Easy Entry, Gracious Exit Model for Provision of Medical Services in Small Rural and Remote Towns

Revised 2019

1. Background

1.1. The AMA believes that the best solution to the maldistribution of Australia's medical workforce lies in providing appropriate remuneration and conditions for permanent resident doctors in rural and remote areas, ensuring that appropriate infrastructure and supports are put in place,[1,2] in selecting more rural origin medical students and providing positive rural exposure to more medical students.[3] However, it acknowledges that the *Easy Entry, Gracious Exit* model is a useful temporary solution in circumstances where there is a chronic shortage (or total absence) of local medical professionals.

1.2. The *Easy Entry, Gracious Exit* model refers to a walk-in-walk-out approach, which aims to make general practice in rural areas more attractive by enabling rural GPs and rural generalists to work as clinicians without having to become small business owners and managers.[4,5] It also facilitates the retirement of rural GPs and Rural Generalists who may have no long-term replacement.

1.3. The model seeks to support both the desire of rural GPs and rural generalists to focus their work on clinical care (rather than practice management) and to reduce the need for any significant up front financial investment on their part. Reduced financial commitments for doctors allow more freedom for them to come and go as circumstances dictate. Domestic and surgery accommodation, and full infrastructure for the general practice is provided by a third party, as well as the option for visiting medical officer (VMO) rights and contracts to be negotiated on behalf of the doctor.

1.4. This recruitment model prioritises continuity of the practice or practice management structure over continuity of the doctor. The intention is that by removing barriers to recruitment it will be easier to attract doctors. The ideal outcome is that doctors remain in rural and remote towns due to their experiences of support, financial arrangements and the interesting medicine.[6]

1.5. This position statement outlines the AMA's key principles in support of the *Easy Entry, Gracious Exit* model to improve access to quality health care in small rural and remote towns that are experiencing chronic shortage of medical professionals. While new programs and initiatives to encourage more doctors to practise rurally have been introduced since the original version of this position statement was released, the significant barriers to private general practice in small rural or remote communities remain. Indeed, this model may facilitate the recruitment of rural generalists for communities.

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[1] AMA position statement *Regional/Rural Workforce Initiatives 2017* https://ama.com.au/position-statement/rural-workforce-initiatives-2017

[2] AMA *2019 Rural Health Issues Survey* https://ama.com.au/2019-ama-rural-health-issues-survey

[3] Playford, D, Ngo, H, Gupta, S and Puddey, I. (2017) Opting for rural practice: the influence of medical student origin, intention and immersion experience. MJA Vol. 207 (4). https://www.mja.com.au/journal/2017/207/4/opting-rural-practice-influence-medical-student-origin-intention-and-immersion

[4] NSW Rural Doctors Network (2003) Easy Entry, Gracious Exit http://www.nswrdn.com.au/client_images/246595.pdf

[5] Kamien, M. (2004) The viability of general practice in Australia. MJA Vol. 180(7).. https://www.mja.com.au/journal/2004/180/7/viability-general-practice-rural-australia

[6] NSW Rural Doctors Network (2003) Op. Cit.

2. Models of delivery

Three primary variations of the *Easy Entry, Gracious Exit* model have been used:

2.1. Local council supported

The local council is financially responsible for the practice. They provide all practice infrastructure and all staff, including GPs, are salaried employees of the Council. This model has been used in Wentworth Shire in South-West New South Wales.

2.2. Not-for-profit run

Practice management services are provided by a not-for-profit organisation in a flexible agreement with doctors. One such model is the Rural and Remote Medical Services Ltd (RaRMS), where GPs are provided with access to surgery facilities and equipment, IT equipment and services, accounting services, and employment of practice support staff. GPs determine their work arrangements, including fees.

Since its establishment by the New South Wales Rural Doctors Network (RDN) in 2001, RaRMS has expanded to provide services in 13 towns in New South Wales.[7]

Another example is Rural Health Management Services in Queensland. They run eight practices in rural Queensland and work with local governments and other health service providers.[8]

2.3. Government funded

The Remote Area Health Corps (RAHC) is an Australian Government funded organisation that has been successful in meeting the needs of remote Indigenous communities in the Northern Territory. The RAHC is designed to attract urban health professionals to work for a short period (3 to 12 weeks) in remote Indigenous communities in the Northern Territory where there is a need for a clinical service but there is no local health professional available.

RAHC provides support and training and covers transport costs to the location. The receiving health service provides accommodation and employs the health professional on a casual basis at the usual pay rate for the position. This means there are none of the additional costs associated with agency staff.

RAHC states that its model is an “alternative workforce for remote settings” that supplements local permanent staff.[9]

3. Benefits of the model

3.1. The *Easy Entry, Gracious Exit* model has been successful in recruiting GPs to towns where previously they have been unable to. Benefits to the community include:

- An increase in the number of doctors in participating towns.
- Retention of several doctors beyond originally stated departure dates.
- Viability of outreach services to outlying communities and more clinician time to participate in disease prevention and health promotion activities.
- The creation of a platform that can be used to provide a wider range of Primary Health Care services.
- Stability in the professional and clinical working environment, resulting in more productive, less stressed doctors.
- Continuity of practice infrastructure and practice management skills independent of continuity of the medical practitioner.

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[7] Rural and Remote Medical Services (2019) About RaRMS https://www.rarms.com.au/about-rarms
[8] Rural Health Management Services (2019) https://www.rhms.com.au/
[9] Remote Health Corps http://www.rahc.com.au/about-us

- Enhanced continuity of services and patient record management.
- Minimising the impact and incidence of crisis situations whereby doctors are available to cover emergent leave due to sickness or personal reasons.

3.2. The benefits to the medical practitioner are that the entity:
- Owns the practice infrastructure, employs all staff, is responsible for all administration requirements and supplying IT support and other services as required from time to time.
- Enters into all leases for housing and practices (or can broker such leases).
- Negotiates with Councils and various regional health service organisations.
- Manages any VMO agreements that may be necessary.
- Removes the significant financial risk, including provision of operating capital (although the key financial risk to the GP remains medical liability).

4. Key concerns

4.1. Research suggests private practice in remote Australia is not sustainable under the traditional small business model.[10] For example, in New South Wales general practice in the past has been subsidised by regularly indexed payments (in line with the Rural Doctors Association Settlement Package) from Area Health Services to doctors for VMO services. The doctor, and sometimes the doctor's spouse, perform unpaid administrative services after hours. This creates a secondary problem that when the doctor leaves town, the practice company structure and practice management is also lost.

4.2. Rural and remote areas are typified by a shortage of people with practice management, management, IT, nursing and financial skills relevant to running a medical practice. Because of remoteness there is limited opportunity to share human resources, and this problem is compounded by the increasing complexity of practice and small business management.

4.3. More importantly, without some form of subsidy, income generated through bulk billing does not sustain quality general practice and its administration. There is evidence to suggest that the *Easy Entry, Gracious Exit* model is best suited to towns with larger populations, where there is adequate opportunity to establish a discrete general practice and provide VMO services. Smaller rural and remote areas or catchment populations may be better suited to an outreach, fly-in fly-out or satellite/hub-and-spoke model of service delivery.

4.4. The model can also place undue financial burden and risk on small Councils or Not-for-profit organisations to address an issue which is traditionally a Commonwealth and State/Territory responsibility. In fact, it should be an imperative for Commonwealth and State/Territory Governments to provide assistance as required to entities assuming this responsibility in rural and remote areas, to enable holistic and quality primary care services in order to improve health outcomes for rural communities.

5. AMA Key Principles

5.1. The AMA supports the *Easy Entry, Gracious Exit* model to improve access to quality health care for people in rural towns experiencing chronic shortage of doctors with the following key principles:

a) The financial burden of supporting a practice operating under the *Easy Entry, Gracious Exit* model should not be the sole responsibility of local governments. Federal and State/Territory funding should be made available to support communities to attract and retain rural GPs and rural generalists.

b) The arrangement must ensure continuity and support holistic patient care.

[10] NSW Rural Doctors Network (2003), Op. Cit.

c) The doctors should maintain complete independence in clinical decision-making.

d) The entity set up must be cost effective to ensure the sustainability and financial stability of the service/model of care promoted.

e) Practices should be accredited to RACGP standards, except where they are very remote and small in order to meet the required activity levels for accreditation in their own right or where the infrastructure is suboptimal and will require considerable expense.

f) The entity set up should not be in competition with a local practice (if there is one) and that local doctors (if any) should not be disadvantaged in terms of remuneration.

g) In order to ensure that services match the needs of the community, planning should involve the local community and all relevant stakeholders and strong linkages should be established and maintained with local government, relevant doctor organisations, allied health, the local hospital and Area Health Network, neighbouring towns and relevant Aboriginal health services.

h) The practice must remain responsive to the changing needs of the community and encourage rural capacity building.

i) The full infrastructure must be provided by the entity rather than by the doctor including:
   - Practice facility.
   - Staff, including where possible a practice manager and nurse.
   - Consumables, medical equipment and medical records systems as outlined in the RACGP standards for general practice.
   - IT and broadband internet access enabling the performing of telehealth services.
   - Utilities.
   - Continuity and security of medical records as doctors change.

5.2. In addition, entities adopting the *Easy entry, gracious exit* model should be supported by rural workforce agencies and primary health networks under following principles:

j) Doctors must have access to appropriate training, skills, experience and cultural preparedness to work in rural and remote areas.

k) Doctors who work at the practice must be supported if they choose to provide education and training to medical students and doctors in training.

l) The arrangement should provide a realistic and sustainable work-life balance and working conditions, including ability to readily access leave for recreation or professional development with certainty of backfill or locum relief, so that there is no interruption of service to the community.

See also:
AMA/RDAA Rural Rescue Package
AMA Position Statement: Rural Workforce Incentives 2017
AMA Position Statement: Fostering Generalism in the Medical Workforce 2019
AMA Position Statement: Medical Workforce and Training 2019