funding, there may be conditions attached which increase auditing, reporting and compliance costs.

Cash flow is an issue likely to arise when a new practice opens or an existing practice is taken over – unless there are grant funds, borrowings or resources available from a well-resourced parent organisation. There will be initial time lags in the flow of Medicare (HIC) payments, and up-front costs if fit out and purchase of equipment is necessary. Some minor financial assistance may be available from RDN.

The circumstances and opportunities in each rural community will vary. The most cost-effective approach to generating an attractive doctor-remuneration package, and supplying quality medical and medical practice services, will normally require some tailoring either to build on local advantage or overcome local obstacles.

3.9 Remote Management and Governance

When RARMS was initially established, given the limited local availability of experienced staff and the experimental nature of the initiative, some management functions (policy development, contract and funding negotiations, accounting, IT etc.) were supplied to a large degree from outside the communities, with some significant local contributions. If appropriately skilled staff had been available at the time, RARMS would have preferred to employ local people to take on the management and financial management roles of the entity. Remote management was less than ideal but probably inevitable under the initial circumstances.

In Brewarrina, remote management of the practice by RDN was less difficult due to retention of an experienced medical receptionist. The new entity now operating the Brewarrina practice continues to operate with elements of remote management. An example of local management arrangements for the Wentworth Shire's medical practice is described briefly in Section 5.1.

An important issue to work through is the nature of relationships, accountability and authority of the key people – the practice manager, the doctor(s), and the Board or structure that governs the provision of practice services. The more that day-to-day management can be vested to experienced practice personnel and local management and oversight the better – ideally with access to external advice and support when needed e.g. from the local Division of General practice, or RDN etc. Clarity is required around financial and expenditure delegation, staff recruitment processes and decision-making. Appropriate mechanisms should be in place for monitoring activity and resolving uncertainties or problems – these will need to be regular and frequent, so that problems are identified early, and issues resolved promptly.

Remote governance (the RARMS Board comprises both local and external representatives) can permit a blending of valuable local knowledge and medical experience with strong external medical and management expertise and provide an important element of stability and links to other supportive organisations.

3.10 Utilising Existing Services

In rural and remote areas, many services must work together to ensure they all survive. In the developmental stages of this approach, it would be worth thinking through all the services that would be required for a functioning general practice and look at what is already available and in use. Such services may include: pathology, laundry, contaminated waste disposal, autoclaving, blood collection, purchase of medical equipment and supplies, etc.

In many rural and remote areas, where the Easy, Entry, Gracious Exit model is to be implemented, it is likely that there will be an existing general practice or health provider. In such situations it can be more cost effective to look at utilising the services that are already in use, rather than establishing new services. Consider the following questions:

- Do these existing services work well? What will be the consequences of introducing a new service? What would be the consequences of modifying the old system?
- Look at the historical set up of the services, and think about how a relationship with the entity might affect the current system and the new system, if one is put in place.
- Start discussions with the service providers early, so that agreements do not have to be rushed and all options can be explored.
- It is essential to negotiate and sign a Service Agreement that both parties are happy with and to ensure that the parameters of the relationship are set.
- Think about the location of the services in relation to the general practice. Is it more effective to have the blood collector at the practice or at the hospital? Can current set ups be altered? What are the legal ramifications?
- If introducing IT to help improve the delivery of a service, it will be more effective if it is developed in direct consultation with the people who will be using the service, eg: patients, staff, GPs, etc.

3.11 Medical Records

Continuity of medical records is a significant issue for rural and remote communities. Under the historical model, patient records are the property of the doctor who sees the patient. This can cause problems when the doctor leaves town or dies because the records may go with them or to their next of kin and may not be readily available to patients and the incoming GP. How will continuity of medical records be maintained in the future? It would be beneficial for the entity to own the records and any new records that are created.

Ownership/control of patient records, when vested in a continuing local entity can work well for the patients, the new doctor and subsequently the practice. Health outcomes for patients may be improved because the new GP already has access to their complete medical history. GP time is saved because new doctors don't have to spend time recreating a complete medical history. RARMS found that the communities in which its practices are located, are very happy with the resolution of this issue, because they know their medical records will stay in town, which is a positive outcome of the model. Whatever model of medical service is adopted, when trying to establish continuity of patient records into the future, there also needs to be a certainty of legitimate access to medical records and reports, by outgoing GPs, for medico legal purposes.



3.12 Information Technology

Information technology (IT) is an increasingly important part of rural and remote general practice, and is made more so due to the computerisation of medical practices being a pre-requisite for some (Commonwealth) Practice Incentive Program (PIP) Payments. It is essential to think through all the issues to ensure that IT assists rather than hinders the efficiency of the practice. Such issues include:

- Quality, specification and number of computers and how they can best be networked
- Choice of medical and practice management software
- Local IT support and services
- Location of computers within the practice
- Knowledge of how IT can support general practice procedures
- Where to seek advice, eg: other leading practices and the local DGP
- Security and privacy requirements
- IT training for doctors and especially for permanent staff

These issues will be further explored below.

Increasingly, records, payments and many other practice activities are dependent upon computing and internet technology. Unless the IT is robust, well understood and integrated with the systems and processes of the general practice, inefficiencies and stress are likely and the quality of practice services may be adversely affected.

In general with IT in practices, it is better to have fewer well-understood systems than a raft of poorly understood ones.

Consider the following:

- Reception staff must be trained in general computer use. This does not mean spreadsheet, word processor etc, but more along the lines of 'what is a computer' 'what is the file system' 'how to use folders', 'what is the network', 'how do I use a network' and most importantly 'what is a backup and how do I use it' etc etc. If you have one computer-interested long-term staff member, they should be mentored to become very competent in general computing and hardware concepts.
- Someone trained in backup of the practice data.
- Good backup hardware – tape recommended.
- Practice staff and doctors need to be involved in making IT decisions, they are the users of the system.
- Robust Backup.
- For maximum benefits, you will require one computer per staff member, including receptionists. For practices with more than three computers, you should consider a separate server. Guidance by Division and/or local IT support should be sought here, as many different features and operating systems are available.
- Reliable Backup.
- Each workstation used for prescription needs a reliable black and white laser printer. Don't use inkjet style printers anywhere in the surgery. They are slow, unreliable and have a very high print cost. A low-cost laser has a substantially lower print cost, is faster, more reliable and usually more versatile. Normally they have two paper feed mechanisms allowing easy choice between prescription and plain paper. The front desk also needs a laser printer. Try to standardise on a single type of printer throughout the surgery to facilitate simple swapping of faulty equipment.
- If there are outreach clinics, you should weigh up the benefits of a portable versus desktop computer, for use at that clinic. Remember a portable is more easily misplaced or stolen. A printer will normally also be necessary for this job.
- Backup of data.
- Local IT support is essential to ensure smooth integration and maintenance.
- Software choice could be influenced by your assessment of the best software, balanced with market penetration. A short term GP who can already use the software at the surgery will be productive with minimal training requirements.
- Backups.
- Appropriate wiring, cabling and placement of computers is important to limit disruptions during servicing and management of the system. Be generous with cabling, provide more than you expect to need. It can be very costly in terms of business disruption, time and recall of trades people when needs are underestimated. The same applies to network hardware like hubs/switches. Buy a hub with a capacity of at least twice your expected needs.
- Some varieties of software require a very fast network, so if considering a slow or wireless LAN, ask around first.
- Use at least 15" TFT screens or large (at least 17") monitors where possible.
- Permanent internet connection is crucial to enable access to email results, clinical and patient information, and access to present and future PKI/Medicare systems.
- Security to go with the internet should at least include some kind of firewall and virus protection software.
- Did we mention backup?
- Office software is expensive to buy, train and maintain. Install only where necessary.

It is critical to have competent people who are familiar with the workings of general practice, to set up the computer systems. They need to understand all the medical programs and the way a general practice functions in order to help establish the most logical way for processes to run. An analysis of the IT needs of the practice (keeping the above factors in mind) should be performed at the outset, so that it is clear what is required to make up any short fall.

Planning should keep in mind at all times that 'standard is good'. Only deviate from normal or ordinary or popular when you have a very good reason. This keeps documentation, maintenance and management simple and straightforward.

IT system management is an important part of an efficient business operation. This should include basic documentation for matters such as :

Information for Technical people:

- computer network configuration (only when the network is not self-explanatory or deviates from 'normal'). This should take the form of a diagram where possible, and be posted on the wall near the server.
- warranty records
- software license information where appropriate

Information for Users:

- contact information for software Help Desks
- contact information for computer support personnel
- operating procedures for the computer equipment or programs
- security and privacy policies for information used or maintained on practice computers

It is useful to have a more experienced technician available to the entity for bigger picture IT issues such as expansion of services, etc. It is also useful to have access to expert knowledge and experience for advice on the use of IT in general practices. This may be available from your local Division of General Practice, otherwise, large practices often have a resident 'computer nerd' who is often very ready to help.

3.13 Visiting Medical Officers (VMOs)

In many country towns, GPs are appointed as VMOs to the town hospital. Without the additional income from such an appointment it may be difficult if not impossible to attract a doctor. It is important for a community or entity to establish whether a VMO appointment is going to be essential to generate a competitive remuneration package. If so then it will also be important to establish that any potential recruit would be seen by the Area Health Service as suitable for a VMO appointment. It will also be important to ascertain from the AHS, what is the current number of available VMO positions at the local hospital and if there are any vacancies.

The traditional method of working out VMO payments (RDASP fee for service) does not provide any guarantee of a regular or minimum income, because it depends on how many patients a doctor sees and for what kinds of ailments.

In a small number of locations, including Walgett and Lightning Ridge, the "cashing out" of VMO services has occurred. The "cashing out" of VMO services can provide some stability in income. Doctors receive a guaranteed set income for each 24hrs they are on call. This has enabled RARMS to market medical appointments that have a greater degree of certainty of remuneration levels than otherwise.

This "cashing out" of VMO services was a big step, not taken lightly. It is well understood that the RDA(NSW) package has underpinned the stability of the rural general practice workforce in NSW. This new model was not intended to undermine the RDA fee-for-service system. RDA (NSW) was consulted, and concurred with RARMS trying another arrangement as part of a broad range of initiatives to overcome a major doctor supply crisis. RARMS at one stage contracted with the AHS to provide VMO services to the hospital but this arrangement barred the VMOs from access to the NSW Government medical indemnity scheme, covering doctors treating public patients in public hospitals. RARMS now "manages" the VMO arrangements for a fee (recruiting VMOs, arranging rosters etc.), and the VMOs are directly contracted by the AHS, an arrangement that enables them to access the NSW Government medical indemnity scheme.

If an incoming GP is willing to work under the RDA settlement package, there is little point in seeking change.

If appointed as a VMO, the GP has contractual obligations to attend emergencies and care for in-hospital patients. There will be times when the GP will be called away from the practice on emergencies, to the detriment of waiting patients and practice income unless another doctor is available to pick up the workload. It is in the interests of all parties that rosters, hospital triage, call outs and associated activity be managed efficiently and effectively.

Good on-call relationships have been quoted as being of primary importance in the retention of GPs in rural areas. For an on-call roster to be successful it needs input from the doctors.

The roster needs to be flexible and have continuity, so that the doctors know the patients. The roster should be settled for an extended period so the VMO's are aware of their commitments well in advance and can make their personal plans around those. There should be agreed procedures for handling VMO requests for roster changes to ensure that flexibility and convenience are not at the cost of goodwill or the cause of undue stress and inconvenience. Historical agreements between the AHS and existing doctors need to be honoured. Proceduralists must be taken into account as, for example, there may need to be a GP/obstetrician and a GP/anaesthetist on call at the same time. The procedures and responsibility for developing the roster and for handling change requests should be clear to all involved, including the Hospital Services Manager. Will the VMOs make their own arrangements or will the entity manage the roster on their behalf? If the latter, will there be a fee involved?

3.14 Triage

For GP/VMOs, the practical application of Triage at the local hospital can potentially have a significant bearing upon their attitude towards continuing to practice in the community. Obviously, when a patient has a genuinely urgent need to be seen by a doctor, the rostered VMO should be called any time, day or night. Experienced hospital personnel will know when to call the VMO in, when to ring for advice on a patient's circumstances, and when a patient can be attended to by hospital personnel or asked to return or attend the surgery at a later time.

Particularly in solo doctor towns or towns with an under-supply of VMOs, unless VMO call-outs are restricted to genuinely urgent and necessary cases, there is a risk of frequent sleep interruption and doctor burnout. Doctor enthusiasm can quickly diminish in such stressful circumstances. They are stressful for the doctor and the doctor's family and can also impact significantly upon the hours and efficiency of the medical practice. Concern about the potential of such circumstances to arise in rural medical practice is one of the major barriers to recruitment of rural doctors.

The doctor engagement entity and the community have a strong interest in ensuring the triage/VMO call-out arrangements meet essential patient needs but do not unnecessarily stress the VMO and undermine the doctor's capacity or willingness to continue serving the community.

3.15 Recruitment of GPs including Locums

Doctor recruitment services are available from RDN for rural GP appointments and vacancies in NSW. Free advertising of vacancies is available on the RDN Website (www.nswrdn.com.au) and in "A Country Practice", the NSW Rural Medical Vacancy Booklet published by RDN.

RDN may also be able to help in other ways, such as:

- Relocation grants for GPs taking up rural appointments;
- Information and advice on medical registration options, including "Area of Need" designation;
- Information and advice on Medicare Provider Numbers, including legislative requirements;
- Guidance on immigration issues.

If a practice is seeking a Locum GP, the RDN Locum Service based in Dubbo may be able to assist with one of its own locums or refer you to a number of doctors who have advised RDN they are willing to occasionally undertake locum work.

It may also be helpful to contact the local Division of General Practice for assistance with recruitment or locums. RARMS locum arrangements are briefly covered in Section 4.6.

3.16 Retention of GPs

Once a GP is recruited the effort cannot finish there. Systems need to be set in place to help retain the GP for as long as possible, for the benefit of the community as well as the entity. Such issues to consider include:

- A welcome and introduction to the community is vital to assist with the settling in of a new GP. The community can play an important role in ensuring the new GP feels welcome in the town by showing them the services available in the town and region and inviting them to join in community activities. This should not be a one off process, and should occur regularly until the GP feels comfortable in the community.
- Time off for GP education is imperative to the successful retention of GPs in GP employment entity practices. GPs need to feel supported in their work and need to be able to attend or participate in continuing professional development activities on a regular basis. The local Division of General Practice should be able to assist with provision of education activities.
- Regular personal time off is necessary to help combat doctor fatigue, for example, a long weekend off each month may be more beneficial than a 2-3 week block every 6 months, and may be needed in addition to longer blocks of leave.
- Mentoring and support from other medical practitioners either in the practice or in the local area is important for both professional and social networking and encourages sharing of problems.
- Help with finding meaningful work for a GPs spouse or life partner can mean the difference between a short-term stay and a long-term stay. The NSW Rural Medical Family Network (RMFN – www.rmfn.org.au) can provide assistance with re-training or re-skilling partners of rural GPs. The RMFN can also help partners of GPs through the provision of a support network and regular networking opportunities.
- The possibility of introducing monetary or non-monetary recognition for extended service and/or acquisition of additional medical skills, to encourage long term retention.

Note that Retention Grants are also payable to doctors on a sliding scale after specified periods of service in rural and remote locations.

3.17 Practice Accreditation

Practice Accreditation involves recognition of the fact that a practice is providing a quality service, and is compliant with a set of standards set by the Royal Australian College of GPs (RACGP). Being accredited is important because it demonstrates to patients and the community that the practice provides a quality service. The local DGP is an appropriate first point of call on accreditation matters. There are also financial benefits associated with accreditation.

"*The RACGP Standards for General Practice, 2nd Edition* were developed after extensive trialing as minimum acceptable standards for general practices. The standards are designed to be assessed by peers during a practice visit and cover five key areas of practice:

- Practice Services
- Rights and Needs of Patients
- Quality Assurance and Education
- Practice Administration
- Physical Factors

In order to become accredited, a practice must demonstrate that it can comply with the Australian Standards of Practice Management. During the accreditation process practice staff will be interviewed about practice procedures, so staff education is important in ensuring successful accreditation. It is also very important to include all staff in all stages of the accreditation process.

Accreditation is the gateway to a range of benefits including the Practice Incentives Programme (PIP). The Commonwealth government's PIP aims to recognise general practices that provide quality care and which are either accredited or working towards accreditation against the *RACGP's Standards for General Practices.*

The PIP is part of a blended payment approach for general practice. Payments made through the program are in addition to other income earned by the general practitioners and the practice, such as patient payments and Medicare rebates. Practices may spend their payment as they wish, though the usual taxation rules apply (including GST). The PIP grew out of the Better Practice Program in response to a series of recommendations made by the General Practice Strategy Review Group (GPSRG) that reported to the Government in March 1998" (www.agpal.com.au, 17/1/03)[3].

It is useful to know:

- What the PIP processes are.
- How to implement them.
- What the triggers for payments are.

There currently are only 2 organisations in Australia, which are designed to assist Practices to become accredited:

- *Australian General Practice Accreditation Limited (AGPAL)* www.agpal.com.au
- *General Practice Australia GPA Accreditation plus* www.gpa.net.au

Accreditation cannot be left to the month before testing. The practice needs to be working towards this for at least 6 months. Sometimes it can take a practice 12 months to prepare.

Detailed information on the PIP can be found under the Health Insurance Commission (HIC) website www.hic.gov.au/providers

3.18 Cultural Safety Training

If an incoming doctor is from overseas and has not previously practiced in Australia, there may be a need for an appropriate introduction to the social and medical culture of the community. If an Australian or overseas doctor is to practice in a community with indigenous residents, an orientation to the indigenous cultural landscape as it relates to health and medical issues is highly desirable. How this might be arranged and the opportunity to do so will vary but is important if the incoming doctor is to have the understanding necessary to treat indigenous patients effectively.

3.19 External Resources

There are several organisations that could become valuable resources, in terms of knowledge, experience or funding. Such organisations include:

- Local Divisions of General Practice
- NSW Rural Doctors Network (RDN)
- Alliance of NSW Divisions
- Local Councils
- Area Health Services
- NSW Department of Health
- Australian College of Rural and Remote Medicine (ACRRM)
- RACGP
- Australian Medical Association (AMA)

It could be useful to include some or all other these groups in your initial stakeholder consultations.

RDN is the main reference point in NSW for doctors seeking a rural placement and for rural practices and communities seeking a GP. RDN can assist in the following ways:

- Assistance with obtaining Provider Numbers and medical registration for GPs.
- Grants for relocating doctors from urban areas or less rural areas to more rural areas.
- Assistance with knowing what other grants or funding is available to rural general practices.
- Assisting rural practices to find locums and recruit full time GPs.
- The "RDN Vacancy Book" and Vacancy Website www.nswrdn.com.au/vacancies/vacancies.cfm
- Locating and helping place Permanent Resident Overseas Trained Doctors with rural practices.
- The "RDN Reference Booklet" provides useful descriptions and contact information on important rural health organisations in NSW and nationally.
- Assisting rural practices with understanding and obtaining an Area of Need appointment.
- Grants to local Divisions for CME and Locum support.

Information on certain General Practice processes, requirements, etc can be found on the following websites or by contacting the organisations:

EPC requirements:

- ADGP Enhanced Primary Care website http://epc.adgp.com.au
- The Drs Reference Site www.drsref.com.au/epc.html
- The Alliance of NSW Divisions www.answd.com.au

AHS processes:

- Contact your local AHS www.health.nsw.gov.au/iasd/areas

Requirements for a GP to practice in NSW:

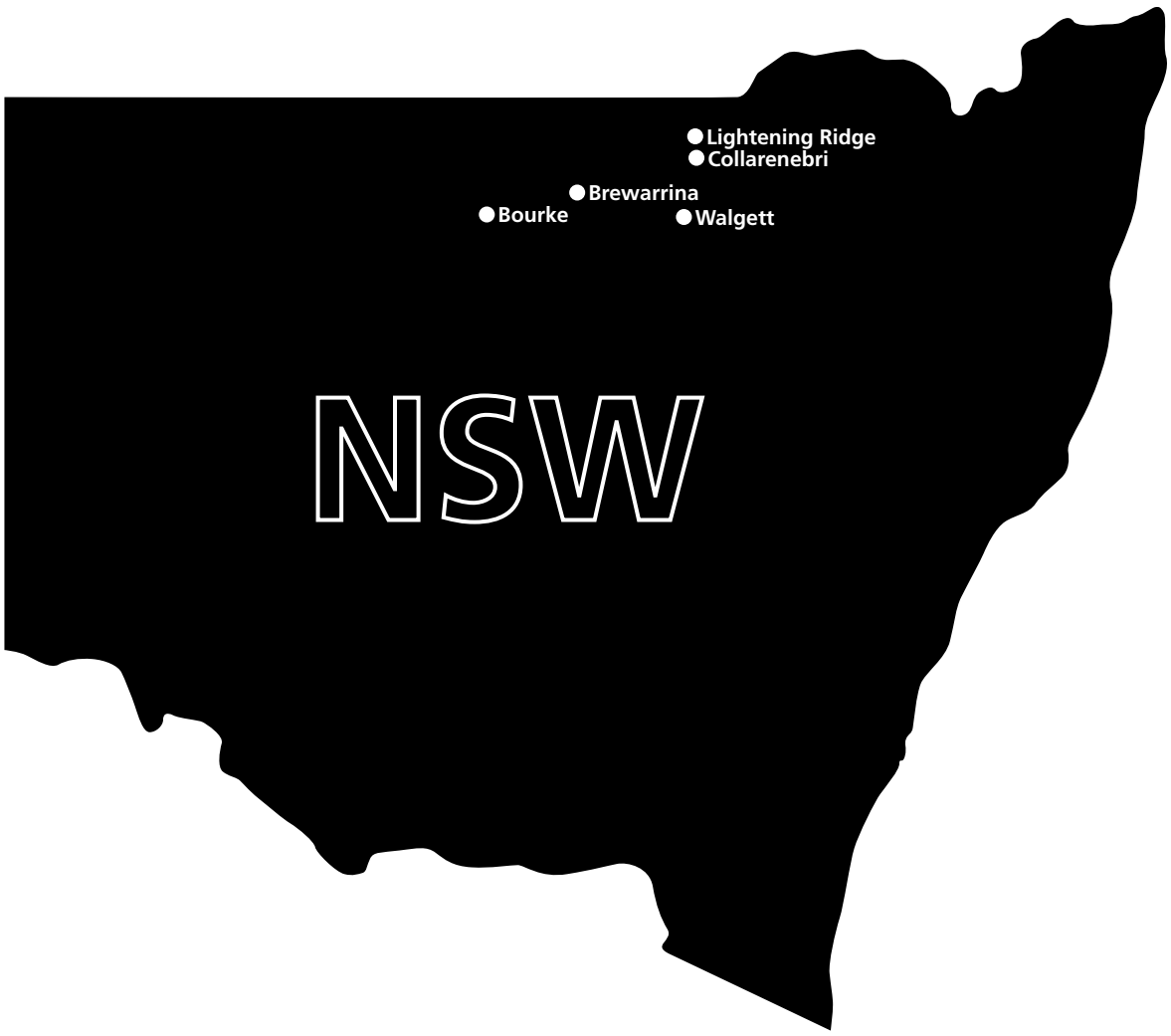
- RDN www.nswrdn.com.au
- Local Division of General Practice (see RDN Reference Book 2003 for Divisional contact details)
- ACRRM www.acrrm.org.au

HIC services, programs and incentives such as:

- Medicare
- Pharmaceutical Benefits Scheme (PBS)
- GP Immunisation Incentive (GPII) Scheme
- Practice Incentives Program (PIP)
- Chronic Disease Management
- Many more

can be found on the HIC website at www.hic.gov.au/providers

Section 4: The RARMS Experience



4.1 Development of RARMS

Background

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 and 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. That it took 22 locums over the next 20 months before RDN could return the practice to local management is illustrative of the degree of difficulty being experienced in finding doctors for remote NSW communities.

From early 2000 RDN was involved in discussions with a wide range of stakeholders and individual doctors, on the best ways to provide health and medical services in the region. Focus was on development of a FWAHS Health Plan, public (population) health services, after-hours services, Aboriginal health and the chronic shortage of doctors. Building pressure on the local Area Health Service to maintain emergency (hospital VMO) services was being exacerbated by pressure to provide community based GP services – an area in which they had previously desired little or no responsibility.

Meanwhile it was becoming obvious that the traditional GP model was probably not sustainable in these remote towns. 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; Collarenabri had not had a permanent doctor for some time.

The FWAHS was by then taking on significant responsibility for recruitment, employment/contracting and support of doctors for both hospital and community services – including the actual management of general practice – an area in which they had minimal experience or understanding. Cost blowouts, poor levels of infrastructure and additional recruitment difficulties were becoming apparent and catalysed a close planning relationship developing between FWAHS and NSW RDN including an integrated approach to planning local GP workforce needs at both hospital VMO and GP community level.

The aim of RDN throughout was to facilitate local stakeholder co-operation to achieve more attractive circumstances for recruiting GPs and sustainable General Practice. The creation and maintenance of a walk in walk out environment ("easy entry, gracious exit"), was identified as a key initiative to attract more GPs to the area.

RARMS was initially formed in mid 2001, as a not-for-profit company separate to RDN to provide a general practice entity – providing both the infrastructure for practice and an employment entity for doctors in remote areas. For a variety of reasons, which will be discussed in Section 4.5, RARMS has not continued employing doctors but continues to provide a full range of medical practice support services and practice infrastructure to GPs in return for an administration fee. The GPs conduct their own medical practices using RARMS personnel, buildings and equipment. RARMS also provides doctors with furnished rental housing. In some cases, for an initial period, a vehicle was also provided. RARMS has Board representation from RDN, RDA (NSW), Outback Division of General Practice, and Walgett AMS.

RARMS purchased the long-standing but then inactive Lightning Ridge practice, combining it with the remnants of the FWAHS practice there, to establish a new 2-3 doctor well resourced practice facility in Lightning Ridge in October 2001. The practice achieved GP accreditation in early 2003 and has expanded to include a practice nurse, visiting midwife and capacity for a third GP. In Walgett, RARMS took over the existing private practice in early 2002. The private GP has remained in Walgett and now runs his practice in RARMS facilities. The facilities have been upgraded and expanded. The VMO workload is now shared between 3 GPs, 2 of whom are resident in Walgett.

Involvement of Stakeholders

The early involvement of stakeholders and community representatives assisted with the development of RARMS and the successful implementation of this model.

Early in 2000, RDN initiated a meeting of all the significant stakeholders. Those with broad regional involvement (Shires, FWAHS, ATSIC, the University Department of Rural Health in Broken Hill, the RFDS, and the Outback Division of General Practice) 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, the Outback Division of General Practice and community members usually drawn from hospital advisory committees. Again, these meetings 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 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 increase the chances of improving overall medical and health services in the area. RDN also maintained communications with the RDA (NSW) to ensure that VMO initiatives did not undermine the RDA Settlement Package, which determines the VMO payment arrangements in most rural hospitals in NSW, and has been an important factor in maintaining services.

Those attending these meetings 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.

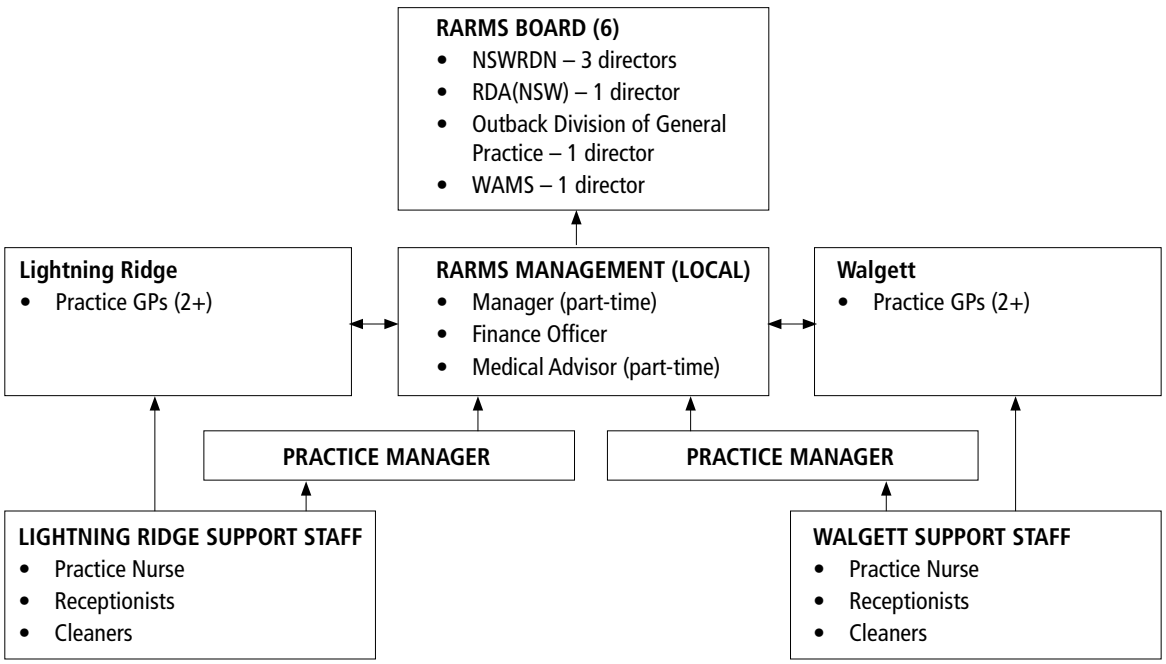
The Walgett Shire Health Forum continues to meet. Following attendance by Brewarrina observers at a Forum meeting early in 2002, a Brewarrina/Bourke Health Forum was established in mid-2002 with similar intentions.

Of all the stakeholders involved in discussions, RARMS felt that the relationship with the local AHS was the most critical. The Far West Area Health Service (FWAHS) was integral to the development of the Medical Services Plan that lent support to the RARMS model, so it was vital to have their support.

4.2 RARMS the Entity

Structure

RARMS is a non profit company limited by guarantee, with a Board of 6 Directors. This is the RARMS structure as at June 2003.

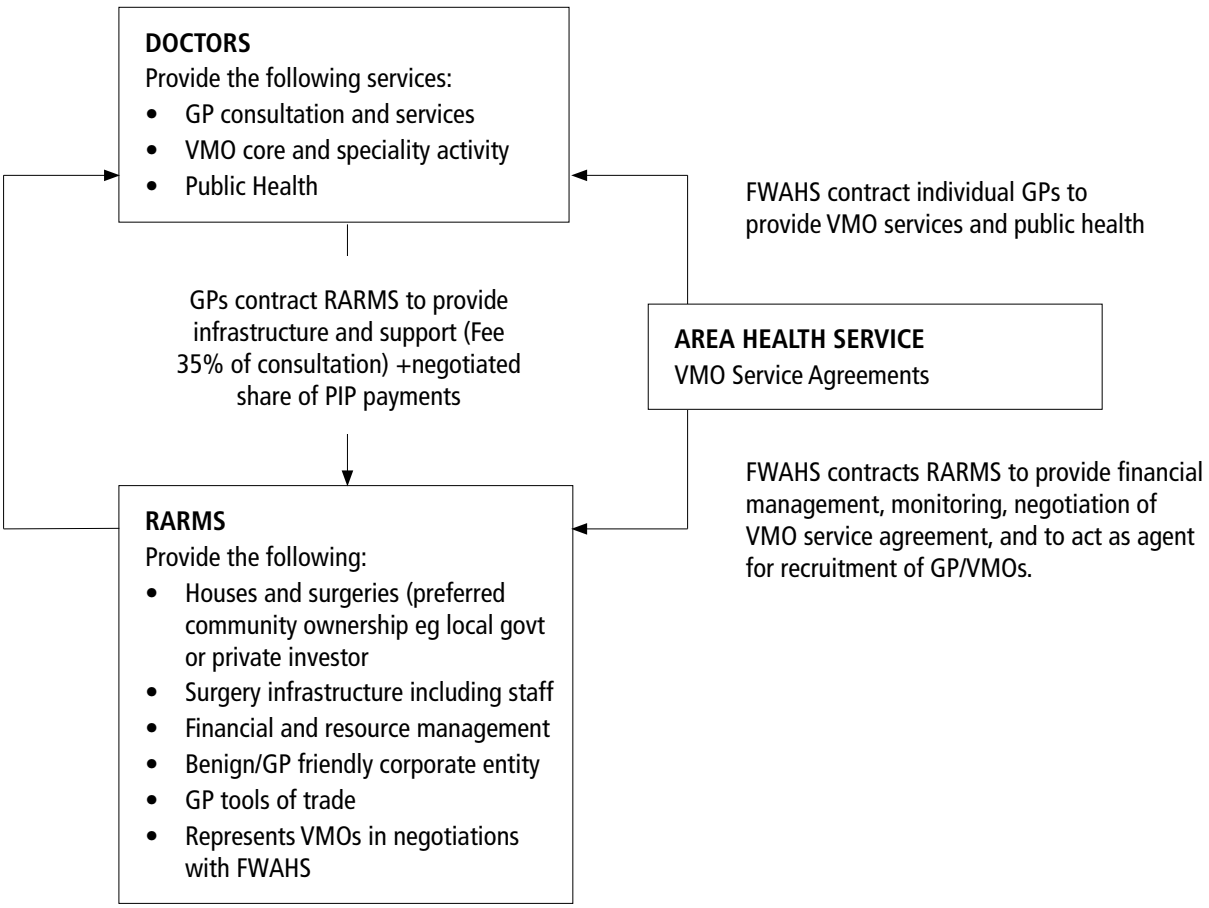


Not-For-Profit versus For-Profit

Establishing an organisation to set up and manage a general practice in a remote location is not a licence for printing money. RARMS was established in response to a doctor-shortage crisis, with the primary objective of improving health outcomes, initially by increasing the number of GPs and thereby providing improved medical services. It developed a package of remuneration, infrastructure and services that would attract GPs to the area. RARMS was established as a Not-For-Profit organisation because it was conceived as a community service initiative, which in the event of a surplus would re-invest it in further enhancing health services in the community from which the surplus was derived. At the time, the Commonwealth Government funding may not have been available to a For-Profit organisation. The focus was not upon profit but upon attracting doctors by ensuring competitive GP remuneration and support, excellent practice and domestic infrastructure, and the opportunity to deliver quality medical services. The non-profit status and the form of Constitution enabled RARMS to be classified as a charity, with useful tax advantages, resulting in additional funds available for health services.

RARMS Roles and Responsibilities

The following diagram illustrates the roles and responsibilities of the various parties associated with RARMS.



GP Responsibilities

In order for the GP to be able to begin work in the RARMS supported practice, the GP must agree to the following:

- Enter into contracts for GP services and where required VMO service provision.
- Undertake to maintain or work towards attainment of FRACGP.
- Maintain their eligibility for ROMPS or be vocationally registered.
- Maintain NSW Medical Registration, in accordance with the Medical Practice Act.
- Maintain a Medicare provider number for the hospital and any other location that is mutually agreed.
- Obtain an Australian Business Number and remit income and other taxes as required.
- Provide proof of appropriate medical indemnity cover (a prerequisite for medical registration).

Human Resources

RARMS Manager

Because RARMS was initially established to improve doctor recruitment and improve the volume and range of medical services available in the North West of NSW, the company saw itself as having a dual role of establishing and managing medical practices and further developing medical services, even if those services did not add to RARMS income. Initially the AHS and RDN jointly contributed to a position of Coordinator (later Manager) to undertake the many extra tasks associated with establishing the RARMS model (negotiating leases, liaison with hospital managers, the AHS and the Walgett AMS, arranging fit out of premises, recruiting personnel, and so on).

It was important to have a suitably experienced and well-connected person available on the ground to undertake these tasks. This position was funded as part of the Department of Health and Ageing grant. The RARMS Manager also reported on activity and developed policy proposals for the Board. Over time, as operations became more settled, practice management responsibilities were increasingly devolved to staff working in the practices. Whatever management structure is adopted, it is extremely important for doctors, for practice personnel, and for the Board, to have clear lines of reporting and accountability.

Financial Officer

For the first year of operation, RARMS appointed the RDN Finance Manager in Newcastle (who was already handling the accounts of the Brewarrina medical practice) to be responsible for RARMS finances. Subsequently, a person with practice management qualifications and experience was appointed RARMS Finance Officer based in Lightning Ridge. These arrangements may not have been necessary if RARMS had had access to well experienced practice management at the outset. The RARMS Finance Officer position has evolved to take on a range of management responsibilities and to devolve the management of financial activity in the two practices to the practice managers. The need for practice based financial management with timely, accurate reporting of finances to both GPs and RARMS Board has become increasingly apparent.

Medical Advisor

There have been two "medical advisor" positions utilised by RARMS since its inception.

1. External Medical Advisor (External MA) - a rural GP with an understanding of the politics and genesis of RARMS, who became a conduit between the local GPs and the Board/management.
2. Local Medical Advisor (Local MA) – a local (senior/ experienced) GP with good knowledge of local systems and history.

The RARMS part-time External MA took the lead on many of the clinical and doctor-related issues that required attention. These included:

- Negotiations/arbitration with the Far West AHS on clinical and hospital issues, such as payment/non payment of accounts, development of Triage and nursing/hospital/ contract issues
- Consultations with RARMS doctors on policy and clinical issues
- Development of VMO contracts, fees, etc
- Being the point of contact for potential doctors
- Advising potential doctors on clinical, registration and financial issues
- Acting as mentor for newly arrived doctors and locums
- Acting occasionally as mediator on issues between doctors or between doctors and other parties
- Alleviating GP stress that was generated through poor communication

It was important that the External MA had good local knowledge, sound policy and historical knowledge and competent negotiating skills, as the external nature of this position meant that the Advisor could be a more effective mediator.

The key role of the Local MA was to assist with development of quality local general practice including uptake of EPC items, access to PIP, assistance with accreditation and quality improvement especially at the local practice level. The Local MA was also a GP resource for the local practice managers and an advocate for the practices and the GPs.

Over time, the roles of External MA and Local MA have evolved so that the Local MA has taken on many of the communication and mentoring roles, which allows the External MA to continue to carry a strategic corporate-wide role and remain active in doctor recruitment.

4.3 RARMS the Model

Provision of Infrastructure

The key principle underlying the provision of infrastructure has been **continuity** and **immediacy** of available resources – in particular housing, surgery premises, GP tools of trade, qualified practice staff, and services (eg phone, power, internet).

House and Car

Accommodation for GPs in North-West NSW has historically often been provided either through the FWAHS or the Shire Council at a subsidised rate. In other areas, the more usual historical model has been that the GP owns their own house or rents it at market rates, although this is changing.

RARMS entered into an agreement with the local councils and private lessors to provide accommodation for the GPs. RARMS leases the houses from the council at an agreed rate, then sub-lets the houses to the GPs. RARMS also furnishes the houses and, initially, subsidised the rent and paid for a certain level of grounds maintenance.

RARMS also initially provided a car, but no longer does so, as it has progressively been able to improve doctor remuneration. This has overcome issues of equity for GPs and reduced costs.

Practice Building

In Walgett, RARMS leases the practice building from the shire council. In Lightning Ridge, RARMS has leased privately owned surgery premises released at short notice by the shire council to allow prompt establishment of the practice. When RARMS took over the Walgett practice, the lease area was not large enough to allow for expansion. Three potential options were considered:

- relocate the practice to the Walgett AMS
- relocate to the hospital, or
- expand the original practice lease in the shire's building on Wee Waa street.

The community tended to prefer a practice in the shopping precinct because it was easier to access than going out to the hospital, which was located on the outskirts of town. The Walgett AMS would have had to find alternative accommodation for some of its existing staff, and there were neither funds nor premises available. Consulting with the community before determining the practice location led to the shire agreeing to provide a larger space in its building, resulting in the practice remaining in a central location.

Practice Infrastructure

RARMS provides the following to doctors who work in a RARMS managed Practice:

- Practice premises and equipment necessary for the GP to operate his or her medical practice.
- Maintenance of the practice premises and practice equipment in a condition reasonably acceptable for operation.
- Adequate paramedical support for the running of the practice.
- Carrying out of all administrative operations on behalf of the GP in respect of the medical practice, including:
  - Organising appointments
  - Providing suitable reception and typing services
  - Providing practice equipment and medical supplies
  - Establishing and maintaining appropriate bookkeeping
  - Billing, banking and collecting professional fees
  - Tracking payments, costs, expenditure
  - Payments of creditors
  - Tracking revenue potential
  - Accounting to Practitioner for Practitioner payments
  - Determining the Practice or GPs eligibility for any Grant funding
  - Accessing and Monitoring Practice Incentive Program (PIP) payments
  - Keeping the practice up to Accreditation standards
  - Tracking payments associated with HIC and Department of Veteran Affairs (DVA)
  - Maintaining and forecasting budgets

The initial purchases of office and medical equipment for the practices and of furniture for the doctor houses were financed from a special Commonwealth Department of Health and Ageing Grant through RDN.

RARMS practice operations were originally financed from a percentage of the doctors' two main revenue streams (practice consultations and VMO).

Forms of Doctor Engagement

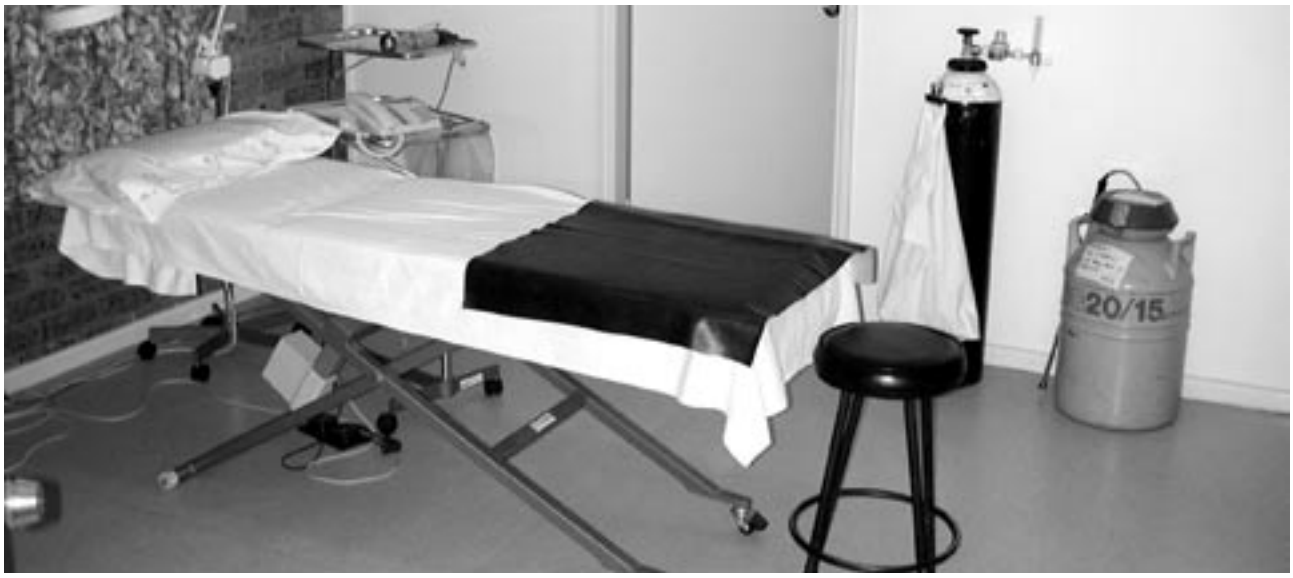
RARMS trialled two forms of doctor engagement for undertaking medical practice consultations:

1. *Direct employment contract*, and
2. *Independent contractor agreement*

More recently RARMS moved to a contracted *Infrastructure and Services Agreement* – to provide practice infrastructure and services to the **doctors' practices** for agreed fees.

In RARMS' experience there are several particularly important factors to weigh in considering the form and content of doctor engagement contracts.

Direct Employment: RARMS took over the direct employment of some locums from Far West AHS. With the emergence of the medical indemnity crisis in 2002, it was considered that this form of engagement involved the greatest potential risk of vicarious liability for medical malpractice claims that may be lodged against employed doctors and/or their employer. While the likelihood of such claim being lodged and being successful was seen to be low, the financial risk associated with any such claim, if it was successful, was seen to be high. At present there does not seem to be appropriate insurance available to an employing body, to cover claims made in future years that relate to present activity (claims incurred but not reported – IBNRs). Such insurance is available to individual doctors, but there is potential difficulty for the employing entity in that it cannot be certain that the doctor will maintain that cover into the future, long after leaving its practice.



Direct employment also involves the employer being responsible for obligatory worker compensation payments, compulsory superannuation contributions, and (depending upon the nature and size of the employer) payroll tax.

There can also be difficulties associated with a fixed salary if the employed doctor is unable or unwilling to undertake sufficient medical activity to generate enough income for the practice to cover the employment and associated practice costs. While it would be wise and effective to incorporate financial incentives linked to income generation, this may still not be sufficient if, for example, the doctor is not well enough to carry a high patient load, or needs extensive training to be able to do so.

Independent Contractor: The main concern with this form of engagement was the uncertainty as to whether, if challenged, the contractual arrangements in some cases might be seen in any way as being de facto employment, with the attendant risks and concerns already mentioned above.

Infrastructure and Services Agreement: This form provides the least likelihood of vicarious liability for medical malpractice claims against a doctor as RARMS is simply contracted to provide services to the doctor's practice and does not exert any control over the way in which the doctor conducts clinical practice. RARMS supports the GPs in developing the non-clinical practice policies (such as accounting and staff training) and supporting "best practice" administration. RARMS facilitates good clinical practice eg through timely access to clinical decision support such as broadband internet access and full practice computerization. All doctors, whether they bill as individuals or as a medical practice company, have an Australian Business Number for invoicing and tax purposes with accounts billed by the practitioners but collected and accounted for by RARMS on behalf of the GP. The financial arrangements (fee as a proportion of consultation income) provide incentives for both RARMS and the doctors to generate a healthy income stream. RARMS has found it essential for both the GPs and RARMS to identify minimum levels of service provision at the surgery in order to ensure the financial viability of both parties.

The two forms of GP engagement and the Services Agreement clearly involve varying degrees of respective responsibility between the entity and the doctor. Whatever the relationship, RARMS (with several doctors working in two remote practice locations) has found it both beneficial and necessary to have access to experienced rural doctors to perform the roles of an External Medical Advisor (External MA) and Local Medical Advisor (Local MA). The role of External MA has included informing potential doctors of the medical work and working conditions involved; negotiating remuneration and workloads; maintaining liaison with the doctors on professional and medical issues; and helping to settle issues that may arise between doctors, or medical issues involving doctors and the hospital or AHS. The Local MA has been essential for the mentoring of new doctors.

VMO services

As mentioned previously, RARMS obtained agreement from Far West AHS for VMO payments to be "cashed out" as a daily rate. The sole purpose for this was to improve the capacity of RARMS and RDN to state with certainty to prospective doctors what the likely VMO income would be for a given level of activity (e.g. for a VMO providing general VMO services 1 week in two; with additional rates for anaesthetic and obstetric skills). Such certainty was particularly helpful when negotiating with doctors from overseas or interstate who were unfamiliar with rural NSW VMO practice.

The second reason was to create an environment where there were no perverse (financial) incentives for GPs to see patients with minor clinical problems at the hospital out of hours. The unfortunate corollary of this is the elimination of the AHS disincentive (financial) to call GP-VMOs to the hospital for minor clinical problems.

The third reason was to attempt to develop and support the acquisition and maintenance of additional clinical skills by Registered Nurses in the hospitals as a mechanism to:

- Increase the attractiveness of rural nursing practice and
- Reduce the burden on busy and sometimes tired GP-VMOs through better Triage and enhanced nurse initiated management of appropriate clinical conditions.

RARMS has experienced two forms of VMO arrangements. Originally, following a public tender process, RARMS was contracted to manage and deliver VMO Services in Walgett and Lightning Ridge under agreements with the Far West AHS. RARMS then contracted the doctors to provide VMO services at these hospitals. RARMS invoiced the AHS for the services provided and paid the doctors for the VMO work they undertook, less a management fee. RARMS played an active role in negotiating improvements in VMO arrangements with the AHS – for many months a fortnightly meeting dealt with a wide range of issues, including triage and efforts to re-establish obstetric services.

In mid-2002, the medical indemnity crisis developed and uncertainties were raised about whether the doctors' medical indemnity insurer (which had been placed in the hands of an administrator) would cover VMO services provided by RARMS VMOs. Additional complexity was added to these negotiations when RARMS was advised that while State Government medical indemnity was available to most rual GP/VMOs through the Treasury Managed Fund (TMF) for treatment of public patients in public hospitals, such coverage would not be provided to RARMS VMOs under the arrangements entered into. RARMS VMOs promptly advised they could no longer provide such VMO services without assured TMF cover. New contracts were rapidly developed which enabled the RARMS VMOs to have access to TMF cover. Recent developments include the availability (from 1 July 2003) of TMF cover for VMOs treating private patients in NSW public hospitals.

The new (and current) arrangements are that RARMS has a VMO Services Management contract with the AHS, but no longer sub-contracts the doctors. The VMOs are directly contracted by the AHS for VMO services. The RARMS VMO management services are the same as previously, including VMO recruitment as an agent of the AHS, rosters and acting as the interface between VMOs and the AHS on hospital medical services issues. The RARMS/AHS agreement provides for review of arrangements, fees indexed to RDA Settlement Package adjustments, and payment of interest on late payment of fees.

The process of VMO contract negotiation and finalisation was drawn out, taking a lot of time and energy and slowed RARMS progress on its contractual relations with its own doctors. In the end, only 6 weeks after finalisation the contracts had to be restructured and rewritten to accommodate the medical indemnity issue mentioned above.

4.4 Benefits of the RARMS Model

Experience tells us that increasingly, GPs in rural and remote NSW do not want to do the following:

- Risk their capital by purchasing a medical practice, housing or surgery building.
- Be employers.
- Enter long term contracts.
- Negotiate with Shires.
- Negotiate with Area Health Services.
- Suffer low cash flows during start-up.
- Take financial risks.
- Find employment for spouses or obligate the spouse to work with them (often for no reward).
- Navigate through the minefields of practice accreditation, and PIP registration.
- Be responsible for running a medical practice company with all the associated requirements surrounding tax, superannuation and workers compensation.
- Worry about succession planning and recruitment of other doctors when needed.

RARMS has addressed many of the barriers and found a mechanism whereby the GPs retain control over the clinical and major policy aspects of their practices without incurring many of the negatives. The benefits to the GP are that RARMS:

- Owns the practice infrastructure, employs all staff, is responsible for all paperwork and supplying IT support and other services.
- Enters into all leases for housing and surgeries (or can broker such leases).
- Negotiates with Shire.
- Negotiates with the Area Health Service.
- Manages the VMO agreements.
- Takes many of the financial risks including provision of operating capital (although the key financial risk remains medical indemnity/liability and the RARMS model now avoids this risk by not employing GPs).
- Lowers stress levels, provides a more regular doctor income, plus more control over hours worked.
- Creates ease of entry into a general practice and simple exit from it, when the doctor decides the time is appropriate.

The benefits to the community are:

- Increased number of GPs.
- Improved level of service and range of services.
- Greater stability in medical workforce.
- Continuity of practice records.
- Increased local employment.
- Community retention of practice/GP infrastructure.

The benefits to the Far West AHS have been:

- Having an entity (RARMS) that has been able to provide continuity as a contact point on VMO and other medical activities.
- RARMS acting as agent for the AHS in recruiting VMOs.
- Increased availability of doctors for both VMO and general medical activity and a dramatic reduction in the previous frequent crises to obtain VMO cover whenever an incumbent solo VMO or locum was sick or absent for any reason.
- Financial predictability of VMO payments.
- Withdrawal from provision and management of community based GP services in Lightning Ridge with improved ability to concentrate on core business.
- Opportunities for more rational separation of patients that could be seen in the GP surgery versus Hospital Emergency type patients.
- Less stressed relationship between GP VMOs and hospital managers.

4.5 Major Obstacles encountered

Medical Indemnity

In its developmental stage, RARMS was intending to employ doctors willing to work in rural NSW or to engage doctors as independent contractors. Soon after the establishment of RARMS, widespread concern began to build across NSW and Australia generally about the escalating costs of medical indemnity and the uncertain financial strength of medical indemnity providers. The concern was heightened by the financial fragility of United Medical Protection (UMP), the main insurer in NSW, with whom all RARMS doctors were insured. With UMP in the hands of an Administrator, RARMS VMOs became alarmed. Unlike most other rural VMOs they were not at that time covered by the TMF for their VMO treatment of public patients in the hospital, and now there was a heightened risk of them also not being covered by UMP.

The outcomes were two-fold. RARMS re-negotiated the VMO arrangements with Far West AHS so that the VMOs did have TMF cover for their treatment of public patients in the hospital. Secondly, RARMS found it difficult to obtain satisfactory insurance for itself, to cover the possibility of vicarious liability for the medical activities of doctors it employed or had engaged as independent contractors. It was at this point that RARMS then chose to become a company that provided management and other services to doctors' practices, thereby reducing the likelihood of legal action being taken against it, and reducing greatly the likelihood of any such action being successful.

Human Resources

A major difficulty in establishing practices in the remote Walgett and Lightning Ridge areas was a shortage of experienced and available medical practice personnel. In both locations, the practices had to rely at first upon inexperienced staff. Personnel were initially employed on a temporary or casual basis and most staff wanted to work part-time. As some more experienced people have become involved and as staff have gained experience, things have become more settled. Most personnel still work part-time. It is also the case that a number of staff would not be regarded as long-term residents and may leave in the short to medium term. Teachers, police and a number of other professional families often tend to be posted to remote areas for limited periods, thereby also limiting the availability of their family members to work long-term. As doctor staffing becomes more stable, RARMS will need to pay more attention to long-term practice staffing strategies to minimise the frequency and impact of staff departures.

The RARMS experience has shown the value of having continuity of skills and knowledge in practice staff particularly practice managers. If it is possible to retain competent incumbent practice managers, they bring the benefit of generally superior knowledge of how a medical practice works, how the records can be easily accessed, and who the patients are. If that is not possible, then it is sensible to employ someone with a background in practice management and preferably rural practice. One advantage of employing part-time staff in small practices is that it can be easier to cover absences for illness or leave when there is more than one person familiar with the duties of a position.

Clear job descriptions and job tasking is important for ensuring the smooth running of a practice. New staff should have very clear guidelines and parameters for their work. Performance appraisals are easier when performance can be measured against specific performance indicators.

A Practice Manual is a useful tool, providing detailed information on all aspects of the general practice, from the way to answer the phone, to dealing with aggressive patients. University of New England Partnerships (UNEP) was contracted to provide a detailed Practice Manual for RARMS practices (see appendix and also available on RDN website www.nswrdn.com.au). It has sections covering Patient Focus; Front Desk Activity; Office Activity; Clinical Activity; Practice Communication; Workplace Health and Safety; and Privacy. UNEP was also contracted to provide training to practice personnel.

Recruitment of practice nurses has also been a major challenge. For an extended period in Lightning Ridge, 3 different nurses provided a combined total of 3 days per week of practice nursing. A full time nurse has now been employed. In Walgett the nurse commutes 70kms over sometimes-impassable roads for 3 days per week. Incentives are available from the HIC, and possibly the local Division of General Practice, for the employment of a practice nurse.

Information Technology

RARMS was fortunate in having access to funds at the outset to establish a reasonable standard of IT hardware and software in its practices. As the practices and activity levels grew, so did the demands placed on the systems. Poor telecommunications services undermined practice efficiency (lines dropping out before fax documents or emails had been fully received etc.). The RARMS practices, as part of a wider project providing improved telecommunications to North West medical practices, was supplied with 2-way satellite-based broadband internet access – this has improved external telecommunications, although there remain times when access is not available.

It was a challenge to design, install and configure computer systems when some of the staff were unfamiliar with the technology, what it could do, and how to operate it. Also a number of doctors were locums or working for short periods and not all were proficient in the use of medical practice software.

RARMS was initially supported by the RDN IT Manager in Newcastle. This was less than ideal given the time and dollar costs of visiting the North West, and the inability to address some issues promptly other than by remote guidance of practice staff. Eventually a service contract was entered into with an IT technician in Walgett who was on the verge of leaving the area. A guarantee of a certain amount of work over 12 months was sufficient to retain his services for the time being. While experienced with computers, he also had to develop further his understanding of medical practice requirements and of medical practice software.

RARMS had numerous problems with IT from the outset, because:

- IT decisions were made offsite.
- There was no local IT support for a long time.
- There were limitations with existing hardware, configuration and software.

In the RARMS experience, the most contentious issue of all was the pace of change associated with the introduction of computerisation, and the absolute need for training prior to the staged transfer to new systems. Failure to properly manage the IM/IT system introduction caused frustration, inefficiency, legitimate concerns for patient management and an impression of unreliability of the IT. To ensure a smoothly functioning work place, Practice Managers and staff need to be confident that their computers have the capacity to work under high loads and that all Programs are current.

The RARMS experience has shown that it is important to:

- Not use off cast poor quality computers. Make the initial outlay and purchase good quality computers and software. (RARMS initially used some old printers in the surgeries – this was a disaster!)
- Ensure consistency in equipment eg of printers, computers, office software, etc on GP desks and at different surgeries if possible. This will make maintenance and identifying and fixing faults easier and will ensure that GPs moving from one room or town to another will still be familiar with the system.
- Standardise other equipment eg: Spirometers, ECG machines etc is also a good idea for the same reasons outlined above. If not standardised then instructions should be retained and available.
- Schedule routine maintenance of computers and equipment.
- Train all staff adequately in the use of their computers and software, so they are capable of helping themselves with standard IT issues.
- Ensure the server is in a position that is quarantined, so that work on it does not disrupt normal office operations.
- Ensure there are enough workstations.

Your local Division may be able to help with a list of the key features of IM/IT systems required in General Practice.

4.6 Other issues to be addressed

Financial Viability of RARMS

Commonwealth Department of Health and Ageing funding supported the establishment of a new practice in Lightning Ridge, involving the purchase of patient records, computing and medical equipment, as well as the furnishing of 2 doctor houses. These funds were also used to acquire the existing private medical practice in Walgett, including medical and practice equipment and patient records. Additional computing and other equipment were also purchased to accommodate up to three doctors as well as creating additional rooms, which were equipped as a treatment room, for a practice nurse and another room for practice management.

It is clear that in the Walgett and Lightning Ridge practices, the current arrangements provide attractive performance-related remuneration levels for doctors and that this has been one of several key factors in substantially increasing doctor numbers.

Obviously, the funding from the Department of Health and Ageing subsidised practice establishment costs through measures such as providing practice equipment and other infrastructure. Without such up-front financial assistance it would not have been possible for RARMS to consider taking on the tasks of creating the new practice model in Walgett and Lightning Ridge and pioneering the Easy Entry, Gracious Exit concept in rural NSW.

The grant funds also ameliorated what would otherwise have been a tight if not impossible cash flow until RARMS income began to build. The funds have effectively subsidised infrastructure and management operations over 2 years and provided a necessary "cash flow" buffer. Even so, a RARMS loss incurred by one employed GP was only offset after another GP voluntarily undertook locum work at another location and assigned the revenue to RARMS.

Financial data is not available as to the costs of operating medical practices in Walgett and Lightning Ridge prior to the involvement of RARMS. Nor do the circumstances of those practices easily lend themselves to "then and now" comparisons even if the figures were available. For example, in Walgett there was previously a solo practice with an enormous VMO workload (and hence major cross subsidy of practice costs). The doctor's partner also took a significant role in financial and practice management, which is not uncommon and often works to further subsidise and support the financial viability of rural medical practices.

It is important to emphasise that today in Walgett there is a larger, better-equipped, fully computerised surgery with 2 resident GPs (possibly 3 soon) and a part-time non-resident doctor. Practice nursing is available 3 days per week. Standards of service are higher in several important respects as doctors are less stressed and have more time to devote to their patients. On the other hand, there is no cross-subsidy of VMO income to RARMS (a Management Fee covers only the costs of management of VMO services) and all financial

and practice management services have to be met out of a practice management fee. Similarly, in Lightning Ridge "before and after" comparisons would not be valid due to the very different circumstances.

[In Brewarrina, with the assistance of infrastructure funds, it was possible for RDN to run a solo practice on a near break-even basis over 20 months despite a turn-over of 22 locums. A key factor was the continuity and dedication of an experienced medical receptionist, and close financial monitoring.]

Clearly, the establishment of RARMS was a threshold factor in testing new approaches to doctor recruitment and medical services in northwest communities. The results include more doctors, better medical services and better medical practice services. In Walgett and Lightning Ridge, the results also include higher practice costs and the isolation of RARMS from any de facto subsidy from VMO activities. There are also additional costs incurred by virtue of the corporate structure adopted for RARMS, such as for director insurance, meetings costs, RARMS manager and Finance manager, and corporate fees etc. The expanded level and improved quality of practice services provided by RARMS are not at present financially self-sufficient. Recent action to improve financial viability includes a reduction in nursing staff levels in Walgett, removal of vehicle and housing subsidy and extending practice hours without adding to staff levels. Over time, further marginal efficiency improvements may be obtained without compromising service levels but there are also risk factors that could increase costs, such as loss of staff.

It may be financially compelling to withdraw bulk-billing but the socio-economic status of the communities, including high levels of unemployment and disadvantage, the persisting long, severe drought and the large indigenous population are just some of the reasons to continue. The bottom line is that in remote locations such as Walgett and Lightning Ridge, quality medical and medical practice services cannot be financially sustained under bulk-billing arrangements unless practice service fees charged to doctors are significantly increased (with the adverse effect of reducing the remuneration levels that have successfully attracted GPs to the area), or ongoing targeted financial subsidy is obtained.

The alternatives are a serious reduction in practice services or a, probably unsuccessful, attempt to revert to the old model of doctor-owned practice. In such communities the alternative of doctors charging on a fee-for service basis is more likely to impede access to medical services than to improve practice sustainability. However, under the current RARMS model the individual doctors control their practices and decide the fee policy in their own practices, provided those policies do not unduly impact upon RARMS costs or the ability of RARMS to continue to deliver quality support services to the doctor.

The RARMS experience suggests that significant factors contributing to not being financially self-sustaining (other than with a grant subsidy) in the first 2 years of operation include:

- extra costs associated with remote location, and
- the costs of providing a remuneration framework that is sufficiently attractive and competitive to attract doctors.

It may be that medical practice entities in less remote communities might not experience the same degree of financial disadvantage.

Ownership, Professional and Clinical Independence

Just as the forms of RARMS doctor engagement have evolved, so also has the nature of the relationship between RARMS and the doctors. The first doctor employed by RARMS was located in Walgett AMS under an agreement by which the AMS provided infrastructure and services on a basis similar to that provided to the resident doctor employed by the AMS. The RARMS doctor was independent on clinical matters but required to fit into the day-to-day arrangements and procedures of the AMS practice. A brief protocol set out the arrangements.

The second employed doctor commenced working for RARMS when the practice was established virtually overnight in Lightning Ridge. Both the doctor and the practice personnel worked for some weeks under very basic conditions until facilities and equipment were up to standard. The doctor was the most senior staff member in the practice and inevitably carried a supervisory role to some degree, although the RARMS Coordinator and the External Medical Advisor were primarily responsible for setting up the practice, recruiting personnel and acquiring appropriate equipment.

Subsequently, RARMS engaged doctors as independent contractors under agreements that outlined the respective responsibilities of doctor and company. The doctors were not employees. They were engaged to provide specified medical (and at that stage VMO) services in the RARMS practices and at the hospital. The doctors did not direct policy on matters such as practice fees – not that this was an issue over which there were differences. The doctors were paid an agreed percentage of consultation fees, with an incentive payment if income was generated above a specified monthly level.

Now, RARMS has moved to the position where it supplies practice management and support services to the doctors' own practices, in return for a fee that is set as a percentage of practice revenues. In the two RARMS supported surgeries the Practice Manual forms the basis of operational procedures. These may be modified from time to time in consultation with the doctors to improve efficiency or standards of patient care. The RARMS agreement with each doctor describes in broad terms the respective roles. The

doctor on the one hand has sole and unfettered conduct of the clinical practice. RARMS on the other hand may give reasonable instructions to the doctor on administrative matters, to ensure effective operation of the medical centre. For example, doctors are required to utilise the computing facilities available to them and make electronic rather than hand-written records.

There have been occasions when aspects of practice operations have been unsatisfactory either for the doctor or for practice staff. These have been addressed in a variety of ways, including:

- through regular liaison meetings between doctors and practice staff
- by mediation or discussion with the RARMS Manager and/or the Medical Advisor (External or Local)
- by referral to the RARMS Board, or
- by joint discussion between doctors and Board members.

In the situation where there is more than one doctor operating a practice in the same surgery, supported by the same staff and administrative systems, there is obviously scope for individual doctors to hold differing opinions on some aspects of surgery arrangements. If these cannot be resolved within the surgery, the External Medical Advisor is usually called upon to resolve matters.

Similarly, locum doctors may at times be used to working differently. It will be a matter for the doctor in whose practice the locum is working, to inform the locum how it is expected the locum will work in the practice.

The relationship, procedures and expectations of doctors and practice personnel continue to evolve and vary with changes in circumstances and individual personalities. For some practice personnel it took a period of adjustment when the RARMS role changed to being a service provider to the doctors' practice, where previously the doctor had been providing a service to the RARMS practice.

Similarly, some doctors and locums who had been used to being in charge of all aspects of a medical practice (e.g. as owner of the practice and infrastructure and employer of the staff) have found they also have undergone adjustment when working in the RARMS model. While they have been pleased that they are relieved of business management and employment responsibilities, they have had to adapt to no longer being able to make unilateral decisions about buying equipment, instituting administrative change or employing personnel. Those are now RARMS responsibilities, and RARMS agreement is necessary. It is RARMS that carries the financial and other consequences of such decisions.

RARMS appreciates that no contract will be able to specify fully or permanently, the respective roles of doctor and RARMS (including RARMS personnel). The critical requirements are to be clear in the contract about philosophy and principles, and ensure that there are fair, informal and formal, processes in place for resolution of issues. Good communication and working relationships in the surgeries go a long way to keeping matters on an even keel and working well. It is probably the case that, especially in the early evolutionary phases of RARMS practices, communication could have been better than it was – when circumstances forced much of the management and accounting to be conducted a long way from the practice locations.

The current arrangement, based upon the practice belonging to the doctor and the infrastructure, support services and personnel being provided by RARMS, creates a stronger doctor ownership. The practice earnings of the doctor are directly related to the level of surgery activity undertaken. Both the doctor and RARMS have a positive incentive to generate surgery income.

Practice Accreditation

The Walgett medical practice attained accreditation just prior to RARMS becoming involved. The new practice in Lighting Ridge was accredited a year later.

RARMS practices initially had difficulty accessing PIP payments. The inherent complexities of PIP and the relative lack of general practice experience of RARMS staff contributed to this. It is necessary that the GP entity management has a clear understanding of GP funding sources and incentives, as not all GPs will be familiar with them.

UNE Partnerships is the Education and Training Company of the University of New England. Specialising in vocational training, UNE Partnerships designs and provides industry-specific programs that are nationally recognised and conform to the requirements of the Australian Qualifications Framework (www.unepartnerships.com.au, June 2003)[4]. UNEP was contracted by RDN to assist medical practice management in the North West and provided particular help to build the Lightning Ridge Practice from the ground up, so that it was based on GP Accreditation standards and could apply for accreditation as soon as possible. The local Division of general practice is probably the first port of call to seek assistance in GP accreditation matters. A practice manual was developed with assistance from UNEP and has been adopted in Lightning Ridge, Walgett and Brewarrina.

Medical Records

In both RARMS locations it was possible for RARMS to acquire the medical records of resident doctors – in one case paper-based, and in another a mixture of paper and electronic records.

RARMS ensured that there would be continuity of patient records, by including in the GP contracts that the medical records of each patient seen remains the property of RARMS, so that when the GP leaves, the records will remain in town. In return RARMS agreed to ensure records are always available to the GPs practice and that the records would also be made available to the GP following cessation of the contract, for the purposes of professional development, clinical research or defence of medico-legal litigation.

Use of Existing Services

RARMS has made use of a number of existing services, and sought to utilise AHS/local hospital based services in an effort to contain costs, enhance local service provision and enhance financial viability of existing services, eg: sterilization, waste disposal, pathology services. Below is an outline of some of the major issues encountered.

Pathology Service Agreement

RARMS was committed to using the existing services of the Institute of Clinical Pathology and Medical Research (ICPMR) as the preferred pathology provider for a number of reasons including:

- Philosophy of support for public sector provider in spirit of partnership between RARMS and NSW Health.
- They were the existing provider with small, local (stat) labs at both Walgett and Bourke.
- The locally supplied, but limited, services were highly valued and provided rapid results with local employment and infrastructure.
- They were committed to a "free at point of service" (bulk-billing) arrangement.

The utilisation of the existing Pathology service was at times quite problematic in the RARMS experience. Issues included transport to Sydney, handling of results, electronic importation of results into practice software, and general apparent lack of responsiveness to GP issues from an organisation that seemed largely focused on a teaching hospital environment/system.

Private Clinical Lease Agreement

RARMS has negotiated with the FWAHS to lease a room at the hospital to provide a branch practice facility (mainly for after hours work, but it can be used during office hours). The concept of the branch facility is that it allows the GP on call to see non-emergency patients (typically Triage category 4 & 5 patients) and privately bill them. Categories 1, 2 and most 3's are seen under VMO arrangements, but other patients may be seen as general practice patients. This allows rural GPs to see non-emergency patients more promptly in private rooms at the hospital rather than having to return to the surgery (after hours) and open the surgery in an unsafe working environment and without nursing and administrative support. A computer link from the GP rooms to the hospital allows access to the GPs electronic patient health record. It is important to have a lease agreement for private rooms at the hospital or health service specifically for private general practice patients, to maintain eligibility for Medicare benefits.

Recruitment

GPs

RARMS has obtained resident doctors mainly through RDN and from the personal networks of doctors already working in RARMS managed practices.

Contract arrangements allowing some flexibility for GPs to work in other communities or other services within the same town are worthy of consideration in the interests of maintaining medical service levels. Walgett GPs have occasionally supported Lightning Ridge, Brewarrina and Wee Waa, and provided sessions at the Walgett AMS.

Locums

By agreement, the organization of locums may be undertaken by RARMS or an individual GP and responsibility for housing, travel, payments etc will reside with the party who has arranged the locum. Similarly, if a locum subsidy is available from RDN or the Division, it is payable to the organising party.

It remains the responsibility of RARMS (the practice manager) to ensure the GP has a provider number, indemnity insurance, registration, etc and to manage a VMO appointment if necessary.

It is highly desirable to pre-negotiate and state clearly in any contract with a doctor, that if they go on leave and vacate their (RARMS leased) house, then their house should be able to be used for a locum.

RARMS has found their locums through RDN, a locum agency, and primarily through other Doctors.

Section 5: Alternative Models in existence

5.1 Wentworth Shire Council

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The Wentworth Shire Council provides an example of a successful version of medical practice similar to the Easy Entry, Gracious Exit model, where practice infrastructure is provided and the doctor is employed by a third party.

The council has, for several years, owned and operated the local medical practice in Wentworth and a subsidiary practice in the next community of Dareton. Practice equipment and furniture were purchased from the existing GP who was leaving Wentworth. The building and medical records were not purchased. The medical records of these new practices are now the property of the shire/practice and will stay with the practice when the doctor leaves. The council had new practice premises purpose built, which they lease, rather than own. The council employs the practice staff (doctor, practice manager/registered nurse, and a receptionist). All are employed under normal council employment conditions - salary, super, recreation and sick leave etc.

The doctor was initially engaged on a contract basis and was responsible for covering the cost of their Medical Indemnity insurance. The doctor has since been employed and despite the shire wanting the doctor to continue responsibility for Medical Indemnity, the shire has had to assume liability. The council provides IT support, maintenance, human resources and financial management services for free, as the general practice is seen to be another arm of the shire. The Practice Manager has no authority to make any purchases and is not responsible for any Human Resources issues or any high level financial management. These functions are all the responsibility of the shire.

Until recently the practice was a bulk-billing practice. Most patients continue to be bulk-billed. An option to pay a gap fee is now available and a number of patients exercise the option to do so.

Initially the council provided the doctor with a housing subsidy and a car and the doctor did not have access to a Visiting Medical Officer (VMO) appointment at the hospital. VMO services were at that time provided by two doctors from Mildura in Victoria.

With assistance from the local Mallee Division of General Practice, the arrangements have evolved to where the doctor is now employed, has purchased a house and vehicle and now also has an appointment to provide VMO services to the hospital on a 1:3 basis. VMO payments are provided directly to the doctor under the traditional "fee for service" basis.

The council has a medical service committee that meets once a quarter to review the general practice situation, provide strategic direction and address any concerns relating to the practice and its operations. The committee comprises the Mayor, the General Manager, the Director of Corporate Services, two pharmacists (from Dareton and Wentworth) and a community representative. The doctor and the practice manager also attend. The Director of Corporate Services meets on a weekly basis with the Practice Manager to assist with the day-to-day management issues of the practice.

The Practice Manager, who also provides Practice Nurse services, and the Receptionist have been recruited (and commute) from Mildura, 34 kms away.

5.2 Australian Outback Medical Services

Formation of AOMS

Australian Outback Medical Services (AOMS) was formed just over a year ago in response to a doctor crisis in Bourke and Brewarrina. Brewarrina had seen 22 doctors in 20 months and Bourke was at risk of losing 3 of its 4 GPs.

Drs Hamish Meldrum and Ross Lamplugh decided to merge their practices and negotiated non-standard contracts, based on the RDA package, with the Far West Area Health Service to provide VMO services to Bourke and Brewarrina hospitals.

The Brewarrina VMO contract provided a financial basis for taking over the Brewarrina practice. AOMS then built on the RARMS concept of Easy Entry, Gracious Exit by enhancing practice management services, locum support and incentive remuneration arrangements.

Their Bourke practice is also now modeled along similar lines, but is co-located with another independent GP practice.

Achievements

Bourke now has 5 full-time and 2 part-time doctors, including four GP Proceduralists and a GP Registrar. Brewarrina has had a fantastic husband and wife team for over a year – with no plans to leave for some time.

AOMS also provides medical services to the Bourke Aboriginal Health Service and the Brewarrina Detention Centre.

Last year AOMS established "Australian Outback Locums" (AOL) to provide locum doctors for clients in rural and remote locations. AOL has been successful in providing a large number of fully registered doctors in many practices in rural Australia over the last six months.

AOMS also established and funded a Nursing Foundation to support clinical education of nurses in Brewarrina.

The secret of the Bourke and Brewarrina success

Existing and new doctors were engaged by AOMS on attractive incentive remuneration arrangements, and are supported with increased education and time off. AOMS recruits permanent and locum doctors through its agency, Australian Outback Locums.

AOMS offers practice management services to relieve doctors of administration duties to enable them to concentrate on patient care. AOMS developed complex clinical data sharing and other IT communication between various practice sites. AOMS increased practice turnover and increased the range of services available through use of EPCs, public health projects, allied health partnerships and enhanced nursing services.

AOMS worked with the local Shire Councils, the local hospitals, public health and similar programs, residential care facility, the Bourke Aboriginal Medical Service and other organisations as required to develop long-term arrangements which guarantee a supply of doctors to these communities. Links with specialists were maintained and cultivated.

AOMS is in the process of developing other health services in the towns where possible such as physiotherapy and occupational therapy.

The Directors of AOMS are Drs Meldrum and Lamplugh who have worked in outback areas for many years, and are supported by a small team of contracted experts in practice management, information technology, finance and healthcare management.

Doctor Retention

AOMS understands the requirements for retention and recruitment of general practitioners in rural and remote locations.

It is important that doctors are professionally and socially supported, not be overwhelmed with an unmanageable patient load, have access to continuing education, research and public health opportunities, and have flexibility or choice over involvement with practice management. It is also critical for doctors to have regular and planned time out from the rigors of long hours and evening/weekend on-call duties.

AOMS's success in Bourke and Brewarrina relates to finding great, appropriate doctors to staff the towns, preparing them for their roles, and then providing comfortable accommodation, social support and interesting and varied work. AOMS ensures doctors are well rewarded with an incentive based package, and have regular leave (at least a long weekend each six weeks and two weeks off each three months). AOMS provides a regular and stimulating education program and personal and professional support as required.

For any further information contact:

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5.3 Murrumbidgee Division of General Practice

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The Murrumbidgee Division of General Practice (MDGP) has provided alternative examples for sustainable rural general practice. The RARMS model has introduced a long term sustainable model of "easy entry, gracious exit", the MDGP have provided short to medium term solution, whilst continuing to pursue permanent GP placement.

Hay Medical Services:
The loss of two (2) full-time GPs in Hay in October 2001, meant that a continued Hay medical services was at risk. The MDGP and Hay shire council commenced a partnership to resolve the immediate need.

Infrastructure was provided by the Hay Shire Council. A four bedroom house, and surgery located within the grounds of the Hay District Hospital were secured. Rental for the properties are provided at no cost to the MDGP. This will be introduced with the permanent placement of GPs to ensure sustainability for the local Shire.

The employment of staff was arranged through the Hay Shire Council. Reimbursement for all staff cost is provided from the MDGP.

The employment of locum GPs is undertaken by the MDGP. This involves the sourcing, administration and travel. Management, consumables and accounting of the practice is all borne by the MDGP. Each locum GP signs a service agreement that allows MBS and Fee-For-Service payment to be returned to the MDGP. GP locums are paid as a percentage of their earnings. VMO payments (for a 1:2 on-call) have been negotiated separately with the Area Health Service that ensures that the Division is paid a flat rate in advance for the locum. This ensures that the locum engagement/payment is undertaken from one source only. The locum service continues to be maintained in Hay. The prospect of two full-time, vocationally registered GPs, taking ownership of the practice is now possible. Two GPs are currently trialing the practice with a view to taking over management.

Coleambally Medical Centre: In this example, the RDN and MDGP were able to identify a suitable GP for full-time placement. Due to immigration status, the individual GP was unable to take on management of a business in Australia, so the RDN, MDGP and Murrumbidgee Shire worked collaboratively to find a solution.

The GP was placed on the Rural Locum Relief Program, sponsored by the RDN. The MDGP took on management of the practice. This involved staff payment, consumables and maintenance of the practice.

The Murrumbidgee Shire had purchased accommodation (four bedroom house) and surgery and were providing the surgery rent free to the MDGP during the short stint as managers.

With a successful process in place for immigration, an official hand-over to the GP for management of the practice will be completed in July 2003.

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2. (Page 8) Corrs, Chambers, Westgarth Lawyers (May 2001) Governance and Leadership of Rural Workforce Agencies in the 21 Century.
3. (Page 20) www.agpal.com.au (17 January 2003)
4. (Page 34) www.unepartnerships.com.au (June 2003)

GP Entity Resources

The NSW Rural Doctors Network website www.nswrdn.com.au will host a variety of information under a section of the website entitled GP Entity Resources. This section of the RDN website will hold a copy of the Easy Entry, Gracious Exit document, as well as all the documents included in the appendices. These documents will be accessible on this website from October 1, 2003 and where relevant may be updated from time to time.

Acronyms used in this Document

AGPAL	Australian General Practice Accreditation Ltd
AHS	Area Health Service
AMA	Australian Medical Association
AMS	Aboriginal Medical Service
ATSIC	Aboriginal and Torres Strait Islander Commission
CWA	Country Women's Association
DGP	Division of General Practice
DVA	Department of Veteran Affairs
EN	Enrolled Nurse
EPC	Enhanced Primary Care
FRACGP	Fellowship of the RACGP
FWAHS	Far West Area Health Service
GPA	General Practice Australia
GPII	General Practice Immunisation Incentive Scheme
GPSRG	General Practice Strategy Review Group
HIC	Health Insurance Commission
IBNR	(Claims) Incurred But Not Reported
ICPMR	Institute of Clinical Pathology and Medical Research
MA	Medical Advisor
MDGP	Murrumbidgee Division of General Practice
NGO	Non Government Organisation
PBS	Pharmaceutical Benefits Scheme
PIP	Practice Incentives Program
PKI	Public Key Infrastructure
RACGP	Royal Australian College of General Practitioners
RARMS	Rural and Remote Medical Services Ltd
RDA(NSW)	Rural Doctors Association (NSW Branch)
RDASP	Rural Doctors Association Settlement Package
RDN	NSW Rural Doctors Network
RFDS	Royal Flying Doctor Service
RN	Registered Nurse
ROMPs	Rural Other Medical Practitioners
TMF	Treasury Managed Funds
UMP	United Medical Protection
UNEP	University of New England Partnerships
VMO	Visiting Medical Officer
WAMS	Walgett Aboriginal Medical Service