Engaging Rural Doctors

Final Report 2007

Department of **Health**
Government of **Western Australia**
WA Country Health Service

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Delivering a **Healthy WA**

Preface

The WA Country Health Service commissioned WACRRM to undertake an extensive consultation program with rural doctors from April to August 2006. Over 360 rural doctors were given the opportunity to identify the issues they face working and living in rural and remote Western Australia.

The reference group that supported this process has now been given an understanding of the medical environment and particular concerns of the different regions of Western Australia. This has enabled the group to develop a clear agenda for change and to set 50 specific strategies to address the issues.

For the first time the organisations involved in the delivery of rural health services have a set of clear strategies to assist them to address the needs of doctors and to deliver improved health services to rural and remote Western Australia.

There are particular areas in Western Australia where the local doctor is struggling and where the challenges for future recruitment and retention are acute. This document gives us some new strategies to address these particular areas in Western Australia and give some hope for the future. This will involve piloting new models of health care delivery and systems.

It will be critical for leaders (both innovators and entrepreneurs) to step forward within the medical workforce. These leaders will be needed to take advantage of the new approaches to practice management, to organisational arrangements, and of the opportunities within IT and telehealth. Clinical issues that need clear thinkers and planning include mental health, Aboriginal health and the expansion of primary health services into the community. Many of the rural doctors felt that rural health offered unique opportunities to make real changes in these areas.

The consultation process has allowed:

- Rural doctors to directly convey their views on issues to people and organisations who have an understanding of their environment and their challenges. It also allowed them to air some issues not previously dealt with in a timely manner and to outline their hopes and fears for the future.
- A reference group comprising agencies with direct and broad interests in rural health and rural medicine to come together to address the issues raised by the rural doctors. An unforeseen outcome of the process has been to bring the various organisations that comprise the reference group together for a common purpose. In doing so, it has allowed them to develop a greater understanding of each other's roles and highlighted the benefits of working together.
- The direct input of a significant number of rural doctors as opposed to the views of smaller numbers of representative bodies.
- The issues (and priorities) to be identified at a regional level thus providing local managers with the opportunity to progressively address issues with doctors at the local level.

I commend the report to all with an interest in rural medicine and specifically to those charged with improving health services to rural Western Australians.

It has been a privilege for WACRRM to facilitate the consultation process. The platform provided by rural doctors is a significant base for all health service stakeholders, and in particular those represented on the reference group, to work together.

Dr Felicity Jefferies
Director
Western Australian Centre for Remote and Rural Medicine

Foreword

The WA Country Health Service (WACHS) is the major provider of rural health and medical services in seven regions and as such we willingly took on responsibility to deliver on our promise to undertake a significant program of rural doctor consultations during 2006.

I have felt fortunate to have Dr Felicity Jefferies and the WA Centre for Remote and Rural Medicine (WACRRM) to share the development of this process from the very start. I also salute the members of the Reference Group. Every one of us is fully committed to the continuation of this extraordinary partnership so that the collective energy, passion and expertise can be brought to bear as we take this agenda forward.

This program clearly shows us that there is a place for optimism for rural medical services at the present time and into the future as we take the things we have learned and translate them into action.

There are key areas for attention encompassed in this work and if I were asked to choose the most significant area, I would unhesitatingly say that it lies in the domain of relationships, teamwork and leadership between and amongst our managers, our doctors and our nursing leaders. And embedded within this domain are critical elements like listening, respect, understanding, service of each other and goodwill.

The solution lies with all of us together and I can see clearly that there is tremendous scope for genuine commitment and collaboration.

If we achieve advancement in these areas, in combination with progressive action on the other key areas emerging from this work, we can be truly confident about quality health care for country people in our country care settings.

I urge clinicians and managers to be vigilant and persistently communicative about issues or problems experienced in the workplace as they relate to the findings from this consultation process. Responsibility and leadership are needed everywhere as never before. In settings where these attributes are rich in supply, the other measures we implement will be far more potent.

Thank you to every one of the great many rural doctors who work in or provide visiting services to the country regions. Your work is inspiring, you are highly valued, and if you feel less than that for any reason, we give you our commitment to do our very best to ensure this changes for the better.

Christine O'Farrell
Chief Executive Officer
WA Country Health Service

Acknowledgements

We would like to acknowledge the support of:

- Government of South Australia Department of Health
- South Australian Rural Doctors Workforce Agency

The consultation process was undertaken by a team of doctors and health professionals. These include:

- Mr Noel Carlin
- Dr David Mildenhall
- Mr Martin Cutler
- Mrs Chris O'Farrell
- Dr Mike Eaton
- Ms Suzanne Spitz
- Ms Sue Eslick
- Dr Karl Staer
- Dr Felicity Jefferies

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Executive Summary - the Outcomes

The purpose of this final report is to describe the collective responses and agreed actions to address the issues raised during the course of the rural doctor consultation process.

The consultations have reached 361 rural doctors representing 64% of rural doctors, as well as canvassing visiting specialists (40) and students (30). This represents a remarkable result considering that a similar process in South Australia last year achieved coverage of 185 rural doctors, just under 50% of South Australian rural General Practitioners. Table 1 below shows a breakdown of doctors consulted by region.

The quality of the information arising from these consultations, and the enthusiasm with which rural doctors have embraced the opportunity to voice their views, demands a comprehensive and equally enthusiastic and high quality response to the issues.

To assist in the design and management of the consultation process a reference group was formed in April 2006. The reference group carried two key roles. The first was to oversee the design and implementation of the consultative process. The second was to respond to the issues that were raised by rural doctors. The reference group was drawn from key rural health stakeholders and agencies and its membership comprised:

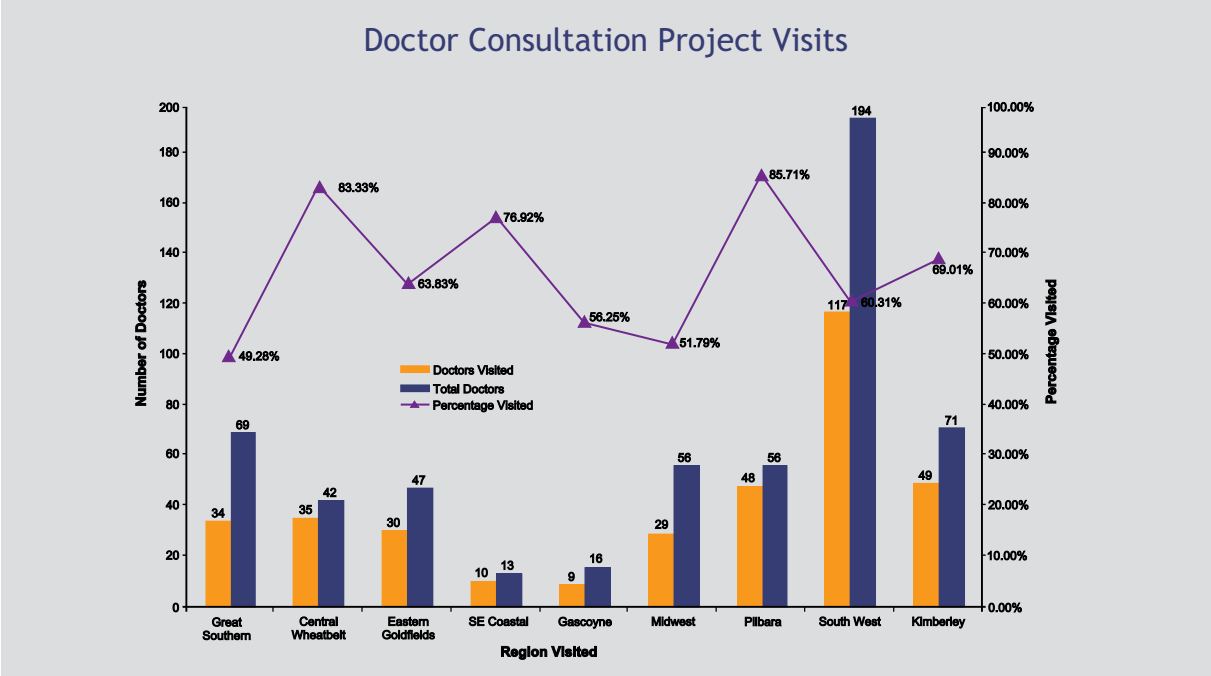
- Dr Felicity Jefferies, Western Australian Centre for Remote and Rural Medicine (WACRRM) (Chair)
- Ms Noelle Jones, Australian Medical Association (WA) (AMAWA)
- Dr Tim Leahy, Aboriginal Health Council of Western Australia (AHCWA)
- Ms Gloria Khan, Aboriginal Health Council of Western Australia (AHCWA)
- Mr Bruce Rathbone and Mr Chris Carter, WA GP Network (WAGPN)
- Dr Stephen Langford, Royal Flying Doctor Service (RFDS)
- Mr Alan Philp, Department of Health and Ageing (DoHA)
- Dr Janice Bell, Western Australian General Practice Education and Training Ltd (WAGPET)
- Dr Iain Hague, Rural Doctors Association of Western Australia (RDAWA)
- Ms Christine O'Farrell, WA Country Health Service (WACHS)
- Mr Martin Cutler, WA Country Health Service (WACHS)
- Mr Kim Snowball, Project Director
- Ms Andrea Howden, WACRRM, Executive Support

L to R: Mrs Christine O'Farrell, Dr Iain Hague, Dr Janice Bell, Mr Alan Philp, Mr Kim Snowball, Dr Felicity Jefferies, Ms Noelle Jones, Ms Gloria Khan.
Absent: Dr Tim Leahy, Mr Chris Carter, Dr Stephen Langford, Mr Martin Cutler, Ms Andrea Howden.

Reference group members offered their full support for the project and welcomed the opportunity to participate. Many indicated their enthusiasm for the process which, by talking first hand to rural doctors and addressing the issues raised by doctors in a coordinated way through the reference group, meant a comprehensive and shared response to the issues was possible.

The final report outlines the solutions or resolutions to the issues and themes that have emerged. The views recorded through this consultation process are unfiltered views and observations, some of which are confronting and challenging. The reference group has enabled members to respond in a meaningful way with associated and colleague organisations involved in rural health and rural medical workforce issues.

The project is the most comprehensive analysis of the views of rural doctors ever conducted in Western Australia and perhaps nationally. While, in common with the work of Professor Max Kamien in the 1980s, it addresses traditional recruitment and retention issues it goes much further. The project seeks views from specialists both resident and visiting and also canvasses views about relationships with the wider health system, the gaps in services, the extent of involvement with clinical service planning and views about the future innovations and ideas to improve access and quality of health care services in rural Western Australia.



The reference group has collated the issues and themes arising from the rural doctor consultations and these are contained in the 50 actions detailed in this report. In each case an agency represented on the reference group has been identified to take primary carriage of the implementation of the action.

The reference group will remain in place for some time to oversee the implementation of the actions. This structure and process will ensure all of the issues will be actioned and the consultation report will remain a living document.

While the actions are designed to address the specific issues raised, it is equally important that this report convey the overall sentiment expressed by rural doctors and the potential for the future.

In essence, the consultation process identified doctors who are struggling with difficult circumstances and demands, others who are entirely comfortable with their current practice and role within the health system, and a group who are anxious to see change, innovation and reform.

The overall sense is that rural doctors are relatively comfortable and the perception of them all as a struggling and unhappy group is not the reality. In fact many rural doctors very much enjoy the rural lifestyle and rural practice. It has much to offer doctors who are willing and prepared to have variety in their working life and experience the sense of community and contribution to improving the health of rural Western Australians. There was a positive sense of the future and many of the concerns are related to a lack of information and clarity about the future direction of the health system and the impact that may have on their practice.

This does not mean there are not areas or issues of concern. The ongoing difficulties in attracting and retaining doctors, the overall workforce shortages, the impact of long working hours, on-call demands, and the sense of isolation that many experience continue to be present in rural medicine.

The community expects the health system to operate as a seamless system focused on addressing their needs for high quality, safety, and easy access to the health system. In many cases the current health system operates in separate streams without the connections required to achieve this outcome. This report recommends actions to improve communication, planning and engagement of doctors to address this problem now and into the future.

Of particular interest to the reference group and to those interested in rural health is the importance of relationships. This is a major factor in recruiting and retaining doctors and maintaining their sense of support and being valued in rural health system. The attitudes of the respective professionals, the relationships between health managers and doctors and between service providers are critically important and can be addressed through leadership, cultural change and all parties working together.

The consultation program has highlighted the natural tension which exists due to the conflicting requirements to satisfy patient needs and at the same time, manage within resource limitations. The reference group considers that by working together and using proactive joint planning approaches, conflict can be minimised.

In its response to the issues raised by rural doctors, the reference group believes that the overall themes and issues can best be summarised in two key areas:

- Firstly, there are particular locations in Western Australia where the local doctor is struggling and where the challenges for future recruitment and retention are acute. These areas will receive particular attention and this will include considering new or alternative models and methods for delivering health and medical services in these locations.
- Secondly, rural health offers many opportunities for growth and innovation. To gain best results from these opportunities, innovators, leaders and entrepreneurs are important within the medical workforce. Areas such as mental health, Aboriginal health and the development of broader primary health care in prevention and health promotion are examples where rural medical services can play a leading and active role. Similarly, opportunities for new approaches in practice management, organisational arrangements, flexible working arrangements and other measures that will be attractive to future doctors entering rural practice are needed. These innovators can expect to receive the support of rural health agencies in this endeavour.

The following agreed actions arising from the rural doctor consultation process, address both of these core issues and also lay the foundation for piloting and implementing new approaches that will help to secure a future where rural doctors are more closely engaged for the benefit of rural communities and rural health outcomes.

The actions arising from the consultations have been grouped to reflect the need for support of the broad rural doctor workforce, improving relationships, involvement in planning, addressing continued workforce shortages, supporting overseas trained doctors, rural specialists and doctors working in Aboriginal Medical Services.

Summary of agreed actions

Actions – To support the broad rural doctor workforce

1. The reference group accepts the concerns expressed by rural doctors about safe hours. The employers agree to consult with the AMAWA and develop policy on safe hours suited to the various care, demand and workplace settings. The employers also agree to develop transition arrangements for rural centres to improve areas where there are currently safe hours concerns. Specific actions will include addressing safe hours concerns in the North West. It is suggested that this could be actioned by identifying one location to develop and test the efficacy of a flow chart and practical tools for doctors and managers to better manage workloads prior to their wider implementation.
2. WACHS will examine workloads and how practice and patient management is handled in the North West, as a matter of urgency and prior to the next dry season, with a view to joint management of workloads within the context of budget requirements. The approach will seek to develop solutions jointly between management and local doctors and may consider nurse practitioners, junior doctors and may, as an example, include restructuring outpatient clinics to be managed in a community setting.
3. The group recommends to all employers that they commit in principle and through concerted and progressive action over the next twelve months to a standard of on-call at 1:3. The group also recommends that where there are on-call situations of less than 1:3, the employers review and monitor patient safety risks and doctor workloads, and develop and deploy available solutions so as to avoid clinical risks. The employers agree that this will be done with the involvement of the affected clinicians. The group recognises that on-call duties are part of a safe hours package, and respects the importance of manageable workloads as a key attraction and retention element for rural and remote doctors.
4. WACHS regional directors will carry leadership responsibility to bring key stakeholders together to address emerging clinical issues. WACHS Area Office will support new approaches and change management.
5. Employers will endorse and support the establishment of more flexible family friendly arrangements for medical practitioners over 55 years (in recognition of service), part time doctors and doctors with parental responsibilities or who have special needs. These needs will be taken into account in negotiating on-call requirements with public hospitals without automatic penalty to their admission rights. It is recognised that hospitals must maintain adequate in and out of hours medical cover.
6. WACHS will explore options for child day care services for staff. Financial support will be sought from key external stakeholders.
7. Employers should (potentially matched by the Australian Government) fund a bursary support for child secondary education (boarders) to be used as a retention benefit and focused on areas of identified retention problems and poorer relative access to secondary schooling. Criteria will be developed and administered by WACRRM. WACHS agrees to undertake this for salaried hospital and public health doctors.
8. WACRRM and Divisions of General Practice will develop and promote a process for recognising service amongst rural doctors so that the contribution they have made will be acknowledged through local events involving the Divisions, governments and local health services.

Actions to improve relationships

9. WACHS commits to improving communication and relationships between managers and doctors based on mutual respect. Specific areas for action include:
   - Responding to doctors' written and verbal concerns/issues in a timely manner;
   - Attending doctor practices at least six monthly for open discussion;
   - Informing and involving doctors in clinical and related decisions and so avoiding the risks of last minute written directives;
   - Seeking input from doctors for clinical equipment planning and purchasing and relevant budget submissions.

   The reference group encourages other health service providers to apply similar standards to ensure a good level of engagement and communication between health service managers and rural doctors.
10. WACHS will explore mechanisms to improve access to rural based mental health professionals and review the criteria applied by mental health services for access, with particular focus on managing co-morbidities. Opportunities under the new COAG and MBS initiatives will be examined for community based mental health in collaboration with Divisions.
11. Teaching hospitals will be given feedback on the outcome of the rural doctor consultation process. A response is required to address delays in discharge information to local doctors. The potential for appointing a central referral point for rural doctors to accelerate the patient transfer process is also suggested.
12. WACHS and the Royal Flying Doctor Service (RFDS) will review emergency protocols and the management of patient transfers. It is suggested that there should be a greater level of integration between RFDS and hospitals.
13. WACHS will distribute Medical Service Agreements and associated remuneration offers to doctors at least three months prior to the expiry of previous agreements. Doctors will be given sufficient time to negotiate to address local issues.

Actions on rural health planning

14. The group acknowledges inadequate past involvement of doctors in clinical service planning. WACHS will involve doctors in the planning of clinical services and observe the following protocols:
   - Where clinical service plans are available they will be distributed to all doctors within the local catchment area;
   - Locums and doctors new to the district should be provided with access to local plans as part of their orientation; and
   - Doctors will be engaged in the regional clinical services planning being undertaken in 2007.
15. Vehicles for engaging doctors in planning will be agreed locally with the involvement of the Division of General Practice, resident and visiting specialists.

Actions to address emerging workforce shortages

16. Attraction and retention of the rural medical workforce is dependant upon modern information and communication technology to support patient care, communication and connectivity between hospitals, doctors' surgeries and other clinical services. It is recommended that WACHS urgently address this key result area.

    As an interim measure, hospitals and divisions should examine the introduction of terminals/laptops to allow doctors working in hospitals access to their surgery records.

17. WACRRM, RDAWA and WAGPET will develop succession plans and support for rural proceduralists in recognition of the low entry rates into the generalist proceduralist field of medicine so crucially important to the country health care system.

18. WACHS and WACRRM will consider the application and implementation of the Australian Centre for Rural and Remote Medicine (ACRRM) curriculum into Western Australia for proceduralists (currently under pilot in Queensland). This will include examination of the potential for UK "general registered" doctors to be included into the ACRRM program in preparation for hospital based positions in rural WA.

19. WACHS and WACRRM will explore the establishment of metropolitan hospitals as training centres for rural proceduralists which also enable staff rotations between metropolitan and rural centres.

20. It is recommended that doctors working in the country with Fellow of the Australian Centre for Rural and Remote Medicine (FACRRM) qualifications are paid a premium under Medicare Australia in recognition of them being rural medical specialists.

21. WACHS will pilot arrangements to integrate ambulatory and primary care services currently provided by a range of service providers and examine alternative models for the provision of these services. These models will be developed and piloted following discussion with rural doctors, health advisory groups and local government. In particular WACHS will pursue running multidisciplinary, ambulatory care and primary care services from a general practice model under a pilot arrangement.

22. Rural doctors should develop, pilot and implement arrangements for extending the role of practice nurses. WACHS should extend the role and coverage of nurse practitioners within the country health system and including in accident and emergency departments.

23. WAGPET will expand the concept of learning hubs, allowing more PGY1 and 2s to train and learn in regional centres.

24. The group supports expansion of the Rural Clinical School program as an effective strategy for attracting new graduates to rural practice.

Actions to address specific areas of aggravation

25. The reference group acknowledges that the Patient Assisted Travel Scheme (PATS) is a complex scheme to administer and doctors have reported that in some circumstances the administration of the system has contributed towards poor clinical care. WACHS will review the scheme to address the key issues raised by rural doctors and to introduce a more responsive and accessible system for referring general practitioners and consumers.

26. Multiple specialist visits during the course of treatment over a 12 month period should be approved once through PATS, avoiding the need for multiple revisits to doctors.

27. WACHS will ensure that doctors are provided with information on visiting specialist visits and the procedures/work they will undertake within the region to enable more referrals to regional visiting specialists.
28. WACHS will develop coordinated regional systems covering visiting specialists, outpatient bookings, transport, and financial and practical assistance with travel and accommodation arrangements.
29. The shortage of locums is a nationwide problem. The reference group recommends priority be given to solo practices and Aboriginal Medical Services for locums providing leave relief. WACRRM will evaluate the locum program in WA and explore ways to improve its effectiveness. There will be a strong focus on building capacity, retaining the existing rural medical workforce and reducing the over reliance on locum doctors to fill medium to longer term position vacancies. WACHS and WACRRM will work together to improve medical recruitment, build local capacity, reduce vacancy durations, improve doctor orientation, and support professional development.
30. The cost of locums has been increasing exponentially, pressure nationally should be applied to address concerns about locum rates, particularly amongst public providers. WACRRM, with the endorsement of the reference group, will raise this issue with Australian and State/Territory governments to consider alternatives to stabilise the locum costs.

31. WACHS is committed to specific action focused on reducing paperwork, including:
    - Exploring annual cashed out payments for hospital services as an alternative to individual patient billing/hospital invoices for rural doctors;
    - Implementing paperless systems and medical records;
    - Streamlining credentialing processes including extending the period admission rights are provided; and
    - Engaging with doctors locally about key aggravations with paperwork and examining ways to reduce the load.
32. WACRRM and Divisions of General Practice should examine mechanisms for offering practice management support for small and solo practices.
33. Wide debate is required on flexible delivery systems for medicine in rural areas including examination of the costs and benefits associated with salaried systems and VMP systems of delivery (undertaken by WACHS and RDAWA). This assessment will include associated on-costs, impact on patient management, recruitment and retention, locum demand and the potential for de-skilling of private GPs. This will build upon the recent experiences in Geraldton and the pros and cons of the model as described in the consultation process in that region.

    WACHS will be undertaking regional service planning in the first six months of 2007. This will provide an opportunity for doctors to be involved in regional health service planning, including debate over models of service delivery.
34. Examination of the role and functions of the Medical Advisory Committees (MAC) will be undertaken by WACHS in conjunction with RDAWA to address concerns that these committees have lost their focus and credibility.

Actions supporting Overseas Trained Doctors

35. WACRRM and WACHS will continue to explore opportunities to facilitate a minimum of four weeks paid orientation for non proceduralists and explore methodologies for skills assessment for proceduralists.
36. The Medical Board of Western Australia will be approached by the reference group to refer overseas trained doctors engaged through alternative recruitment agencies to WACRRM so they are informed about available support structures and to make orientation and assessment compulsory.
37. WACRRM and WAGPET will seek support from ACRRM and the Royal Australian College of General Practitioners (RACGP) to assign mentors to each overseas trained doctor, as required, and as they commence.
38. AMAWA will explore opportunities for overseas trained doctors to access credit facilities with the relevant credit providers.
39. The reference group strongly recommends that recruiting agencies provide essential information to overseas trained doctors prior to their appointments. This should include at least information on access to Medicare, purchasing property, the education system and associated costs, Australian drivers' licensing requirements, conditions of entry, medical registration and medical provider numbers.

40. The reference group will seek minimum standards for employment contracts with overseas trained doctors with all recruitment agencies.
41. WACRRM will clarify avenues for confidential and independent advice and grievance procedures for overseas trained doctors who may have concerns about their contractual or other arrangements. Spouse issues may also be supported through WACRRM or Divisions of General Practice.
42. WACRRM will advocate for change to access to Medicare and emergency evacuations for overseas trained doctors located in areas of need. WACHS will investigate options to waive public hospital fees for rural overseas trained doctors working in areas of unmet need.
43. WACRRM and the RDAWA will market and recognise overseas trained doctors as an essential and well-credentialed part of the health system. These doctors have been prepared to provide services in difficult and often isolated environments. The outcome will be to achieve professional and community recognition for their contribution. In addition, the AMAWA should develop regular newsletters and communication mechanisms with overseas trained doctors.

Actions to support rural specialists

44. Teaching hospitals should provide locums for rural resident specialists. This may be achieved by requiring tertiary institutions to take a statewide support role for the relatively fragile rural specialist workforce. This could be by rotations of consultants who have rural placements included within their employment contracts. This will also have the effect of improving the understanding of rural settings by metropolitan consultants.
45. The reference group recommends the establishment of advanced specialist training posts in rural areas and the upskilling of resident clinicians supported through teaching hospitals.

Actions to address Aboriginal Medical Service issues

46. The AMAWA, WACRRM and the Aboriginal Health Council of Western Australia (AHCWA) will address award and career structures within Aboriginal Medical Services.

Photo from the GP Consultation session at WACRRM's 2006 Aboriginal Medical Services Annual Weekend

47. The AHCWA should address the ease of transfer of doctors' employment across Aboriginal Medical Services.
48. WACRRM, WAGPET and AHCWA will explore ways of ensuring greater recognition of training and skills assessment within Aboriginal health services including the potential for the development of a post graduate qualification in Aboriginal health.
49. State, Territory and Australian governments should consider their approaches to health planning in conjunction with Aboriginal Medical Services to address the issue of "bungee planning" and ensure planning and consultation approaches recognise cultural preferences and norms.
50. WACRRM, WAGPN and the AHCWA will consider methods and training programs to allow professional development of practice managers within Aboriginal Medical Services.

Project design and initiation

The design of the project was based on a similar model undertaken by the South Australian Department of Health in association with the Rural Doctors Association and Rural Workforce Agency in 2005.

Based upon the benefits achieved in South Australia, the WA Country Health Service committed to undertake a similar process in Western Australia.

WACHS commissioned WACRRM to be the lead agency to undertake the consultation program in WA. WACRRM engaged Mr Kim Snowball from Healthfix Consulting to manage the project, including preparation of a draft report and recommendations.

A schedule of consultation visits to each region was developed commencing in April 2006 with the Great Southern and concluding in September 2006 with the South West. In each visit a doctor (RDAWA and/or WACRRM) accompanied the consulting team.

The timetable allowed input into the WACHS planning process (development of the "Foundations for Country Health Services 2007 - 2010").

It was agreed that confidentiality was essential to allow doctors to raise issues freely. Each of the rural practices was then given the opportunity to meet with the consultation team as a group, or as individuals.

All relevant health agencies and local governments were alerted to the consultation process in their areas in advance.

The proposed questions were agreed by the reference group and included four open ended questions based on the South Australian model and four subsidiary questions which were added to gain input and views about rural health planning, gaps in services, relationships and innovations and ideas about change and reform required over the next five to ten years.

The questions posed in each of the consultations were:

1. What are the things that would make you stay (supports needed) in rural areas?
2. What are the things that would make you leave?
3. What are the things that annoy or aggravate you about working in rural areas?
4. What are the things you like about rural practice?
5. How would you describe the relationship with the local health service/hospital and how might it be improved?
6. In terms of clinical care and treatment, what would improve health services to your patients?
7. What are your observations about rural health planning and how might it be improved?
8. Looking forward 5-10 years what do you see as the key changes or innovations that are needed to improve country health services?

The set questions were asked by each of the consultation teams to ensure a consistent approach. An introductory explanation of the consultation process was given including its background and purpose and how the relevant doctors' input would be recorded and actioned.

Reassurance on confidentiality was also given and it was explained that input and comments would be de-identified and aggregated so that broad themes would be reported rather than individual concerns and views. Where a local issue was raised the relevant doctor was given the option for the consulting team to raise the issue directly with the relevant organisation, but in doing so the doctor would be identified. The organisations represented on the reference group agreed with this process and undertook to address any issues raised as quickly as possible. A number of doctors took up this option and so two processes were agreed by the reference group to address both broad themes and individual issues.

It was decided that on the completion of the visits, the outcome from the discussions would be organised into themes and put before the reference group for discussion and action. In the event specific issues were raised with specific organisations then these would be directed only to those agencies for action. This approach sought to protect the identity of the relevant doctors, unless specific approval was granted from them to represent their issue.

Of critical importance to the project was confidentiality of the discussions with doctors and each representative on the reference group completed a confidentiality agreement. This effectively means that issues raised with the reference group and the particular agency's efforts to address them would be confidential to the group. The confidentiality agreement only related to those issues brought before the group and to the participation of the agency in fulfilling their responsibilities as a member of the reference group.

Each agency represented on the reference group gave an undertaking to use their best endeavours to quickly address the issues raised and to assist in responding collectively on issues that relate to one or more of the representative agencies.

It was agreed that the aggregation of issues into themes would assist in this process and following the completion of all of the consultations there would be the opportunity for a collective response and agreement on an agenda to address both short and long term issues.

Principles

In addition to the key themes that have emerged from the consultation process, a number of broader issues of principle were raised. These came from within the consultation process and also through discussions of the reference group. These are considered to be important as they underpin understanding of the rationale and behaviour of organisations and understanding of rural health systems.

To illustrate this through an example, the disparate nature of the health service providers was reported to be an issue in some locations. Each provider understands the need to collaborate more closely and plan and communicate together regularly. However, there were observations that there is competition and even hostility between services in a small number of cases, and this brings with it the risk of poor outcomes for patients and the community and potential wastage of resources through duplication. This was an expressed concern of some of the doctors and was acknowledged by the reference Group as a longstanding issue needing some attention and leadership.

All the providers are looking for leadership to bring them together in a respectful and productive way. WACHS is generally the most significant player and it falls mainly to this organisation to undertake the leadership role. There needs to be greater respect for the needs, views and values of organisations who are partners in service provision than is currently the case in some regional health settings. A failure of leadership in this domain will result in unhelpful and even hostile behaviour becoming reciprocal, with unhealthy rivalry, poor communication and damaged reputations. This is not the light in which health organisations want the community to view them.

Outlined below are several opportunities within rural Western Australia that require some discussion and in some circumstances negotiation to arrive at a clear understanding of roles and responsibilities.

Leadership in planning

It was generally acknowledged that duplication of services, in particular medical services exists in a number of locations. Leadership is required to explore opportunities and reach agreement on integrated or transferred service models, associated roles and responsibilities, financial and operating arrangements and the conduct and behaviours expected to make systems function properly (see Action 4).

Doctor/patient relations

In some areas there appears to be a natural tension in the system between a doctor's individual relationships with his or her patients, the extent to which the doctor is prepared to make themselves available within the hospital setting for their patients in and out of hours, and the accountability public hospitals have to ensure all patients have access to medical treatment.

The challenge is to preserve the vocational nature and relationship of doctors with their individual patients while meeting the total needs of public hospitals for comprehensive medical services and clinical governance.

WACHS values the doctors' commitments as private medical practitioners and the relationship with their private practice patients, and is prepared to consider options that allow this principle to be preserved as well as meeting the broader hospital medical service needs.

Balancing the demand of surgeries and demands from hospitals

With the introduction of Medical Service Agreements, hospitals have now specified the accountability and requirements upon doctors for their medical services, particularly on-call support and response times as an element of improved clinical governance. It was reported by many doctors that this does not sufficiently acknowledge the workload demands they have in their private surgeries. They asked that hospitals consider reducing their demands so that doctors are not drawn away from their private surgeries to meet the needs of hospital emergencies or their sick inpatients.

Generalist specialists and procedural general practitioners

A key underpinning of the health system in rural areas is a reliance on a highly specialised workforce with generalist procedural skills. This is in stark contrast to the metropolitan health system where there is increasing sub-specialisation across most disciplines particularly medicine. The future supply of generalist doctors with procedural qualifications and skills is bleak. Too few are in training and many modern GPs are unlikely to consider working in rural areas because their skills are a poor match to the demands of rural practice. Action needs to be taken if we are to have the workforce desperately needed for rural areas, in the future (see Actions 17, 18, 19, 44 and 45).

Recognising service/commitment

Many doctors involved in the consultation process are long standing and committed individuals who receive little acknowledgement and recognition for the sacrifices they have made during the course of their career. It was considered important to redress this, and some celebration of their contribution should be made in a public way (see Action 8).

Education and training in rural areas

The future of rural health largely depends on the attraction of the next generation of doctors. While changes will be needed to accommodate their particular approach and values, a clear requirement is to engage them early in their training in order that they understand and experience rural practice. The consultation found that rural doctors consider that the Rural Clinical School model will benefit both students and doctors. Similarly, in a number of larger regional centres the need to strengthen support for rural registrars was identified. The principle that wherever possible, learning and education should be delivered in rural settings consistent with the Rural Clinical School model, is supported.

Contextual issues

It is important when considering actions and responses to have enough context about the rural doctors' views about what keeps them in rural areas and what would lead them to leave. Knowing what rural doctors value can then inform us about the likely acceptance and support for initiatives we might undertake.

What doctors like about rural practice?

Perhaps not surprisingly the largest response to this question was the attraction of the rural lifestyle, with 212 doctors identifying lifestyle as the major attraction.

The variety of practice (151), relationship with patients/families and the community (126) and being able to exercise their skills, particularly procedural skills (137) were the next highest rated aspects of what doctors like about rural practice. A further 35 liked the sense of meeting a need and 28 identified 'interesting medicine'. These latter were largely identified by doctors in the North West of the State.

It is recognised that the above factors are important considerations for attracting and retaining doctors in rural practice, and wherever possible these factors should be considered within any actions or response to the issues raised by rural doctors.

What would make you leave?

The most common work related reasons cited by doctors were the following:

- Loss of procedural work (92)
- Loss of admission rights to hospital (68)
- Work pressure and burnout (63)
- Hospital relationship (47)
- Poor comparative remuneration (24).

These areas emphasise the importance of enjoying the professional work, having good collegiate relationships and working reasonable hours as essential for maintaining and retaining rural doctors. In respect to the comment on poor comparative remuneration there was general observation that the premium that previously existed for many rural doctors had been eroded over time. The advent of care planning meant that many metropolitan doctors were now able to substantially increase their income without major increase to their workload and without the need to provide out of hours services to hospitals. The Wheatbelt was a particular location where incomes were not seen to be attractive unless the practice also dispensed pharmaceuticals.

Other issues raised that would make doctors leave included:

- Poor access to quality schooling (85)
- Spouse/family unhappy (49)
- Poor access to day care (32) (almost exclusively in the North West).

Support for the families of rural doctors is clearly important, and access to quality schooling impacts on how long doctors are prepared to remain in rural areas. These comments challenge health service providers to consider methods of retaining doctors through collaborative approaches.

What would make you stay (supports)?

For doctors working in rural areas the types of support they require or they identified as useful, included:

- Address the culture of poor relationships with hospital/health service managers (81)
- Address on-call demands and ensure safe hours of work (64)
- Look for ways of supporting and investing in resident doctors rather than looking towards locums or recruitment of overseas trained doctors (52)
- Provision of reliable locum support (19)
- Better organised/coordinated access to education and training with emphasis on Division of General Practice for coordination (13)
- One stop shop/advice on incentives (8).
- Provide local GP training support (6)
- Provision of child care access (26)

The concern about unsafe hours was largely confined to the North West (64), while the broader issue of excessive on-call demands was common across the State. The on-call demands were felt most acutely by older medical practitioners and female practitioners with young families. This concern will need to be addressed in view of the increased and substantial number of female medical practitioners in the workforce and the importance of supporting older doctors to remain in practice, particularly over the next five to ten years.

Actions – Broader rural doctor supports

1. The reference group accepts the concerns expressed by rural doctors about safe hours. The employers agree to consult with the AMAWA and develop policy on safe hours suited to the various care, demand and workplace settings. The employers also agree to develop transition arrangements for rural centres to improve areas where there are currently safe hours concerns. Specific actions will include addressing safe hours concerns in the North West. It is suggested that this could be actioned by identifying one location to develop and test the efficacy of a flow chart and practical tools for doctors and managers to better manage workloads prior to their wider implementation.
2. WACHS will examine workloads and how practice and patient management is handled in the North West, as a matter of urgency and prior to the next dry season, with a view to joint management of workloads within the context of budget requirements. The approach will seek to develop solutions jointly between management and local doctors and may consider nurse practitioners, junior doctors and may, as an example, include restructuring outpatients to manage in a community setting.
3. The group recommends to all employers that they commit in principle and through concerted and progressive action over the next 12 months to a standard of on-call at 1:3. The group also recommends that where there are on-call situations of less than 1:3, the employers review and monitor patient safety risks and doctor workloads, and develop and deploy available solutions so as to avoid clinical risks. The employers agree that this will be done with the involvement of the affected clinicians. The group recognises that on-call duties areas part of a safe hours package, and respects the importance of manageable workloads as a key attraction and retention element for rural and remote doctors.

4. WACHS regional directors will carry leadership responsibility to bring key stakeholders together to address emerging clinical issues. WACHS Area Office will support new approaches and change management.
5. Employers will endorse and support the establishment of more flexible family friendly arrangements for medical practitioners over 55 years (in recognition of service), part time doctors and doctors with parental responsibilities or who have special needs. These needs will be taken into account in negotiating on-call requirements with public hospitals without automatic penalty to their admission rights. It is recognized that hospitals must maintain adequate in and out of hours medical cover.
6. WACHS will explore options for child day care services for staff. Financial support will be sought from key external stakeholders.
7. Employers should (potentially matched by the Australian Government) fund a bursary support for child secondary education (boarders) to be used as a retention benefit and focused on areas of identified retention problems and poorer relative access to secondary schooling. Criteria will be developed and administered by WACRRM. WACHS agrees to undertake this for salaried hospital and public health doctors.
8. WACRRM and Divisions of General Practice will develop and promote a process for recognising service amongst rural doctors so that the contribution they have made will be acknowledged through local events involving the Divisions, governments and local health services.

Relationships

Local health service/hospital

In the main, doctors were comfortable with their relationships at the local hospital level (61). However, in some locations relationships with the hospital and health service managers were strained (120). This was reflected in the overall conversations about aggravations and annoyances where 223 doctors identified the senior and upper management of health services as by far their most significant source of aggravation.

A key issue for rural doctors was their relationship with the local hospital staff. Of the doctors consulted, 47 said they would leave because of a poor or unworkable relationship with the hospital staff. This was largely directed at hospital or health service management. The relationship with other hospital staff, including nurses was generally good. This view was then reinforced when doctors were asked what would see them stay, 81 cited improved relationships with hospital health service management. This was coupled with the observation that doctors felt they were not valued or supported (52).

When delving deeper into this issue it appeared to be a contributing factor in doctor disengagement. The thrust of the views and comments were that doctors were largely excluded from decisions made by the local hospital and health service managers. Most doctors reported that they did not have an idea of the local health service plan, and also said they were not involved or asked to contribute towards clinical service planning. Decisions made by the hospital or health service staff were reported to be communicated through operational instructions or memos with little prior personal contact, explanation or consultation.

This sense of disengagement appeared to have been further exacerbated by the handling of new Medical Service Agreements - the main vehicle used to contractually engage rural doctors (Visiting Medical Practitioners - VMPs). Many doctors reported that they received their new Medical Service Agreement offers months after the previous agreement had expired. Some also reported that they were given no opportunity for negotiation. Some of these doctors clearly felt that access to retrospectivity was used as a tool to get them to sign their Agreements by a certain date.

Mental Health

In the area of mental health services, 169 doctors identified the relationship with health service staff as poor or difficult and impacting upon patient services. This was mainly in regard to the availability of the mental health service staff both in and out of hours. Many doctors identified that mental health service staff could not be reached as they were in meetings or the service was limited to work hours only.

Mental health services were seen to only provide services to people with acute mental illness, and not people with associated alcohol or other drug addiction. Doctors saw this as overly limiting as most people with mental illnesses have co-morbidities, particularly addictions, and resulting in a gap in services. The only alternative for treatment was seen to be admission into the local hospital where nurses are sometimes reluctant to care for the patients, or the transfer of patients to tertiary hospitals.

Tertiary hospitals

Relationship with other health service providers and with the tertiary hospitals (43) was generally reported to be good. Other observations regarding relationships were that at times it was difficult to admit patients (35), or that doctors were required to keep repeating the reason for admission and patient history to a variety of registrars in the teaching hospitals before transferring. Similarly, there were sometimes delays in receiving feedback on patients transferred (32) and this created problems when the patient subsequently attended the rural doctors surgery following treatment in Perth.

RFDS

Relationships with the RFDS were considered good by most rural doctors (35) although there were many observations that the RFDS was under immense pressure and on occasions was unable to meet response times. This was not a criticism of the RFDS, rather a recognition that the workload was not matched by sufficient resources.

Some doctors questioned the lack of integration between the RFDS and emergency departments, with calls for clearer responsibilities and protocols between the services to better streamline patient transfers.

Other health services

Concerns were expressed about the perceived absence of joint planning and protocols between Aboriginal Medical Services, hospitals, RFDS and private practitioners. Each body was seen to be operating independently and were not jointly planning services or communicating on effective protocols (25). This comment was most prevalent in the North West of the State where duplication and gaps between the services were identified.

Actions to improve relationships

9. WACHS commits to improving communication and relationships between managers and doctors based on mutual respect. Specific areas for action include:
   - Responding to doctors' written and verbal concerns/issues in a timely manner;
   - Attending doctor practices at least six monthly for open discussion;
   - Informing and involving doctors in clinical and related decisions and so avoiding the risks of last minute written directives;
   - Seeking input from doctors for clinical equipment planning and purchasing and relevant budget submissions.

   The reference group encourages other health service providers to apply similar standards to ensure a good level of engagement and communication between health service managers and rural doctors.
10. WACHS will explore mechanisms to improve access to rural based mental health professionals and review the criteria applied by mental health services for access, with particular focus on managing co-morbidities. Opportunities under the new COAG and MBS initiatives will be examined for community based mental health in collaboration with Divisions.
11. Teaching hospitals will be given feedback on the outcome of the rural doctor consultation process. A response is required to address delays in discharge information to local doctors. The potential for appointing a central referral point for rural doctors to accelerate the patient transfer process is also suggested.
12. WACHS and the Royal Flying Doctor Service (RFDS) will review emergency protocols and the management of patient transfers. It is suggested that there should be a greater level of integration between RFDS and hospitals.
13. WACHS will distribute Medical Service Agreements and associated remuneration offers to doctors at least three months prior to the expiry of previous agreements. Doctors will be given sufficient time to negotiate to address local issues.

Rural health planning

The observations about rural health planning were very consistent with 192 doctors indicating they were not involved but would like to be. A further 71 doctors observed that they needed at least to be involved in a local clinical service plan.

Other observations included the following:

- Decisions on planning are delivered with no discussion (62)
- Do not have a regional or district clinical service plan (46)
- AMS doctors are involved with AMS plans, but not the wider district or region plan (22)
- Data for planning is inaccurate and flawed (7).

Observations were also made about the impact on doctors of their not being involved in clinical services planning or having access to the local plan:

- Fear of hospital downgrades (28)
- Doctors felt they were being sidelined deliberately (18).
- Too much uncertainty (12)

Many doctors indicated that the lack of information on local hospital and health service plans meant they could not adequately plan their own services or surgery plans for the future. The lack of clear plans can leave a vacuum which is often filled by rumour or guesswork. With adequate clarity about local plans, the doctors can plan their own practices with certainty and so that they are better aligned to public health services and local needs. Doctors felt strongly that their involvement in service planning is essential for successful implementation.

Involving doctors in service planning presents a very clear opportunity to re-engage with rural doctors. The desire by doctors to be involved was widely expressed and there was a genuine interest and hunger to participate.

Vehicles for involvement in planning

While there were regional differences in terms of the appropriate vehicle for involvement in planning, several doctors expressed a preference to be involved at the stage when different options were being considered (43).

There was a mixed response to other suggestions for involvement in planning:

- Use Divisions of General Practice (20)
- Do not use Medical Advisory Committees (15)
- Involve community (4)
- Medical Advisory Committees are a good vehicle (10)
- Use doctor association (12).

Actions on rural health planning

14. The group acknowledges inadequate past involvement of doctors in clinical service planning. WACHS will involve doctors in the planning of clinical services and observe the following protocols:
    - Where clinical service plans are available they will be distributed to all doctors within the local catchment area;
    - Locums and doctors new to the district should be provided with access to local plans as part of their orientation; and
    - Doctors will be engaged in the regional clinical services planning being undertaken in 2007.
15. Vehicles for engaging doctors in planning will be agreed locally with the involvement of the Division of General Practice, resident and visiting specialists.

Key changes and innovations over the next five to ten years

The changes identified by doctors as critical innovations to address the expected worsening of the rural doctor shortages were focused in three key areas.

Firstly, information services were seen as important through:

- Linking medical records between hospitals and surgeries (84);
- Increasing use of telehealth systems (21);
- Addressing over reliance on paper based systems (12).

The second area of emphasis was to extend the existing rural doctor workforce and reduce the level of turnover by:

- Focusing on supports for resident doctors not locums (39);
- Introducing female friendly practices and hospital policies (30);
- Applying premium for rural practice (27);
- Extending nurses role in Emergency Departments and in practices (23);
- Addressing duplication of services between GPs and hospitals (21).
- Supporting doctors working beyond 65 years (17);

The third area of emphasis was to maintain and enhance skills and increase rural based training by:

- Applying succession planning for rural specialists and address the current paucity of generalist specialists in training (69);
- Maintaining procedural general practice (31);
- Supporting Rural Clinical Schools as they are seen to be a good investment for the future (26), and
- Introducing creative models for Post graduate year (PGY) 1 and 2 placements developing education hubs (20);

A number of suggestions also focused on external recruitment, targeting doctors from other States in Australia (9).

The dual responsibility shared between State and Australian governments was seen as a continuing barrier to effective policy and decision making in health (10). Managing patient expectations was seen as an alternative strategy to addressing the supply of rural doctors (8).

Actions to address emerging workforce shortages

16. Attraction and retention of the rural medical workforce is dependant upon modern information and communication technology to support patient care, communication and connectivity between hospitals, doctors' surgeries and other clinical services. It is recommended that WACHS urgently address this key result area.

    As an interim measure, hospitals and divisions should examine the introduction of terminals/laptops to allow doctors working in hospitals access to their surgery records.

17. WACRRM, RDAWA and WAGPET will develop succession plans and support for rural proceduralists in recognition of the low entry rates into the generalist proceduralist field of medicine so crucially important to the country health care system.
18. WACHS and WACRRM will consider the application and implementation of the Australian Centre for Rural and Remote Medicine (ACRRM) curriculum into Western Australia for proceduralists (currently under pilot in Queensland). This will include examination of the potential for UK "general registered" doctors to be included into the ACRRM program in preparation for hospital based positions in rural WA.
19. WACHS and WACRRM will explore the establishment of metropolitan hospitals as training centres for rural proceduralists which also enable staff rotations between metropolitan and rural centres.
20. It is recommended that doctors working in the country with Fellow of the Australian Centre for Rural and Remote Medicine (FACRRM) qualifications are paid a premium under Medicare Australia in recognition of them being rural medical specialists.
21. WACHS will pilot arrangements to integrate ambulatory and primary care services currently provided by a range of service providers and examine alternative models for the provision of these services. These models will be developed and piloted following discussion with rural doctors, health advisory groups and local government. In particular WACHS will pursue running multidisciplinary, ambulatory care and primary care services from a general practice model under a pilot arrangement.
22. Rural doctors should develop, pilot and implement arrangements for extending the role of practice nurses. WACHS should extend the role and coverage of nurse practitioners within the country health system and including in accident and emergency departments.
23. WAGPET will expand the concept of learning hubs, allowing more PGY1 and 2s to train and learn in regional centres.
24. The group supports expansion of the Rural Clinical School program as an effective strategy for attracting new graduates to rural practice.

Annoyances and aggravations

The issues of most concern and cause of most annoyance and aggravation to rural doctors relate to their relationship with the public health service managers (223), relationship and service provided by rural mental health services (169), demands of on-call services to hospitals (91), the Medical Service Agreement process (71) and relationships with other providers particularly RFDS, Aboriginal Medical Service, hospital and private practices (27). These issues have been largely addressed under the Relationships section of this report. Other issues raised by doctors but not addressed elsewhere are as follows:

- **Patient Assisted Travel Scheme** (85). The aggravations involving PATS were the requirements to justify clinical decisions to administration staff. Some doctors felt the system disadvantages and compromises their patients. The administration of the scheme is perceived to be overly focused on cost containment and inflexible.
- **Paperwork and bureaucracy** were identified by 79 doctors as sources of aggravation in their practice. These included the forms and records required by hospitals, health insurance commission and many other health providers. This also extended to care planning requirements, credentialing and registration. Most doctors felt the pressure of the relentless paperwork and described the inefficiency this brings to their practice and hospital work.
- **Lack of locums** and the cost of locums were identified by 70 doctors as a source of aggravation. Many felt let down by locum services either not being available, falling through or not delivering an adequate service. This was relevant for most private practitioners, specialists and GPs.
- **The introduction of salaried medical services** in many regional locations was reportedly poorly received by some private doctors (24) servicing both small and large regional hospitals. These doctors criticised the decision making and implementation processes.
- For many doctors working in small or solo practices (25) the **obligations of practice management** were a source of aggravation. They reported that the growing volume of paperwork and administration involved in practice management detracted from the direct clinical service and in some cases led to viability problems or increased out of hours work for little or no gain.
- **Care planning** was not widely supported amongst rural doctors (21). Many were cynical about the system and felt it lacked the clinical evidence that it improved health outcomes. Many of the older doctors suggested that the care planning approach is what they already do. They reported that the forms and rules are a bureaucratic impost and likened this to having to “prostitute themselves” in order to be paid properly for doing what they have always done for their patients.

Other aggravations noted by rural doctors included a sense that their skills were being poorly used (21), no administrative support in their clinical practice (12), poorly functioning or non functioning MACs (32), poor access to specialists (11), poorly organised clinics (12), a sense that the health system was focused on budgets and not on patients.

Actions to address major areas of aggravation

25. The reference group acknowledges that the Patient Assisted Travel Scheme (PATS) is a complex scheme to administer and doctors have reported that in some circumstances the administration of the system has contributed towards poor clinical care. WACHS will review the scheme to address the key issues raised by rural doctors and to introduce a more responsive and accessible system for referring general practitioners and consumers.
26. Multiple specialist visits during the course of treatment over a 12 month period should be approved once through PATS, avoiding the need for multiple revisits to doctors.
27. WACHS will ensure that doctors are provided with information on visiting specialist visits and the procedures/work they will undertake within the region to enable more referrals to regional visiting specialists.
28. WACHS will develop coordinated regional systems covering visiting specialists, outpatient bookings, transport, and financial and practical assistance with travel and accommodation arrangements.
29. The shortage of locums is a nationwide problem. The reference group recommends priority be given to solo practices and Aboriginal Medical Services for locums providing leave relief. WACRRM will evaluate the locum program in WA and explore ways to improve its effectiveness. There will be a strong focus on building capacity, retaining the existing rural medical workforce and reducing the over reliance on locum doctors to fill medium to longer-term position vacancies. WACHS and WACRRM will work together to improve medical recruitment, build local capacity, reduce vacancy durations, improve doctor orientation, and support professional development.

30. The cost of locums has been increasing exponentially, pressure nationally should be applied to address concerns about locum rates, particularly amongst public providers. WACRRM with the endorsement of the group as a whole will raise this issue with Australian and State/Territory governments to consider alternatives to stabilise the locum costs.
31. WACHS is committed to specific action focused on reducing paperwork, including:
    - Exploring annual cashed out payments for hospital services as an alternative to individual patient billing/hospital invoices for rural doctors;
    - Implementing paperless systems and medical records;
    - Streamlining credentialing processes including extending the period admission rights are provided; and
    - Engaging with doctors locally about key aggravations with paperwork and examining ways to reduce the load.
32. WACRRM and Divisions of General Practice should examine mechanisms for offering practice management support for small and solo practices.
33. Wide debate is required on flexible delivery systems for medicine in rural areas including examination of the costs and benefits associated with salaried systems and VMP systems of delivery (undertaken by WACHS and RDAWA). This assessment will include associated on-costs, impact on patient management, recruitment and retention, locum demand and the potential for de-skilling of private GPs. This will build upon the recent experiences in Geraldton and the pros and cons of the model as described in the consultation process in that region.

    WACHS will be undertaking regional service planning in the first six months of 2007. This will provide an opportunity for doctors to be involved in regional health service planning, including debate over models of service delivery.
34. Examination of the role and functions of the Medical Advisory Committees (MAC) will be undertaken by WACHS in conjunction with RDAWA to address concerns that these committees have lost their focus and credibility.

Overseas trained doctors

There were particular issues expressed by overseas trained doctors that were common regardless of location. In a number of cases overseas trained doctors were reluctant to speak out about their concerns and issues as they felt there might be repercussions either from their employer or from the Department of Immigration and Multicultural Affairs.

There is a general feeling of being stigmatised and under valued. They reported that they believe they are providing a needed service in remote or difficult environments and feel 'used' by the system, including the recruiting agency. Some perceived their employment contracts as sub-standard. The clear message in their view is that Australian doctors are preferred, but not available or willing to work in these difficult and isolated locations. The overseas doctors do the work but feel that they are perceived as second rate.

Some of the specific supports needed relate to the entry of overseas trained doctors into a complex system that they are unfamiliar with and with a lack of preparation and continuing support for their work. The majority reported they are poorly prepared and informed about the immigration rules and consequences of being a temporary resident. Many also reported they are denied access to key benefits available to Australian citizens.

Overseas trained doctors expressed the view that it is very important to clarify conditions of employment and immigration before recruitment with particular emphasis on:

- Ineligibility for access to Medicare benefits for self and family despite paying the Medicare levy;
- Information on purchasing property;
- Information on the education system;
- Recognition they have no credit history in Australia and therefore they need significant deposits for major purchases;
- Driving licensing (often required to redo tests);
- Clearer information from agencies on immigration and systems of entry (medical colleges, AMC etc); and
- Standard contracts to remove the potential for unfair employment contracts.

In respect to the work as a medical practitioner the priority issues reported are:

- Access to a mentor who can help guide them through the system, or to call upon when they are uncertain;
- More structured and paid orientation prior to commencement; and
- Structured skills assessment and planned upskilling arrangements.

These were similar concerns expressed by overseas doctors working in South Australia. Better support systems for overseas trained doctors have now been introduced. For example, there is a familiarisation trip to South Australia prior to contracts being signed, up to four weeks paid orientation on arrival, provision of mentors for each overseas trained doctor; development of interest-free resettlement loans and improved resettlement grants.

Actions to support overseas trained doctors

35. WACRRM and WACHS will continue to explore opportunities to facilitate a minimum of four weeks paid orientation for non proceduralists and explore methodologies for skills assessment for proceduralists.
36. The Medical Board of Western Australia will be approached by the reference group to refer overseas trained doctors engaged through alternative recruitment agencies to WACRRM so they are informed about available support structures and to make orientation and assessment compulsory.
37. WACRRM and WAGPET will seek support from with ACRRM and the Royal Australian College of General Practitioners (RACGP) to assign mentors to each overseas trained doctor, as required, and as they commence.
38. AMAWA will explore opportunities for overseas trained doctors to access credit facilities with the relevant credit providers.
39. The reference group strongly recommends that recruiting agencies provide essential information to overseas trained doctors prior to their appointments. This should include at least information access to Medicare, purchasing property, the education system and associated costs, Australian drivers' licensing requirements, conditions of entry, medical registration and medical provider numbers.

40. The reference group will seek minimum standards for employment contracts with overseas trained doctors with all recruitment agencies.
41. WACRRM will clarify avenues for confidential and independent advice and grievance procedures for overseas trained doctors who may have concerns about their contractual or other arrangements. Spouse issues may also be supported through WACRRM or Divisions of General Practice.
42. WACRRM will advocate for change to access to Medicare and emergency evacuations for overseas trained doctors located in areas of need. WACHS will investigate options to waive public hospital fees for rural overseas trained doctors working in areas of unmet need.
43. WACRRM and the RDAWA will market and recognise overseas trained doctors as an essential and well-credentialed part of the health system. These doctors have been prepared to provide services in difficult and often isolated environments. The outcome will be to achieve professional and community recognition for their contribution. In addition, the AMAWA should develop regular newsletters and communication mechanisms with overseas trained doctors.

Specialists

An issue identified for most of the resident rural specialists is the lack of locum relief when they are on leave or undertaking upskilling programs (22). The isolation experienced by many of the rural specialists is extreme; they are often operating effectively as sole practitioners and yet enjoy very little support in contrast to many of the general practice programs in existence. The need for reliable locum support, regular upskilling, and support for advanced trainee posts in regional centres from teaching hospitals were identified as necessary to maintain and support the rural specialists.

Visiting specialists were an additional group who were consulted. This was the first time such a discussion was held with this group of medical specialists who provide services to country people. Many had worked and provided visiting services for lengthy periods, some exceeding 25 years. Their contribution has been outstanding in providing access to services that would otherwise only be available in metropolitan areas. The specialists reported that they were not financially motivated but rather chose to provide services because they are needed. Some of the specialists reported that they would be better off financially to concentrate on their metropolitan practices.

The visiting specialists reported that they are rarely engaged in conversation about clinical service planning for their specialty and in many cases had never met the managers of health services in the area they were visiting. Some visiting specialists believed they were employed by the WA Department of Health in Royal Street and seemed not to be aware of the changes that had occurred in country health service management over the last 25 years.

Actions to support rural specialists

44. Teaching hospitals should provide locums for rural resident specialists. This may be achieved by requiring tertiary institutions to take a statewide support role for the relatively fragile rural specialist workforce. This could be by rotations of consultants who have rural placements included within their employment contracts. This will also have the effect of improving the understanding of rural settings by metropolitan consultants.

45. The reference group recommends the establishment of advanced specialist training posts in rural areas and the upskilling of resident clinicians supported through teaching hospitals.

Aboriginal medical services

While many of the overall themes and issues are relevant to all doctors working in rural areas, including doctors working in Aboriginal Medical Services, there were a number of specific concerns and issues raised through forums dedicated to identifying issues encountered by doctors employed through Aboriginal Medical Services.

These issues were chiefly related to employment arrangements and included:

- Award and career structures are limited. It was felt that attention to the current terms and conditions for doctors employed in Aboriginal Medical Services was a priority to ensure that there are opportunities for career advancement within the Aboriginal Medical Services, and that employment terms and conditions remain competitive with other rural based medical service providers.
- A process whereby doctors employed by Aboriginal Medical Services could easily transfer to other Aboriginal Medical Services without the loss of terms, conditions and entitlements was seen as an important initiative to encourage retention within the Aboriginal Medical Service.
- Education and training in Aboriginal health is important as preparation for all doctors seeking to work in Aboriginal health and the development of a post graduate qualification in Aboriginal health is required.
- The capacity and skill levels of practice managers within some Aboriginal Medical Services (AMS) was recognised as a deficit. While this is consistent with many remote practices the AMS doctors feel that improved practice management would not only ease and better manage their workload, it would also ensure improved revenue and returns for AMS through better management of Medicare and efficiency within the clinical service.

- A number of doctors are concerned about the level of support for spouses and families within the communities they work and feel some mentoring and direct support for the families to settle would be of benefit and may improve retention rates.
- Planning of clinical services within Aboriginal Medical Services involves the resident doctors and that is appreciated, however it is felt the wider involvement in planning of clinical and health services in the relevant district or region is inadequate.

  A level of criticism was also directed at the manner in which consultation on planning involving health was conducted. This was directed at both State and Australian governments where consultation is often seen as paying lip service and not undertaken in a culturally secure way. The general pattern involves planners or consultants flying into a community, spending less than a day and then leaving, after having received answers to their pre-prepared questions. This is commonly referred to as "bungee planning" and no follow up from these visits is forthcoming. This approach leaves no opportunity for communities to express their needs or priorities and is so fast that little local ownership is involved. Often the approach involves spending government money quickly due to the finite nature of the funding programs and the sort of long term planning and consultation needed within Aboriginal communities is impossible.

Actions to address Aboriginal Medical Service issues

46. The AMAWA, WACRRM and the Aboriginal Health Council of Western Australia (AHCWA) will address award and career structures within Aboriginal Medical Services.
47. The AHCWA should address the ease of transfer of doctors' employment across Aboriginal Medical Services.
48. WACRRM, WAGPET and AHCWA will explore ways of ensuring greater recognition of training and skills assessment within Aboriginal health services including the potential for the development of a post graduate qualification in Aboriginal health.
49. State, Territory and Australian governments should consider their approaches to health planning in conjunction with Aboriginal Medical Services to address the issue of "bungee planning" and ensure planning and consultation approaches recognise cultural preferences and norms.
50. WACRRM, WAGPN and the AHCWA will consider methods and training programs to allow professional development of practice managers within Aboriginal Medical Services.

Regional issues

A summary of the gaps and issues raised by doctors in each region is provided below.

1. Wheatbelt

Gaps

- Allied health (Moora, Jurien Bay, Lancelin) (4)
- Duplication in services between hospitals and GP (4)
- More specific health service gaps are also identified, with retention of endoscopes at Kellerberrin (5), Ophthalmic services at Cunderdin (3) being valued by local doctors. The need for geriatrician and physiotherapy services and an increased aged care focus are the other gaps identified.

Key issues for the Wheatbelt are:

- The most consistent view is **the importance of the larger centres at Merredin and Northam to be working well**, the current services are seen as inadequate and ineffective.
- Small practices, particularly the solo practices, experience **difficulties in maintaining effective on-call support** as there is little demand and this affects the attractiveness and viability of practices.
- **Shires should be offering a standard package (not competing) to attract and retain doctors** to relieve the current shortage.
- Having **practice nurses** is seen as an important improvement needed by 7 doctors, a further 7 doctors feel that practice management support would relieve them of clerical and administrative work and ensure their productivity.
- Developing a mechanism for **easy entry and gracious exit** from practices in the Wheatbelt is seen as a major challenge in attracting and retaining doctors in the region. Consideration of a model proposed by Dr Dick Newnham to be considered.

2. South West outside Bunbury

Gaps

- Improved mental health services (42)
- Access to specialists, particularly geriatrician, physician (19)
- Dietician (Bridgetown), allied health (Pemberton, Donnybrook, Margaret River) (16)
- Psychological counsellors (9)
- PATS access to services (6)
- Podiatry (Margaret River) (6).
- Aged care and rehabilitation services (4)
- Ear Nose and Throat (3)

The key issues for the South West are:

- To **re-establish relationships between senior management and doctors**. Reportedly the legacy of the previous administration in the South West is an extremely discouraged and disengaged group of doctors, this requires careful and sustained effort to repair. A positive response to the visits by WA Country Health Service senior management show that building the bridges is possible and welcomed.
- Potential for **developing the region as a hub for education and training** is clearly evident. There is good infrastructure, population, strong workforce with interest in teaching and in reasonable proximity to the metropolitan area.
- Achieving **balance of lifestyle with on-call demands** for all doctors and appropriate recognition of stage in life (doctors with young families and older doctors) without impinging on admission rights.

3. Pilbara

Gaps

- Improved mental health services (26)
- PATS - improved access and administration (26)
- RFDS fly a lot unnecessarily (5)
- Midwives in short supply (Nickol Bay)
- Port Hedland – obstetricians and gynaecologists, paediatricians, general surgery, physicians, allied health, pharmacy, diabetes educator
- Physiotherapists and dermatologist (Tom Price, Paraburdoo, Newman).

The key issues for the Pilbara are:

- **Access to child care services** throughout the Pilbara is a barrier for younger doctors who represent the majority of practitioners in this region. All reported that day care places are impossible to find and this has a bearing on both their ability to practice to the fullest extent and reduces the length of time they are prepared to work in the region.
- **Burn out is a major issue** in this region, all doctors are pressed and proceduralists services are stretched to the limit. Most doctors are concerned about the hours they are doing and that a definition of safe hours is urgently needed.
- **Specialist cover for the region** is very fragile and limited. All regional specialists are experiencing major problems in the capacity to cover the region effectively and require back up and support.
- **PATS** came under very heavy criticism in the region for the manner in which it is administered and its lack of connection to the clinical needs and circumstances of patients in the region.

4. Midwest

Gaps

Discharges from Geraldton Hospital

- Need to move towards an electronic discharge system (6)
- Variable standards of discharge report (4) – concerns expressed over quality
- Typically carbon copy (which is often illegible) (3)
- Tests ordered prior to discharge are not being followed up

MBS/PBS

- Frequent changes to MBS items make navigating through the MBS items difficult.
- Need greater ability for MBS items to be claimed when the item is performed by a suitably qualified member of staff (e.g. practice nurse). Solo practitioners should be encouraged to use the skills of available staff without the consequence of loss of income.
- Need to explore scaled Medicare payments for regional, rural and remote areas.
- Significant amount of time is wasted in phoning for permission to prescribe a drug.

The key issues for the Midwest are:

- The **move to salaried doctors within the regional hospital** has changed the dynamics within the medical fraternity. Much can be learnt from the open discussion on relative merits of both the process for introducing the salaried doctors and the clinical outcomes for patients following the change.
- The **demands of on-call services and access to locums** represent key issues, particularly for doctors working in communities surrounding Geraldton. The impact on retention of doctors in these environments is a major challenge. A review is currently being undertaken through the Division of General Practice and WACRRM.
- Approaches to achieve **better service coordination** between health service providers at hospital, Aboriginal Medical Service, mental health services, nursing homes and private practice is seen as a major challenge to improve services in Geraldton.

De-skilling and exclusion of skilled and proceduralist general practitioners with the advent of salaried services at the regional hospital was reported to be an issue. Another issues was the alienation reportedly felt by the local GPs in the transition to the salaried medical service. The depth of feeling and sense of injustice was very evident during the consultations.

5. South West – including Bunbury

Gaps

- Most doctors mentioned the need for electronic discharge summaries that can go directly into patient notes.
- Many doctors also mentioned better access to mental health services, particularly psychiatric consults and support to GPs. Greater communication between the mental health team and GP was also mentioned, for example, notification in changes to medication (1)
- The need for improved radiological services in Bunbury was reported. Current services are reported to be unreliable, with frequent delays and poor quality reports

- It was suggested that chemotherapy could be provided locally by some GPs if the Bunbury oncologists were willing to allow this. Referral to the regional (private) oncologist was seen as being unnecessarily expensive and inconvenient for patients
- Local GPs would benefit from knowledge of the local resource base. For example, equipment available at the local hospital, and greater coordination and sharing of resources between providers. (1)
- Community education about the role of GPs might decrease unreasonable expectations and reduce the pressure on GPs
- Acceptance of computer generated medication charts by hospitals
- Long waiting lists for some specialist appointments was noted by 3 doctors, although it is noted that the South West may be better off than the metropolitan area in this regard.

Key issues for Bunbury and surrounds are:

- To **re-establish relationships between senior management and doctors**. Reportedly the legacy of the previous administration in the South West is an extremely discouraged and disengaged group of doctors, this requires careful and sustained effort to repair. A positive response to the visits by the WA Country Health Service senior management shows that building the bridges is possible and would be welcomed.
- The potential for **developing the region as a hub for education and training** is clearly evident. There is good infrastructure, population, strong workforce with interest in teaching and in reasonable proximity to the metropolitan area.
- The **mental health services in the South West** were heavily criticised by all doctors. While mental health services were reported to be inadequate in most regions, the mental health service (Southwest 24) is seen as an impediment to effective service and patient care between GPs and mental health services.

6. Kimberley

Gaps

- Allied health (Kununurra, Wyndham) (8)
- Use Darwin as referral centre (18)
- Gaps in clinical information (8)
- Too few doctors and nurses for the health need (17)
- Diabetes education (7)
- Mental health excellent but too few (3)
- PATS must be improved for patient treatment and care (28)
- Access to specialists (9)
- Regional resource centres not working (8)
- Specialist clinics wound down (4)

The key issues for the Kimberley are:

- Relationships with management dominated the discussions with doctors across the Kimberley and while addressed within the body of the consultation report, there was a much stronger focus on this amongst Kimberley doctors.
- Integration of service planning and clinic services between hospitals, RFDS, Aboriginal Medical Service and private practitioners is urgently required. All doctors recognise this as a significant issue that requires early resolution to restore confidence and make best use of a limited medical workforce.
- The use of Darwin as the primary referral destination for Kimberley patients is widely supported as a key innovation that will benefit patients, improve RFDS response times and save valuable resources and time. All are aware that discussions between WACHS and Darwin are underway.
- Access to specialists and application of PATS within the region is a consistent issue and frustration for doctors.

7. Goldfields

Gaps

Eight doctors indicated physician services as the highest priority medical service need in Kalgoorlie. Gaps in ancillary services were also highlighted, including diabetes educator (4), audiology (1), podiatry (2), counsellor/social work (2), and therapy services (4)

Further service needs identified include:

- Enhancing frequency of visiting specialist services, specifically ear nose and throat (2), neurology (2), rheumatology (1) and ophthalmology (2)
- Improving the provision of cultural secure services – including increasing number of Aboriginal Health Workers/Aboriginal Liaison Officers in the hospital setting (5)
- Re-open the surgical ward on weekends (3).
- Better dental services (1)

Key issues for the Goldfields were:

- **De-skilling of proceduralist general practitioners** with the advent of salaried services at the regional hospital.
- Unsustainable service model and observations that the use of **Kalgoorlie as a regional resource centre is not working**.
- The introduction of an innovative and heavily resourced **pilot information service system requires involvement of the public system** to achieve optimum results and act as a system that may be extended in other regions.
- The Rural Clinical School in Kalgoorlie is seen as an essential investment for the future. Practitioners are keen to see this extended with **creative solutions for undertaking post graduate training in a rural setting**, including PGY, intern, resident, registrar and proceduralist training. **Creating a learning hub** in this environment with interaction and partnerships with and between training organisations should be championed in the region.

8. South East Coastal

Gaps

The health service gaps are:

- Physician (3)
- Paediatrician (Norseman)
- Lack of Aboriginal health services in Norseman, the view is there is enough medicine for a full time doctor
- Mental health services need a shake up (5)

A further two doctors identified nurse practitioners and practice nurses as required resources.

Key issues for the South East coastal were:

- The desire to move to an **amalgamated practice on the hospital site**, building in education and training opportunities and trialling innovative team practice approaches. The region is reported to be well placed to achieve a unique blend of practical experience with highly skilled proceduralists with primary care in a remote and isolated environment. Support from all agencies should be offered.
- **Supporting solo practices within small communities** surrounding Esperance using different and innovative approaches presents an ongoing challenge. Most communities struggle to retain practitioners and a rotation or visiting service from a base in Esperance would appear to be a model that has great potential.
- Esperance was at least **three doctors short** at the time of consultations and this needs to be addressed to gain the maximum benefit from the goodwill and intent to develop an amalgamated practice in the region.

9. Great Southern

Gaps

- More midwives are needed both in Albany and Mt Barker (6).
- Assessment of new mental health patients is too slow (5)
- A single doctor roster for after hours would be helpful and reduce on-call demand in Albany (3)

Key Issues for the Great Southern are:

- **More community residents and registrars** are seen as necessary for improving services and essential for the future supply of rural doctors.
- Within the medical community the importance of **succession planning** for replacing older doctors is a key issue. Almost all of the doctors recognise the great **value of the local specialists**, and Dr John Lindsay, a long-term specialist Physician in Albany was especially acknowledged for his excellent service to patients and support for GPs. John is clearly seen as someone extremely difficult to replace and doctors urged for greater support for him by way of locum and registrar resources. One doctor mentioned that without him there would need to be three replacements.
- Doctors reported a very effective relationship amongst practices in Albany and that the VMP system in the regional centre remains highly effective. Most doctors are concerned about the future of this arrangement and it was offered that **WACHS would canvass Albany doctors to deliver options that will retain an effective accident and emergency coverage into the future** whilst retaining the best of the existing system.

10. Gascoyne

Gaps

- Provision of CT Scanner
- Access on site for orthopaedic services, funds available to support.
- Establish GP clinic under COAG reforms
- Electronic radiology system

Key issues for the Gascoyne are:

- **On-call arrangements** within a relatively small community.
- Need for more **structured orientation and better support for training and education**, particularly in view of the high turnover experienced in the region.

Notes: