



CELEBRATING **25** YEARS  
CARING BEYOND HEALTH



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Celebrating 25 Years – Caring Beyond Health

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# Foreword

The letter is dated 3 December 1987. It could quite easily have been dated today, because it heralds the forward looking organisation that the Western Australian Centre for Remote and Rural Medicine (WACRRM) became – and remains.

The letter says that while the terms of reference relate to the provision of doctors in country centres, the real issue is meeting the needs of people. It is essential that this remains the primary goal.

We honour and embrace that as our *raison d'être*.

In his letter to the state Health Minister, Emeritus Professor Max Kamien noted his sentinel report did not offer all solutions, however, it did recommend the establishment of WACRRM and also signalled the organisation's alignment as a collaborative partner with others in the development and delivery of services vital to rural health.

Integral to WACRRM's core role in achieving that, is our commitment to innovation as we seek to influence and help shape state and national rural health workforce policy and practice.

This organisation has a proud history of achievement with programs which have been forerunners of those adopted elsewhere – indeed, the establishment of WACRRM itself, was a national first.

Now better known and reflected by our trading name of Rural Health West, we work very much in a holistic sense, going beyond the simple identification and recruitment of doctors, nurses, midwives, dentists and other allied health professionals. To ensure the sustainability of health services to the communities we serve in this vast State, we support and nourish these professionals and their families.

Rural Health West's evolution over the past 25 years has been dynamic but, with the rapid advances of technology, the future will be even more so as we strive to deliver our vision of improving the health of rural, remote and Indigenous Western Australians through innovative workforce solutions. The tools we harness in that pursuit, though, will never replace the people who are at the heart of what Rural Health West is and will remain.



This snapshot of WACRRM and Rural Health West's first 25 years, as seen through historical record and personal reflections, is but Chapter One in the organisation's history; Chapter Two remains our work in progress.

**Belinda Bailey**  
Chief Executive Officer

# WACRRM's long labour

Western Australians living in 'the bush' had felt cheated for a very long time; several decades, in fact.

In the mid-1950s, there was a concerted effort to establish a Western Australian medical school, marketed to the public under the banner of Grow Your Own Doctor. Over two years, with Rotary Clubs around the State galvanising support, the appeal raised £650,000, with the state government providing another £250,000.

However, the appeal also produced a staggering statistic that demonstrated not only the generosity of Western Australians living in rural and remote areas but also how strongly they valued the prospect of having doctors in their communities. Country people contributed 75 per cent of all private donations to the appeal.

But, decades on, doctors were few and far between 'out bush' ... and the anger was palpable. Max Kamien who, in 1976, was appointed Foundation Professor of General Practice at The University of Western Australia recalls: One shire president in the wheatbelt told me, "I gave £10,000 – I have yet to see one of your doctors."

And so it was as the years dragged on. Generally, the very limited number of graduating doctors who went to the country were either from the country or were inspired by friends who worked as country general practitioners. The catalyst for change – when it came in the mid-1980s – was not the power of the logic, nor the overwhelmingly prescient case of need. It was political fear, and Kamien seized the moment.

Ahead of the Western Australian election on 8 February 1986, he rallied doctors in four rural seats, all of them marginal, to seek their local Member of Parliament's support.

The state Health Minister of the time, Barry Hodge, appointed Kamien to lead a Ministerial Inquiry into the Recruitment and Retention of Country Doctors. Having canvassed the views of doctors, shires, peak medical and rural bodies that covered the length and breadth of the State, the Kamien committee presented its report on 3 December 1987. From its opening paragraph, the report laid out the premise of what was to come: *This report may seem to be about doctors but it is really about the medical care of people in rural communities. Rural people comprise 30 per cent of the population and make a major contribution to Western Australia's economic wealth. They deserve the same quality of basic medical care available in the urban areas.*

# 1989

WACRRM is the first of its kind in Australia and the model for other states.



At that time, there were just 282 medical practitioners recorded as working in rural practice across the vast expanse of the 2.5 million square kilometres which make up Western Australia. In Perth, the doctor:patient ratio was 1:442. In the sparseness of rural and remote areas it was up to almost four times that, with the greatest need being in the Kimberley, Pilbara and central regions.

The time was right for change, and not only in Western Australia. On the other side of the nation, country doctors were

resorting to direct action – withdrawing their services from public hospitals in New South Wales in the protracted Rural Doctors' Dispute of 1987-1988. While ostensibly about a minor remuneration matter, the dispute crystallised long-held tensions when the Medical Benefits Schedule fee for attending to patients out of normal hours was cut from \$22 to \$14.95. By comparison, The Australian newspaper reported that television repairs cost \$50 for the first 20 minutes, while plumbing repairs were \$120-\$140 minimum.

In Western Australia, though, Kamien's activism and the Inquiry he chaired had captured the moment of political weakness needed to advance the cause of rural medicine – the state government accepted the recommendation to establish WACRRM, and \$2 million was sourced from the Western Australian Department of Health via a Lotteries Commission grant to support the organisation's first five years of operation.

# Everything can be made better

Emeritus Professor Max Kamien was not a child of privilege – far from it.

The struggles of his family in leaving Poland for the United States in 1905, then returning home in 1923, before emigrating to Palestine where his father laboured on the wharves before eventually being persuaded that Western Australia held the promise of a better life, laid the foundations of his sense of social justice.

It was a sense that was heightened within the young Kamien as he noted the discrimination against Chinese, Aborigines and Catholics as he grew up.

Over the years, his obstinate social conscience has challenged many with its seemingly impenetrable self-belief and determination. But that determination was needed to launch the Western Australian Centre for Remote and Rural Medicine (WACRRM).

*The start of WACRRM was to correct something that had been said would be done for country Western Australians who had so willingly given to the cause of the medical school appeal. There was a dreadful shortage of doctors; it has a huge effect on the economics of a community. People stay in the community if there are medical services and education services.*

*Initiatives don't always succeed through planning and logic. Pathfinders also need to have good maps, be able to read them and make the most from hopefully lucky political events. And pathfinders need to constantly defend their innovations, not with hype and spin, but with good data.*

*WACRRM was a pathfinder for affirmative entry, Aboriginal groups, rural high schools ...*

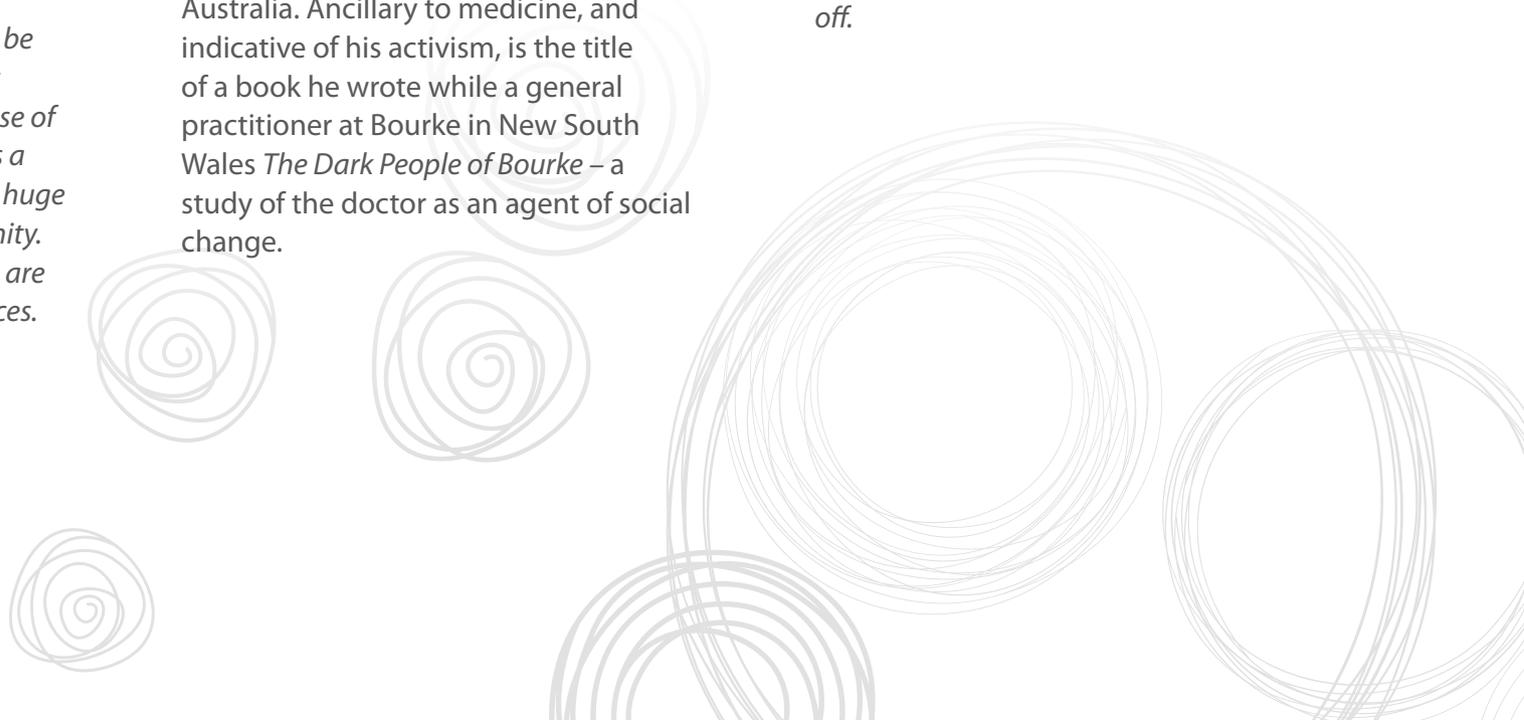
Undertaking his final two years of medical studies at The University of Western Australia, Kamien raised the issue that the course contained nothing about rural medicine or Aboriginal health and he was given the opportunity to go to the country. *I learnt more in six weeks in Collie than I did in six months in medical school. The Rural Clinical School of Western Australia exists because of that experience.*

He graduated in 1960 and worked widely overseas before returning to Australia. Ancillary to medicine, and indicative of his activism, is the title of a book he wrote while a general practitioner at Bourke in New South Wales *The Dark People of Bourke* – a study of the doctor as an agent of social change.

Max Kamien was appointed the Foundation Professor of General Practice at The University of Western Australia in 1976.

Apart from presiding over the Inquiry that brought forth WACRRM, he was also its interim inaugural Director: *I ran WACRRM for about nine months and the very day it started a chap from the Health Department rang me and said "We have a problem in Carnamah and Morawa and Perenjori and Three Springs, and since we are funding WACRRM, we want WACRRM to go and solve the problem."*

*They offered me a car, a little tiny Ford, and I took off. When I got to Midland I was aware that there seemed to be a big car trying to cut me off and so after a while I stopped. The driver said, 'Mate, according to your status, you have to have this one.' Apparently I was classified as a Class II Civil Servant and was entitled to the bigger car! So we swapped cars and I took off.*





**Emeritus Professor  
Max Kamien**

# Building the foundations

WACRRM was at the start of its trailblazing – even as an entity itself, the organisation was a national ‘first’, as so many of its initiatives were to come. However, when the highly regarded Dr Bill Jackson moved from Tasmania to become the full-time Director in 1990, its future was largely a blank canvas.

Jackson – aided by his wife, Doris – had to not only develop policies and programs but also develop a presence for WACRRM. Relationship building with country shires, rural community organisations and fellow medical-related bodies would be as much a key to success as getting more doctors on the ground.

Early action was aligned to the ‘Grow Your Own Doctor’ philosophy.

The Students and Practitioners Interested in Rural Practice Health

Education Xcetera (SPINRPHEX) was the first medical student Rural Health Club of its kind in Australia and the Country Medical Foundation was established to provide financial scholarships for rural students studying medicine and nursing.

There was a need for many more home grown students and ‘the kids most likely to work rural’ were those who already lived in the country. WACRRM and SPINRPHEX embarked on rural high school visits to promote the cause.

Equally important was program funding and federal finance was provided to establish the Rural Training Unit at Fremantle Hospital, while WACRRM was also funded to administer the federal General Practice Rural Incentives Program.

Another key piece of WACRRM’s mosaic for success was the establishment of

the Rural Medical Family Network to support spouses, partners and families – so often the causal factor in doctors leaving rural and remote practice.

In these early years, credibility grew quickly and Bill Jackson, having set the organisation’s sails, decided in late 1992 to move on. Acknowledging his contribution, Keith Wilson, the state Health Minister of the day, said: *WACRRM has made a major contribution to improving the training of country doctors and encouraging them to remain in rural practice ... the centre is now established as a significant resource for people involved in the delivery of health care to rural and remote areas.*

But there was more to be done, a lot more, under the incoming Director, Dr Brian Williams.

# 1990

WACRRM commences operations

SPINRPHEX student Rural Health Club established

# 1991

WACRRM and SPINRPHEX visit rural high schools promoting health careers

Rural Medical Family Network established

# 1992

WACRRM obtains funding to form a Rural Training Unit

Practical collaboration was afoot too. The Western Australian Rural Division Coordinating Unit Inc. (WARDCU) was co-located with WACRRM to further professional development and boost the very real need for locum relief.

The impact was dramatic. In its first year, the Locum Support Program – a co-operative venture between WACRRM, WARDCU and the Australian Medical Association which overtook a solo scheme previously in place – quadrupled the number of locum relief hours provided. A Female Locum Program pilot was also initiated, and, in a move to provide comfort to women patients, the Female GP Program, where female doctors visited country towns which had only a male practitioner, was started.

WACRRM facilitated the formation of the rural Western Australian Divisions of General Practice.

It established the Kalgoorlie Rural Medical Education Centre, along with teaching centres in Carnarvon, Northampton, Merredin, Donnybrook and Karratha; the WACRRM Continuing Medical Education program, including satellite broadcasts, which were set up to assist the career development of country doctors; and started the Princess Margaret Hospital Exchange Program.

At student level, 5th and 6th year medical students were provided with financial support for their rural attachments and, in a milestone event, The University of Western Australia granted six high school students special entry as rural students to study medicine.

There was also growing awareness of the value of WACRRM's research capability, as the organisation was

able to capture what was, essentially, 'real time' information from rural practitioners. A significant improvement on previously available data which could be two or three years out of date.

WACRRM's initial Lotteries Commission funding expired on 31 December 1994 and a new five-year agreement was struck between the state health department and The University of Western Australia (under which the centre operated).

As Brian Williams reported in his annual report that year, while this funding serviced ongoing infrastructure and program costs, additional to it, WACRRM was continuing to secure significant federal funding for its increasing array of services. He also noted an intangible asset: *the extensive network of relationships maintained by WACRRM continues to be one of the key strengths of the organisation.*

WACRRM is funded to assist general practitioners relocating to remote and rural areas

1993

WACRRM initiates comprehensive education and training program

332 medical practitioners in rural practice in Western Australia

1994

Funding continues for the next five years

Kalgoorlie Rural Medical Education Centre established

Locum Support Program established

1995

# A powerful and uplifting feeling

Dr Philip Reid first experienced remote practice as a two-year-old toddler in the mid-1950s, arriving in Boulder after his father had answered an advertisement in the British Medical Journal. *I grew up watching my own father work as a rural doctor. That was of enormous benefit to me. His wisdom and advice as I launched myself into private medical practice in July 1980 and beyond was fantastic.*

Although he worked elsewhere in Western Australia, Christmas Island and New Zealand, Dr Reid did not stray for long away from his adopted home in the Goldfields, where he was named Citizen of the Year for Kalgoorlie-Boulder in 2012 in recognition of his service to the community. He has experienced professional life pre and post WACRRM.

*I have been supported on a professional level by Rural Health West many times; I could not have managed on one or two occasions without that help.*

*The challenges of rural health are best seen in a huge State like Western Australia. The enormous scale of the geography and the widely dispersed population continues to challenge health care agencies.*

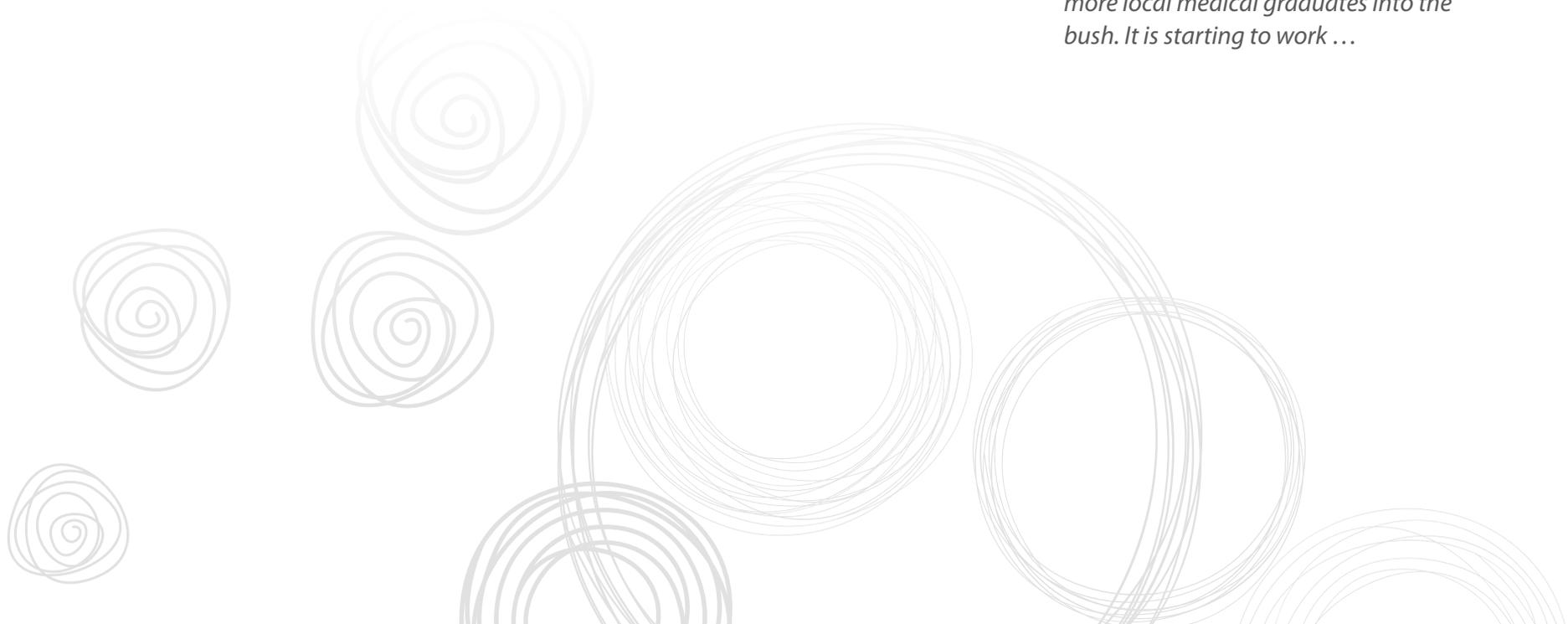
*Over the years, WACRRM/Rural Health West has been a great support to rural doctors providing medical care to the rural doctor by a visiting doctor; having a senior mentor to call at almost any time; providing continuing professional development; dealing with doctor shortages in a collaborative process ...*

*Adequate medical care for rural communities came from recruiting overseas trained doctors.*

For more than a decade Phil Reid combined general practice with his role as Associate Professor of Rural and Remote Medicine with The Rural Clinical School of Western Australia before retiring with his wife, Pippa, to Quindalup on the south-west coast in January 2014.

*The support of family and friends is very important. I could have done none of this without Pippa and our four wonderful children, Emma, Sarah, Kate and William. Families suffer if the general practitioner allows him or herself to become indispensable to the demands of medicine. From the beginning, limit setting is crucial.*

*I hope more like me are coming through – I just sold my practice to a graduate from The University of Western Australia! Rural Health West, WA Country Health Service and The Rural Clinical School of Western Australia are working very hard to get more local medical graduates into the bush. It is starting to work ...*





“

Driving home as the sun rises after delivering a woman of her baby, seeing the joy of that and starting a new day, is a powerful and uplifting feeling.

”

**Dr Philip Reid – Kalgoorlie**

# The challenges of success

1995 signalled a major challenge to the organisation's newly-adopted five year strategic plan and its Vision to *maintain WACRRM as the centre of excellence in the provision of a rural medical workforce*.

Pre-WACRRM, local graduates made up just 37 per cent of Western Australia's rural and remote doctors; by the mid-1990s, that figure had reached 50 per cent. It was far from enough and the federal government was moving to restrict the intake of overseas trained doctors – a clear and looming danger to WACRRM's ability to service the health needs of rural and remote Western Australians.

The federal push to limit foreign doctors – premised on the perceived glut of practitioners in Sydney and Melbourne in the late 1980s and early 1990s threatened WACRRM's capability to provide adequate numbers of general practitioners.

Turnover remained a significant issue as up to 10 per cent of doctors were leaving rural practice each year. Simply to maintain the status quo, about 30 replacements were required annually.

However, with WACRRM playing a pivotal role over the lengthy course of federal-state negotiations, compromise came in April 1999.

WACRRM would administer a new overseas trained doctors scheme, under which suitably trained and experienced foreign doctors, who were prepared to work for five years in a *rural Area of Unmet Need* and gain accreditation, would be eligible to apply for unrestricted registration. There was no shortage of interest – more than 800 applications were received in the first year.

With strong relationships and credibility nationally, the mid-1990s also saw recognition for WACRRM at the first International Conference on Rural Medicine in Shanghai, China.

Brian Williams reported that there was general acceptance of *the WACRRM Model, particularly in regards to the vertical integration of education (for example undergraduate, postgraduate and continuing medical education) being conducted by one organisation which was unique and very beneficial to ultimate workforce requirements*.

Upon Dr Williams' retirement in 1997, Ray Power became Acting Director until Dr Greg Down took charge at a pivotal time. The annual report noted: *WACRRM currently rests at a turning point. The programs that have been established over the last five years have been very well received and have raised the expectation for continuing medical education and locum access*.

1995

Inaugural National Rural Undergraduate Medical Students Conference – Kalgoorlie

Strategic Plan for 1995-1999 adopted

First residential workshop for Year 10 rural and Aboriginal students

1996

First graduates of the WACRRM Rural Training Unit



But surplus funds had been eroded, and WACRRM was not the richly resourced organisation many believed it to be.

The centre's capacity to adequately fund some programs was stretched.

In fact, the state health department paid the 1998 operating grant in advance to address the financial difficulties.

Longer term stability, though, was at hand.

In a matter of months, WACRRM was appointed Rural Workforce Agency for Western Australia, establishing the first such state-based agency to administer federal funding.

Dr Brian Williams  
honoured as  
a Member  
of the Order  
of Australia

1997

1998

WACRRM  
appointed  
as the Rural  
Workforce  
Agency for  
Western  
Australia

1999

Five Year  
Overseas  
Trained  
Doctors  
Scheme  
negotiated and  
implemented

2000

# An unbelievable dream come true

It was 2005 and Dr Sreenivasa Babu Kothalanka was working in Saudi Arabia when a miraculous email popped up on his computer – the offer of a placement which would fulfil the dream he had harboured since high school to practise medicine in Australia.

Adelaide was his entry, Port Hedland was his preference and Babu's contribution since arriving has been immense. In 2011, he was accepted onto the Remote Vocational Training Scheme (RVTS) so he moved to Karratha to work at Nickol Bay Hospital where he also visits Roebourne and Onslow to meet RVTS requirements. Acknowledged throughout the region, his application for permanent residency had support at the highest level, including the local Member of Parliament (and National Party leader) Brendon Grylls; Labor Senator for Western Australia, The Honourable Glenn Sterle; the Mayor of Port Hedland; Rural Health West; and WA Country Health Service. Grateful to all, he particularly appreciates the active endorsement of the Yindjibarndi women of Roebourne.

On their behalf, the Chief Executive of the Juluwarlu and Yindjibarndi Aboriginal Corporation wrote that *Dr Babu has been treating members of Roebourne for a number of years now and his presence here is making a difference.*

*He is caring and compassionate and fits well with the Indigenous and non-Indigenous people of Roebourne and this region.*

Babu's experience represents the full embrace of Rural Health West.

*Rural Health West has been my strong supporter since I made my preferred move to Port Hedland. They organise weekend conferences, family-fun days, spouse programs, etc. Actually, they are the only organisation that looks after our families. Weekend conferences in Perth are a great time-out for most of us and we look forward to them. Rural Health West provide bursaries (small grants for spouse education/training) which is very encouraging. They greatly and persistently supported my repeated application for a general practitioner training position which eventually materialised. Then WA Country Health Service also supported me strongly for my training placement.*

For Babu, wife Gayatri and daughter Prem, these professional and family supports have comforted their transition in Australia and helped facilitate inclusion – not that the family needed encouragement.

They welcome others new to Port Hedland; volunteer for numerous community events, including turtle-watch; and Prem has been declared Best Budding Musician two years running at the Pilbara Music Festival.

In the words of the Mayor of Port Hedland, Kelly Howlett: *Their readiness to be involved in an array of activities locally resulted in a high level of regard by all that came to know them ...*

Recently, however, mother and daughter moved to Perth for Prem's high school education. Babu remains in the Pilbara.

*I particularly chose rural community practice for the joys of providing holistic medicine, delivering care from cradle to grave and building doctor-patient relations. In rural areas, patients are people with a myriad of problems while in cities they are interesting cases. I am there for the long haul without a finish date.*

*It is a particular joy to connect with the family/community in rural areas, while providing comprehensive care. I am most content, happy and productive while I am in remote areas. My patients appreciate it and express it in many ways.*



“ It was an unbelievable dream come true when I landed in Australia –  
I knew I could practise great patient-centred medicine here ... ”

**Dr Sreenivasa Babu Kothalanka – Karratha**

# A changing environment

The turn of the century continued the widening of WACRRM's focus.

Of particular significance were closer links to Indigenous health and the appointment of a liaison officer to foster partnerships and collaboration with key Aboriginal groups and people. Appropriate cultural training and ongoing mentoring was identified as important if the work of doctors in remote regions was to have maximum effect and acceptance.

WACRRM also took steps to safeguard the health of doctors and their families, starting the GPs for GPs program, which later became Care and Co. Initially, it was to counter the issues flowing from remoteness and social isolation for those considered most vulnerable; those living and working in the Kimberleys.

However, its worth was quickly noted and the program of counselling and medical treatment was rolled out to practitioners in other regions.

Also in 2000, the Western Australian ALLied Health Interested In Bush Experience (WAALHIIBE) student Rural Health Club was founded. As SPINRPHEX was to prospective doctors, nurses and dentists WAALHIIBE was to all allied health professionals.

Initiatives to persuade young country people to rural health careers were boosted the following year with the Rural Student Recruitment Program, specifically designed to increase the number of high school students entering medicine and dentistry.

Its success is reflected in the statistics: within two years it had quadrupled the number of rural-based students sitting the University Medical Admissions Test.

At the opposite end of the professional spectrum, another initiative, the Medical Specialist Outreach Assistance Program (MSOAP) was started in 2002 with the objectives of, firstly, assisting specialists to extend their outreach consulting and procedural services to patients and doctors in rural communities and, secondly, to deliver obstetrics and anaesthetics training and upskilling within major rural centres.

There was also change at the top of WACRRM.

Since formation, the organisation had been overseen by a representative advisory committee. However, an inaugural Board of Directors, chaired by Irwin Barrett-Lennard, was appointed in December 2002.

2000

WAALHIIBE student Rural Health Club established

Inaugural Aboriginal Health Conference held

2001

Rural health workforce data and information collection initiated

Rural Student Recruitment Program developed

2002

Overseas trained doctors comprise 40 per cent of all rural general practitioners

The following year, Dr Felicity Jefferies took up the position of Director when Greg Down decided to move on *after five and a half years of highly entrepreneurial and creative leadership*, as noted in the annual report. *During this time, WACRRM's influence, role, funding and the number of general practitioners in rural and remote Western Australia expanded remarkably.*

WACRRM was also looking inward. In 2003, an independent review canvassed how it would respond to the changed landscape it now inhabited.

*There are now many organisations competing for the government's funding support for rural doctors.*

*The growth in rural organisations has meant that WACRRM must recast its core business and develop other approaches to ensure a coordinated effort amongst the myriad of doctor organisations operating in Western Australia.*

The review saw a major opportunity in the area of research, with WACRRM able to capitalise on its statewide role and relationships. *The information and outcomes of this research would then inform governments, rural communities and rural workforce agencies on the models available to maintain and enhance access to medical services.*

The WACRRM database contained information drawn from all practising general practitioners in rural and remote areas and formed the statistical basis for the centre's workforce analysis and planning. Research was expanded to include data relating to locum services, overseas trained doctors and more.

In these testing times an old issue provided another challenge for the new Director.

The federal government had ordered a review of the Five Year Overseas Trained Doctors Scheme – without reference to, or the involvement of, WACRRM. Dr Jefferies lobbied her way onto the review to ensure that any changes would not be to the detriment of recruiting foreign doctors for rural and remote Western Australia.

In fact, among the changes were improved time concessions for doctors in the more isolated localities and funding to help overseas trained doctors achieve their Fellowship of The Royal Australian College of General Practitioners.

As Dr Jefferies reported in 2004: *These changes are important for rural and remote Western Australia as they ensure the scheme's continuing attractiveness given the new Commonwealth initiatives that allow overseas trained doctors to be placed in the outer metropolitan areas of Australia.*

465 medical practitioners in rural practice in Western Australia

Medical Specialist Outreach Assistance Program (MSOAP) launched

2003

Statewide planning strategy reveals deficit of 50-60 doctors

2004

True Blue Dreaming project launched

Medical practitioners in rural Western Australia exceed 500

2005

# A good community of people

Dr Felicity Jefferies has lived the WACRRM experience – from inside and out.

From being a junior doctor in Port Hedland Hospital's emergency department, where she attended more than 60 patients in one day following a cyclone, she has also experienced the more normal and satisfying routine of rural and remote general practice.

*It is really rewarding. A very holistic type of job where you deliver babies through to palliative care at the end of life. You have a really good relationship with your patient. When someone comes into your room you quite often know their grandparents or their nieces and nephews, you know what has happened in their family ...*

After 15 years as a general practitioner in Geraldton, she returned to Perth and took up a position as Assistant Director at WACRRM for five years, followed by five years as Director.

It was in the role as Director that Dr Jefferies led WACRRM through one of its most significant events – its separation from The University of Western Australia, allowing the organisation to *better represent the views and needs of rural doctors and provide a range of services to enhance the recruitment and retention of doctors into the country.*

*We did that in 2007 – took WACRRM outside the university as an independent organisation. That was probably the biggest change in my time as Director. From being a baby of the Department of General Practice – a little centre that was research orientated and state government supported initially – it was now getting a lot of money from the federal government and looking to be, more or less, a service provider.*

*We were doing a lot more things to support general practices as businesses. I could see that as a real need, to get some specific assistance to rural practices to recruit more doctors and be a more attractive career choice, allowing locum support, doctor support network, education grants, retention bonuses and ensuring easiest possible entry of overseas trained doctors into rural practice.*

*You couldn't practically do this as a part of the university, nor could you advocate on behalf of rural doctors without being fully independent.*

Along with Max Kamien as one of just two recipients of Rural Health West Life Membership, Dr Jefferies sees WACRRM's strongest role as influencers of health policy and practice, while maintaining the centre's involvement in the recruitment and retention of the rural medical workforce.

*I think WACRRM has made a significant difference ... people understand the trends of doctors and doctor issues and now at least understand what people need to make general practice work.*



‘

We had a good community of people – passionate; they wanted to make things work.

’

Dr Felicity Jefferies – Perth

# Independence and Rural Health West

WACRRM's course to independence was set in motion in 2005. As part of a restructuring of health service delivery to rural and remote Western Australians, the state's Health Minister, Jim McGinty, ordered a review of the centre's operations.

Not only did the review recommend severing formal ties with The University of Western Australia, but, having identified significant support for the centre during its consultation process – *there was a high degree of consensus that WACRRM provides valued (and well utilised) retention programs* – it urged a change in name to more appropriately reflect WACRRM's core function.

On 1 July 2007, the centre became Rural Health West, a not-for-profit company limited by guarantee, with a former state Health Minister, Ian Taylor, chairing a new Board of Directors.

But the newly-named organisation was quickly facing an old problem, as outlined by the Chairman: *There are major challenges ahead, in particular the introduction of a national assessment process for International Medical Graduates (IMGs) wishing to work in Australia. This process has considerable implications for existing arrangements and has the potential to reduce the number of applicants in the short to medium term.*

Elsewhere, headway continued to be made.

The focus on Indigenous health grew stronger. An Aboriginal Program Manager was appointed to bolster support for the Aboriginal Medical Services (AMS) and the AMS Buddy Program was established, encouraging metropolitan doctors to undertake short-term locums in AMS practices.

At the broad level, Rural Health West was contracted by WA Country Health Service to undertake a statewide doctor consultation process 'Engaging Rural Doctors' which would ultimately establish a wider reference group for state and federal governments on rural health matters.

There was also funding from the state health department to investigate the establishment of a Rural Generalist Pathway scheme, drawing together partnership arrangements among all medical education providers in Western Australia.

Felicity Jefferies is a strong advocate: *It basically gives doctors who are interested in rural practice opportunities to do their training out in the country. Not just their medical school training but their actual postgraduate training, their intern years ... if you train and work in the country, if you live there, you are more likely to stay there.*

2005

Health Minister, Jim McGinty, initiates a Ministerial Review of WACRRM

WA Country Health Service contracts WACRRM to undertake the 'Engaging Rural Doctors' study

Aboriginal Medical Service Locum Buddy Program launched

2006

2007

WACRRM formally becomes an independent public company



In 2008, the Rural Health West Doctors' Service Awards were introduced to acknowledge the enduring commitment and service many doctors had provided to their communities for more than 20 and 30 years.

Also that year, Dr Jefferies resigned to continue her career with WA Country Health Service and Nick Francis became Chief Executive Officer prior to Belinda Bailey taking up the position at the start of 2009.

Despite the Five Year Overseas Trained Doctors Scheme remaining in place, the scheme and its pathway to unrestricted practice in Australia, weighed heavily.

With foreign doctors continuing to make up approximately half of Western Australia's rural and remote medical workforce, any threat of change was significant.

Recruitment strategies were under continuous review and, in 2009, Rural Health West established its own dedicated recruitment team to focus on permanent and short term locum placements.

WACRRM contracted to investigate the establishment of a Rural Generalist Pathway

GP Obstetrics Pilot Project commenced

2008

Overseas trained doctors comprise 52.6 per cent of rural workforce in Western Australia

Rural Health West Doctors' Service Awards introduced

2009

Rural Health West establishes dedicated Recruitment Services and Workforce Development teams

2010

# A fulfilling and rewarding life

Dr Sarah Moore links the past to the present in rural and remote health care and helps to set its future. Phil Reid was her main Medical Co-ordinator when she attended The Rural Clinical School of Western Australia in Kalgoorlie.

*He inspired me to follow my passion to become a rural GP obstetrician.*

Now, balancing that work, her role as the mother of two young children, her position as Director of Postgraduate Medical Education at WA Country Health Service and as Associate Professor and Medical Co-ordinator of The Rural Clinical School of Western Australia based in Busselton, she is the inspiration for future rural health practitioners.

*The students that I have mentored in Busselton have really immersed themselves in the community and had a lot of fun, while making the most of their opportunities to gain clinical experience.*

*I have spoken to many medical students and junior doctors who are very keen to experience rural medicine and consider a career as a rural doctor. They all want clear rural training pathways, they want to feel supported by their colleagues and they want to be able to live where their family can also be a part of the community.*

*Although a lot has been done to develop the Rural Practice Pathway in Western Australia, there are still barriers to junior doctors training in the country. Professional isolation is a real barrier and if your partner can't get a fulfilling job in the same rural area, then most doctors will look elsewhere for a position.*

Aside from people, Dr Moore cites two issues as being significant to the development of rural health.

*Technology is playing a major role ... Telehealth, online professional development, social media, smart phone apps – they are all making it easier to access information and support in the bush, which is fantastic.*

*I think we are still battling to keep generalism alive and prevent sub-specialisation taking over but there are many positive moves by government and Colleges that I think will lead to more rural generalists being trained. Inter-professional practice is also growing and I think the more health professionals work together to support each other and our patients, the healthier rural communities will become.*





Dr Sarah Moore

# Leadership and influence

2010 brought significant change to the organisation's Strategic Plan. In strategy – and practice – Rural Health West was adapting to the evolving landscape as both federal and state governments pursued health reform agendas.

While maintaining core initiatives which had been at the heart of the organisation since its inception, Rural Health West stepped up its objectives in two key areas: Advocacy and Indigenous health.

The organisation's substantial commitment to Indigenous health was written into the strategy, acknowledging the particular primary health care needs of Aboriginal people. A specific focus was to increase locum support to Aboriginal Medical Services, while the annual Aboriginal Health Conference expanded its program scope and consequently, doubled the number of attendees.

In respect of advocacy, the new strategy formalised the mandate for alliances

and partnerships with other influential decision-making bodies. Data collection and analysis continued its growth path to include medical, nursing, midwifery, dentistry and allied health information.

2011 saw the first wilderness medicine course run in Karijini National Park in Western Australia's Pilbara region. Rural Health West, with a team of experienced emergency care physicians, upskilled 30 rural general practitioners on how to manage emergency scenarios in remote settings.

It was also the year that Rural Health West's forebodings about the vexed issue of the International Medical Graduate scheme were quantified.

The Chairman reported that in the three years prior to 2011, the foreign doctor market had essentially collapsed – in some years by as much as 80 per cent, forcing Rural Health West to intensify its international search activity for doctors willing to take up appointments in areas of need.

The following year also saw the organisation's recruitment arm widen its scope via funding from Health Workforce Australia. Tasked to place 40 health professionals, Rural Health West outperformed and placed 51 dentists, physiotherapists, nurses and other health professionals.

A key operational focus on attracting the future Australian trained medical workforce to rural and remote Western Australia saw the launch of '*Choose Country – discover the Rural Practice Pathway to a health career in country WA*'.

Business support for general practices also expanded. Demand was strong and, by way of example, about half of rural general practices requested a copy of the Rural Health West Practice Management Business Support Tool, the wide-ranging resource which guides practice staff through the maze of practical business and employment issues.

## 2010

Rural Health West invited to partner the Eastern Wheatbelt shires to develop sustainable models of health care delivery

Rural Medical Family Network becomes an independent body

GP Anaesthetics Mentoring and Support Program commences

## 2011

## 2012

Emeritus Professor Max Kamien awarded Life Membership

2012 continued at pace – operationally and strategically.

A specialist Telehealth support team was employed to accelerate the uptake of Telehealth among doctors. As noted in the annual report of that year, Telehealth had become *a key focus for rural and remote health practitioners*. It was also the year in which the Strategic Plan was revised, re-setting goals through to 2016 and defining Rural Health West's objective to be not 'a leader' but *the leader* in information and advocacy as well as in attracting and recruiting the rural and remote health workforce.

The organisation's Vision *to improve the health of rural, remote and Indigenous Western Australians* remained constant but there was a nod to the future.

In his last annual report, the retiring Chairman, Ian Taylor, said the current Strategic Plan *aims to provide a clear direction; consolidate growth; and ensure the focus remains on the provision of a high quality, sustainable health workforce*.

Mr Taylor was replaced as Chairman by another former Member of Parliament, Grant Woodhams, in August 2013.

It was a year of external change – a state election at the start, a federal election at the end – and internal consolidation. Rural Health West recruited more doctors in rural and remote areas than ever before, with 48 doctors placed.

The organisation continued its program leadership with an expanded orientation program providing foreign doctors with information and resources about the Australian health care system.

All new medical recruits were offered a tailored orientation program – bespoke and comprehensive support for rural health professionals unmatched by any other organisation in Western Australia.

The family support program was again reviewed. Rural Health West developed a new resource to sustain general practitioners and their families who may need to access personal or professional support services, as well as issuing more spouse financial bursaries than ever before.

Locum relief days also reached highest-ever levels – 2,475 days provided in the financial year.

A second wilderness medicine course – this time specific to coastal emergencies – was held at Gnaraloo on Western Australia's remote and rugged Gascoyne coast.

Ongoing, the Medical Specialist Outreach Assistance Program, branded as Outreach in the Outback in 2010, continued its dramatic expansion into a key business operation. Already rated as one of the most successful medical outreach services programs in Australia, its patient consultations increased to around 30,000 annually.

790 medical practitioners in rural practice in Western Australia

2013

Dr Felicity Jefferies awarded Life Membership

2014

Rural Health West celebrates 25 year anniversary

# Rural practice – myths and fallacies

Courtney Taylor was a natural selection to become a Rural Health West Student Ambassador – his father a country general practitioner and his mother a driving force in establishing the Rural Medical Family Network Program.

His formative years in close-knit rural communities imbued him with a positive outlook; he has observed the personal rewards and challenges of country practice. *Growing up in small towns a lot of people would know me through my dad and tell me how wonderful he was and how he had helped out in situations going beyond his call of duty.*

*There's a lot more variety in his medicine because you have to be a 'Jack of all trades' ... so it makes it more interesting. But there's the time commitment and everyone knowing you're the doctor makes it hard to get free from your medicine. I think I am growing up in a generation where we are finding a better work/life balance. This seems to be getting better from generation to generation.*

Courtney's medical training has also exposed him to the differing challenges that confront health care in the various rural and remote communities scattered across Western Australia. He applied and was accepted into The Rural Clinical School of Western Australia in Broome to give him insight to determine *if my heart was really set on country and Indigenous health or whether this was kind of a fantasy I didn't understand.*

At the moment he is unsure of his path of specialty but he sees rural and remote medicine working differently in different towns.

*The strength of what I saw in Broome was a real sharing of responsibility, a strong teamwork approach where both allied health and medical personnel were, in a sense, working in a sharing and holistic approach and innovatively bridging communication difficulties. Communication was probably the biggest strength they had; meeting almost daily to share information and seek out support for difficult cases. That doesn't work in the same way in Bunbury where I also spent some time – it is too large and they had much more of a specialist approach, a bit like the city ...*

Courtney acknowledges that country practice is not for all his fellow students but he does believe that its future can still involve them. While technology will continue to improve health outcomes for people in rural and remote Western Australia, his city-based colleagues can also provide service to the country. *I have begun to impress upon my fellow students that no matter what you want to do in medicine, whatever specialty, whatever pathway you want to go down, you don't have to be purely based in the country. There are opportunities to go out there and do occasional rotations or locums and visit all these places to help out with the skills you have.*

*I think that this would be a huge step in supporting people in country areas. They are tough but disadvantaged by a range of issues such as distance and working so hard that they don't come in to see the doctor. It is not that they don't want to come but they just don't have time and think their health is not as big a priority as the welfare of their families.*

*But, in spite of all of this, we do what we do because we care, because we are so fortunate ourselves and because the country is a beautiful place.*



‘

There are myths and fallacies about rural practice. Knowing what programs Rural Health West runs, and from living in the country, I can talk to students about it.

’

**Courtney Taylor – Medical Student, The University of Notre Dame Australia – Fremantle**

# 2014 and beyond

## Better health, stronger communities

Rural Health West is the only statewide health workforce organisation that has a focus on providing for, and strengthening the health of rural, remote and Indigenous Western Australian communities.

Meeting the future, we will innovate and adapt to achieve this – unequivocally supportive of general practitioners as the cornerstone of quality health care. Our primary goal remains the securing of high calibre general practitioners, nurses, midwives, dentists and allied health professionals essential for the level of health required by country communities.

Rural Health West's recruitment strategy targets present needs and future demands. It is a strategy without borders.

Experience informs our knowledge that rural students have a natural affinity for the country and we continue to focus on attracting them to careers in health. For international recruits, we are refining support with individual case-by-case management to meet their personal situations.

Other retention strategies to enable long-term, sustainable rural practices include increasing the quantity of locum services; increasing the opportunities for professional development, education and training; the greater facilitation of Australian Government incentive payments and programs; enhanced spouse and family support; and the expansion of services and resources to secure the financial viability needed for sustainable practices, particularly solo practices, through the Business Support Program.

While people remain our essential resource and focus, Telehealth is a key adjunct. Rural Health West is supportive of a statewide strategy for an independent Telehealth entity to deliver a single, harmonised collaboration model which will simplify and accelerate take-up by providers, organisations and clinical programs.

To fulfil Rural Health West's leadership objectives, advocacy holds equal priority to service delivery.

Our ability to influence official health policy and reform on behalf of rural and remote Western Australians and the professionals who provide care for them, is a direct outcome of the credibility established over the past 25 years.

In partnership with the state government, WA Country Health Service and the substantial number of other stakeholder organisations, we can reduce duplication and fragmentation of programs and services and enable shared workforce planning and goals.

Among these, we seek to facilitate the Rural Practice Pathway and training program with a focus on GP obstetrics, GP anaesthetics and surgery. Such a pathway ensures a skilled and capable workforce and lessens the tyranny of distance by reducing travel for low risk procedures and by allowing women to have their babies close to home.

Paramount to the future is Rural Health West's collaboration with the people of rural and remote Western Australia – community by community – and our leadership in promoting and delivering the primary health care they deserve.



## Our vision

*To improve the health of rural, remote and Indigenous Western Australians through innovative health workforce solutions*

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## **WACRRM Directors**

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Bill Jackson  
Felicity Jefferies  
Max Kamien (interim Director)  
Ray Power (Acting Director)  
Brian Williams

## **Rural Health West Chief Executive Officers**

Belinda Bailey  
Nick Francis  
Felicity Jefferies

Disclaimer: The above information has been compiled based on written reports Rural Health West was able to access. Omissions are not intentional.





CELEBRATING **25** YEARS  
CARING BEYOND HEALTH

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