Implementing the Primary Health Care Strategy in Rural New Zealand

A report from the Rural Expert Advisory Group to the Ministry of Health

2002
Foreword

One in four New Zealanders live in rural areas or small towns. Accessible and appropriate services for people living in rural areas is one of five service delivery areas identified in the New Zealand Health Strategy, on which the health sector is to concentrate in the short to medium term. Further, the Primary Health Care Strategy indicated the need to develop a coherent approach to rural health service provision, including the difficult issues of retaining and attracting the appropriate workforce.

In 2001 the Ministry set up a Rural Expert Advisory Group to advise on actions needed to successfully implement the Primary Health Care Strategy in rural New Zealand. Implementing the Primary Health Care Strategy in Rural New Zealand is the culmination of advice to the Ministry from this Group.

I would like to thank the Rural Expert Advisory Group for their hard work and dedication in producing such a comprehensive document. Implementing the recommendations in the report will involve a commitment from the Ministry of Health, District Health Boards, Primary Health Organisations and the rural sector to work together. This emphasis is essential to create sustainable primary health care services in rural New Zealand, and these services are key to the health of rural people.

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Director-General of Health
Acknowledgement

The Rural Expert Advisory Group would like to thank Martin London, who, in collaboration with the directors of rural health, drafted the initial implementation plan.
Treaty of Waitangi Principles

Overarching principles of this document

As a Treaty partner, the Government recognises the special relationship between iwi and the Crown, and appreciates that the principles of the Treaty of Waitangi – partnership, participation and protection – must underpin implementation of the Primary Health Care Strategy in rural New Zealand.

Partnership

Working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.

Participation

Involving Māori at all levels of the sector in planning, development and delivery of health and disability services

Protection

Ensuring Māori enjoy at least the same level of health as non-Māori and safeguarding Māori cultural concepts, values and practices.

Emphasising whānau health and wellbeing

He Korowai Oranga (the Māori Health Strategy) recognises that Māori whānau and communities want improved health status, reduced health inequalities and increased control over the direction and shape of their own institutions, communities and development as a people. He Korowai Oranga therefore emphasises whānau health and wellbeing as its overall aim. Whānau health will be achieved through:

- building on the strengths of whānau to achieve whānau ora (health and wellbeing)
- reducing inequalities in Māori health status in priority areas.
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Executive Summary

The Primary Health Care Strategy identified that rural health problems, including retaining an appropriate workforce, need special attention. This plan highlights ways to help create an effective and vibrant rural primary health care sector which can successfully implement the Primary Health Care Strategy.

The ultimate goal of this plan is to achieve accessible and appropriate primary health care services for people living in rural New Zealand. This goal will be achieved through attention to the following three aims:

1. to create a context for realising opportunities and supporting locally devised solutions to issues in primary health care

2. to ensure equitable and effective access to an appropriate range of quality primary health care services, which are delivered within the rural community or within acceptable travel times

3. to develop, maintain and recruit a skilled, multidisciplinary rural workforce that works in partnership (that is, in a co-operative, co-ordinated and collaborative manner).

The main vehicle for implementing the Primary Health Care Strategy and achieving the aims of this plan in rural areas will be Primary Health Organisations (PHOs), which are not-for-profit organisations of providers. Rural areas are likely to be early leaders in the development of PHOs, and District Health Boards (DHBs) will work with organisations such as rural trusts, Māori provider organisations, independent practitioners associations and their communities to find the best way locally to set up PHOs. Many of the recommended actions of this plan are therefore directed at PHOs because, given the diversity of rural communities, they are best placed to come up with locally devised solutions.

We are aware, however, that PHOs need resources to assist with this process, and hence one of our key recommendations is the development of a rural primary health care premium directed to PHOs that encompass rural communities. This would be aimed at providing a flexible resource to support the rural primary health care team, retain the rural workforce and therefore ensure sustainable, accessible and appropriate primary health care services for rural communities.
Introduction

The Primary Health Care Strategy identified that rural New Zealand faces extra challenges in the provision of sustainable primary health care services, and that rural problems need special consideration. This plan highlights issues that need to be addressed, and recommends actions to help create an effective and vibrant rural primary health sector that can successfully implement the Primary Health Care Strategy.

The Primary Health Care Strategy

The underlying vision of the Primary Health Care Strategy to be achieved over the next five to 10 years is that:

People will be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care.

Primary health care services will focus on better health for a population, and work to reduce health inequalities between different groups. (Ministry of Health, 2001)

The six key directions of the Primary Health Care Strategy are to:

- work with local communities and enrolled populations
- identify and remove health inequalities
- offer access to comprehensive services to improve, maintain and restore people’s health
- co-ordinate care across service areas
- develop the primary health care workforce
- continuously improve quality, using good information.
The goal and aims of this plan

The ultimate goal of this plan is to achieve accessible and appropriate primary health care services for people living in rural New Zealand.

This goal will be achieved through attention to the following three aims:

1. to create a context for realising opportunities and supporting locally devised solutions to issues in primary health care
2. to ensure equitable and effective access to an appropriate range of quality primary health care services, which are delivered within the rural community or within acceptable travel times
3. to develop, maintain and recruit a skilled, multidisciplinary rural workforce that works in partnership (that is, in a co-operative, co-ordinated and collaborative manner).

These three aims are interdependent. The changes in the context of service delivery signalled in the Primary Health Care Strategy support the achievement of Aims 2 and 3. Appropriate services require an effective workforce for their delivery, so the achievement of Aim 2 is reliant on the successful achievement of Aim 3.

This document is structured around the above three aims.

Focus of this plan

Accessible and appropriate services for people living in rural areas is one of five service delivery areas on which the Government wishes the health sector to concentrate in the short to medium term (see The New Zealand Health Strategy, Minister of Health, 2000). The focus of this plan is squarely on rural primary health care services – it is not a comprehensive plan for all rural health services. While recognising the interrelationship between the primary and secondary services, and the need for primary health care workers in rural areas to have good access to specialist advice and back-up, this plan focuses solely on primary health care services. Nor does the plan deal with public health or disability support services. However, it is implicitly understood that these services may be part of a locally based, integrated service.
Within primary health care services the focus of this plan is mainly on those services directed towards improving and maintaining the health of the population, and the first-line services to restore people’s health when they are unwell; that is, the set of essential primary health care services, usually provided by doctors, nurses and community health workers, which PHOs will be expected to provide to their enrolled populations. In rural settings we acknowledge that all locally delivered services tend to be interdependent, so PHOs that encompass rural areas may include a much wider range of services at the outset, including those provided by rural hospitals.

We are well aware that there are important issues to resolve in the areas of rural hospitals, maternity services, mental health services, and ambulance services in order to ensure their viability in rural areas. We have identified these as areas for recommending further work, rather than making specific recommendations.

**Defining ‘rural’**

There is no one definition of ‘rural’ that applies to all situations. In this document two main definitions are used, based on:

- Statistics New Zealand definitions
- shared roster areas.

The health status information included in Appendix 2 refers to Statistics New Zealand definitions of rural areas and minor urban areas of less than 10,000 people.

Dr Martin London, Director, Centre for Rural Health, has defined ‘shared roster areas’ as geographical areas covered by rural GPs sharing an on-call roster. A map showing these shared roster areas is provided in Appendix 3. Rural GPs are defined as those scoring 35 or more points on the rural ranking scale, which was developed as a means of redistributing the rural bonus to GPs according to degrees of ‘rurality’. The scale allows an estimation of rurality based on the following criteria:

- distance from main urban centres
- medical on-call rosters
- availability of practitioners to attend medical and trauma emergencies
- distance from colleagues
- the size of the territory being covered by medical practices
- the servicing of peripheral clinics.
1  Context

Aim 1: To create a context for realising opportunities and supporting locally devised solutions to issues in rural primary health care.

1.1  Creating the context: Primary Health Organisations in rural areas

The implementation of the Primary Health Care Strategy provides the opportunity to build on the successful initiatives and gains of the past, while creating a new context to improve the effectiveness and sustainability of rural primary health care services.

The main vehicle for realising the aims of the Strategy will be PHOs. These will be not-for-profit organisations of providers funded by DHBs to provide services for their enrolled population.

Rural areas are likely to be early leaders in the development of PHOs. Many rural communities have already established health committees or trusts to address the local health service issues, and these may be the obvious forerunners of PHOs. Typically, they could meet the requirements of the strategy for local governance and a non-profit entity. Equally, independent practitioner associations and Māori provider organisations encompassing rural areas may be well positioned to form PHOs. DHBs will work with organisations such as these, as well as rural trusts and their communities, to find the best way locally to set up PHOs.

Factors to consider when setting up a PHO that encompasses a rural area are:

- the need to encourage rural providers and rural enrolled members to be included in its governance
- economy of scale issues – in some cases rural communities, even with their surrounding hinterlands, still only amount to populations of a few thousand people and running a PHO may not make sense. In these cases, several local communities may join forces to form a PHO but structure the organisation so as to retain a voice for each of their constituencies. It may also have arrangements with organisations external to the PHO to provide essential infrastructural support
- the range of services – in some rural areas the range of service providers encompassed within the PHO may not be limited to primary health care services (for example, they may include services provided by the rural hospital, which includes continuing care services).
PHOs that encompass rural areas are an ideal vehicle for achieving collaboration among service providers, for example, by:

- promoting the sharing of out-of-hours rosters among groups of practices in close proximity
- supporting the expanded roles of nurses
- fostering collaborative relationships among Māori and non-Māori providers
- reducing duplication of service delivery and infrastructure costs.

PHOs will be free to use various methods for paying individual practitioners or providers, including, for example, capitation payments, fee for service, and salaries. PHOs serving rural communities will have the opportunity to examine the way they pay practitioners and providers to determine the best way for their community to maintain access to sustainable primary health care services and retain the rural primary health care workforce. Whichever model of provider payment is applied, we would like to see all competition minimised and collaboration encouraged, so that members of the primary health care team are enabled to work within their extended capabilities.

### 1.2 Funding primary health care services in rural areas

A nationally consistent needs-based formula for primary health care will be used to allocate the core funding for PHOs. The funding will reflect characteristics of the enrolled population that determine their need for primary health care services. The formula will cover the minimum essential services, and DHBs may choose to enter other arrangements for other services.

We consider it important that a rural primary health care premium also be paid to PHOs in recognition of the particular needs of rural communities for sustainable services. This includes the additional costs of providing primary health care to rural populations characterised by scarcity, and the need for workforce retention incentives and support. The rural primary health care premium needs to recognise degrees of rurality.

The PHO will need to carefully prioritise in order to determine the best use of the premium. We consider that the highest priority should be given to workforce retention strategies, including support to enable reasonable on-call rosters. The premium could be applied to primary health care workforce support, such as access to continuing professional education, or, alternatively, to additional out-reach services to improve access to primary health care services. The premium could also assist towards the additional travel costs to enable rural community involvement in PHOs.
The advantages of channelling additional resources for rural primary health care through PHOs include:

- providing a flexible resource to support locally devised solutions that address local problems and make the most of local opportunities
- supporting the primary health care team, rather than individual practitioners or a single professional group
- encouraging the widespread development of PHOs to give impetus to the implementation of the Primary Health Care Strategy and ensure rural communities benefit from the health gains it offers.

**Transitional arrangements**

A rural bonus is paid directly to rural GPs according to an agreed rural ranking scale (see Appendix 4 for more details). The rural bonus needs to be reviewed to determine its future in the light of the development of PHOs and the proposed introduction of a rural primary health care premium. We recommend that payment of the rural bonus for GPs who belong to PHOs be channelled through PHOs. We consider that GPs who choose to remain independent from a PHO should continue to receive the rural bonus. Any review process should be done in consultation with key stakeholders.

We propose that transitional funding also be provided to DHBs while PHOs are being developed, to support rural practices where there is a serious risk of a rural community being without essential primary health care services.

**1.3 Creating the context regionally: the role of DHBs**

DHBs have a key role in ensuring accessible, appropriate and sustainable primary health care services for rural communities within their region by their approval, funding and monitoring of PHOs. They will also continue to be directly responsible for ensuring service provision in rural communities that are slow to become part of PHOs.
1.4 Creating the context nationally

Limited role for national initiatives

While we believe that, in general, solutions should be developed at the local level, there is a limited role for national initiatives where efficiency reasons apply. Examples are:

- nationally organised recruitment programmes, including marketing (for both short-term and long-term professionals)
- promotion of practising in rural areas as a positive career choice, and incentives to recent graduates to take up rural practice
- funding postgraduate training programmes.

Information/research on rural health issues

New Zealand has only recently begun to systematically gather information on rural health issues. The Centre for Rural Health has undertaken medical and nursing workforce surveys, and work on models of rural nursing and team work. Other areas in which we would like to see further information obtained and research undertaken include:

- service delivery issues for rural Māori and rural communities that comprise Māori and non-Māori populations
- workforce issues of the wider primary health care team
- scopes of practice and competencies of the rural primary health care workforce
- the use of geographical information systems to assist with rural health needs assessment.

Rural index

Australia and some other countries have developed a ‘rural index’ to define communities according to degrees of ‘remoteness’. The Ministry of Health should explore the development of a New Zealand rural index that is applicable to rural primary health care, in collaboration with key stakeholders. This could be used to:

- identify localities where there are geographical access issues
- assess the health status of rural and remote areas
- assess the degree of remoteness of the communities served by individual PHOs (this may, in the future, be used as a basis for allocating the rural primary health care premium to PHOs)
• assess access to continuing education for the primary health care workforce
• identify localities where there are difficulties with workforce recruitment.

Role of the directors of rural health

The role of the directors of rural health needs to be clarified to take account of responsibilities of DHBs and the future establishment of PHOs, and they should be supported to undertake that role. Consideration also needs to be given to a director of rural health (nursing) in the South Island (as currently exists in the North Island) in recognition of the expanded role rural nurses are expected to play in the future.

Stronger rural focus within the Ministry of Health

There is a need for a stronger rural focus and influence within the Ministry. This could be achieved by developing a strong rural team under senior-level leadership within the Ministry to deal with all rural health issues.

Monitoring of DHBs

The Ministry has an important role in monitoring DHBs, on behalf of the Government, against their district plans and the service coverage schedule concerning DHB performance in achieving accessible and appropriate services for people living in rural areas.

Rural adjuster for DHBs

Currently DHBs receive funding based on existing contracts with providers. This includes a range of adjustments for both rurality and diseconomies of scale. When the population-based funding formula takes effect for DHBs, care will need to be taken to ensure that the rural adjuster is an accurate reflection of the costs of providing services to rural communities. For example, the costs of publicly funded rural hospital services not provided directly by DHBs need to be included within the rural adjuster.

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1 The Government has agreed that there will be an adjustment in the population-based funding formula for DHBs for the unavoidable differences in costs that DHBs face in providing or funding some community services to rural communities, and for the diseconomies of scale involved in maintaining a reasonable level of access to hospital services in rural communities. The Government has decided that this rural adjustment will be based on the actual extra costs incurred by DHBs in providing these services. The interim population-based funding formula uses the current adjustments for rurality and diseconomies in contracts as a proxy for the actual extra costs incurred by DHBs. The earliest that the population-based funding formula with a rural adjuster will be applied to DHBs is from the 2003/04 financial year.
1.5 Recommended actions

The Ministry of Health is asked to:

1.1 develop a primary health care premium to provide extra financial support to PHOs encompassing rural areas, to allow them to flexibly develop local solutions for local needs to ensure sustainable services and retention of the rural workforce

1.2 provide assistance and advice to PHOs encompassing rural areas to enrol their population

1.3 provide transitional funding to DHBs while PHOs are being developed to support rural practices where there is serious risk of services to communities being disrupted

1.4 develop national rural initiatives when there are clear efficiency reasons for undertaking them at national level (for example, recruitment and funding postgraduate training programmes)

1.5 continue to fund the provision of practical rural health information/research to inform policy and service development, including that relevant to rural Māori

1.6 develop a rural index enabling rural and remote areas of New Zealand to be defined consistently, enabling consistent definitions of health status, which may be used in the future to allocate the rural primary health care premium to PHOs

1.7 more clearly define the role of the directors of rural health and support them to carry out that role

1.8 establish a director of rural health (nursing) in the South Island as exists in the North Island (while ensuring that the South and North Island directorships are equitably funded)

1.9 develop a strong rural team under senior-level leadership within the Ministry to deal with all rural health issues

1.10 develop rural-specific performance indicators as part of the funding agreement with DHBs

1.11 undertake further work on the rural adjuster so that it is distributed in an equitable manner.
District Health Boards are asked to:

1.12 consider the need to balance economy-of-scale issues and retaining a rural voice when approving PHOs that encompass rural areas

1.13 empower PHOs that encompass rural communities to apply local solutions to local needs

1.14 provide needs assessment information to PHOs to assist with rural-specific needs identification and prioritisation

1.15 collaborate with local authorities around long-term community planning and needs assessment

1.16 ensure that service agreements with PHOs include the Treaty of Waitangi principles – partnership, participation and protection.

Primary Health Organisations are asked to:

1.17 encourage rural communities to participate in local service planning and governance of the PHO

1.18 ensure that the governance structures of the PHO incorporate the principles of the Treaty of Waitangi – partnership, participation and protection.
2 Access to Services

Aim 2: To ensure equitable and effective access to an appropriate range of quality primary health care services which are delivered within the rural community or within acceptable travel times.

2.1 Access issues

Rural areas can have access problems related to the:

- physical accessibility of a service
- availability of a sustainable service
- affordability of a service
- appropriateness of a service.

Rural New Zealand has features that influence what health services are needed and how they are delivered, including the following.

- Large distances and obstructive geographical features affect the ease of access to health services.
- Small, isolated populations suffer diseconomies of scale when planning and paying for local health services, and are subject to the loss of other social infrastructure associated with the gradual depopulation of rural areas.
- High levels of deprivation (which is closely associated with poor health status) are a feature of some rural regions and some rural communities in otherwise more affluent regions (see Appendix 5). The extra travel costs that rural people incur make access to primary health care services particularly difficult for the people of these communities.
- In rural areas and towns with less than 10,000 people, on average one in five people are Māori. Some regions of rural New Zealand have a high concentration of Māori; for example, in the far north and east coast of the North Island (Appendix 6). These areas experience health problems associated with ethnicity and/or socioeconomic status, and have both challenges and opportunities for the organisation and delivery of culturally appropriate health services.
Rural areas are often tourist destinations, which has both positive and negative social impacts on their residents and the health services. The seasonal fluctuations in population numbers create workforce problems and difficulties when organising and funding health services on a population basis.

The above features vary in degree and are usually present in combinations in different areas.

### 2.2 Improving and maintaining access

Large distances and obstructive geographical features affect the ease of access to local health services and to referral services in the larger towns and cities. Many rural households have to travel on unsealed roads to reach the nearest town in which primary health care services are available. Severe weather conditions can also affect access to services.

**Access to transport**

In rural areas where there are high levels of deprivation, some families have no or poorly maintained vehicles to provide transport to a health service. Eight percent of Māori in rural areas, including minor urban areas, do not have a motor vehicle available to them (see Appendix 7), and public transport is usually sparse or not available in rural areas. The Rural Health Survey (Rural Women New Zealand 2001) found that 79 percent of rural households do not have access to public transport. DHBs and PHOs could encourage the transport sector to improve public transport services in their rural communities to improve access to health and other services. However, even if public transport were available, some may find it hard to afford.

**Mobile services and out-reach clinics**

Even though some primary health care services currently provide mobile services or out-reach clinics, it is mostly the patient who is required to travel to access a service. PHOs should be encouraged to consider ways of taking services out into the community/marae, or of mobilising the community to support initiatives, such as volunteer drivers. It is recognised, however, that there are increased costs in providing mobile services (that is, time spent travelling by staff, running costs and increased wear and tear on vehicles).

Providing services/programmes in a diverse range of sites has the added benefit of the consumer not only accessing the service, but remaining engaged. For example, Māori whānau enrolled in well child services provided by Māori groups (which home visit for all checks) are more likely to remain engaged with the service, and immunisation services provided in the home have achieved high immunisation rates (Crengle 1999).
**Telephone access**

Linked to the issue of physical access is the need for telephone access. The first link between patients and providers is most often by phone. Areas of deprivation are characterised by the difficulty families have in affording telephone landlines and by poor or absent cell-phone coverage. Eighteen percent of Māori living in rural areas, including minor urban areas, do not have a telephone (see Appendix 7). The Rural Health Survey found that 32 percent of the respondents could be without a means of communications at any one time (Rural Women New Zealand 2001).

For routine care, this obstructs the making of appointments and prevents health teams from contacting patients with important information or performing follow-up services. In emergency situations, lack of a phone or phone lines delays access to help. Training members of isolated communities in emergency first aid is one solution. Access to Healthline services – a pilot, free, 24-hour telephone triage and health advice line (outlined in Appendix 4) relies on users having access to a telephone. However, telephone triage services are potential ways of improving access of rural people to health advice, as well as reducing out-of-hours visits for both patients and practitioners.

A further issue associated with telecommunications in some rural areas is that free local calling areas are smaller than free local areas in urban areas, so it may be a toll call to make an appointment at a primary care provider.

DHBs will be expected to agree service coverage or access agreements with PHOs. We recommend that DHBs work with PHOs so that for 95 percent of the population they provide primary medical services and/or nursing services with pre-arranged medical back-up:

- for part of the normal business day within 30 minutes’ travel time
- for after hours within 60 minutes’ travel time.

Justification should be provided for shared-practice areas that do not meet this guideline (this guideline does not include emergency services).

### 2.3 Ensuring availability of services

Confidence in service availability and continuity of care are important to rural communities. A stable workforce is necessary to maintain continuity of services. Sufficient numbers of primary health care workers are needed to cater for population needs and to provide sustainable cover for out-of-hours urgent health care. The next chapter specifically covers the rural workforce issues.
2.4 Recognising affordability issues

A number of rural areas have high levels of deprivation, and these tend to coincide with areas with higher proportions of Māori (see Appendices 5 and 6). Further, the health status of rural Māori is relatively lower than that of urban Māori and rural non-Māori (Ministry of Health 1999). There is evidence that co-payments for health services impact more on those who are poorer and sicker – that is, those with the greatest health need who experience the worst health status. Research has shown that Māori do not utilise GP services at rates consistent with their level of need in the community (Crengle 1999).

Accessing affordable primary health care services is an issue for all low-income people, whether urban or rural. However, the costs are more onerous in rural areas when other factors such as transport are taken into consideration. Also, the time taken to access health care can cause people to be away from their economic activity for several hours at a time, which is another cost in accessing care. The Rural Health Survey found that the biggest obstacles for rural households accessing health care from a GP or pharmacy were cost (63 percent) and distance (19 percent). The cost of GP visits was a matter considered by a review of the Community Services Card undertaken by the Ministry of Health.

It is expected that PHOs will be funded using a formula that recognises both ethnicity and deprivation. Thus PHOs, particularly those serving communities of high deprivation, should be encouraged to develop local solutions to overcome access issues (for example, providing mobile services).

2.5 Improving appropriateness of primary health care

The skill mix of the primary health care team needs to be aligned to the needs of the population it serves. The quality of primary health care services should not be compromised just because they are delivered in a rural setting. Education of the health workforce has advanced over the past decade to address the skill mix of rural health teams. Further development in this area will continue to increase access to appropriate services.

The delivery of appropriate services encompasses the cultural competency of the primary health care team as well as their clinical competency. Cultural competency should have special regard to Māori, and may involve, for example, the primary health care team having an understanding of the Māori model of health.

With the development of Māori providers, the availability of culturally appropriate services has increased. Māori providers have illustrated how the employment of non-Māori staff does not appear to cause difficulties as Māori governance of organisations ensures that Māori kaupapa and tikanga are integral to the daily practice of staff (Crengle 1999).
Some women in rural areas have a limited choice regarding access of services from a female doctor. According to a Royal New Zealand College of General Practitioners survey, only 93 (28 percent) of rural doctors were female, and 33 percent of these work half-time or less, compared to 10 percent of male doctors (Elley, 2001). The expanding role of rural nurses (many of whom are women) may play a part in overcoming this access problem. Further, providing better facilities for child care, flexibility with after-hours commitments and better access to locums may encourage more female doctors to work in rural areas.

2.6 Accessing other essential primary health care services

Ambulance services

Ambulance services in rural areas are part of a wider regional centre response service operating through the emergency 111 telephone call system at regional control rooms for the ambulance service provider. Currently there are eight regional control centres, but this number is being reduced to three as the system is upgraded and rationalised. These control centres are responsible for co-ordinating specialist emergency services at base hospital, road and air ambulance response and, in rural areas, local GPs through PRIME (see Appendix 4).

Historically, the ambulance services in rural areas have relied on volunteers to maintain services. The pool of available volunteers is diminishing for a number of reasons, including:

- employers becoming increasingly reluctant to release volunteers for emergency duties
- self-employed people no longer able to make themselves available because of work commitments
- the high standard of training required to meet safety/quality requirements demanded of the system
- difficulties in gaining enough exposure to first-response treatment to maintain skills and confidence.

Highly trained paramedics are normally concentrated in urban areas in order to retain their confidence and skills, often through attachment to emergency departments in base hospitals. Ways of addressing this issue, such as paying trained people to undertake these duties on a part-time basis, involve additional expenditure, but further progress could be made by closer communication and co-operation between the principal ambulance provider and local communities supporting volunteers.
Pharmacies

Access to dispensed and over-the-counter pharmaceuticals and pharmaceutical advice for rural people is important. The financial viability of rural community pharmacies can be marginal in localities with small populations. Nationally consistent pharmacy contracts include consideration of the additional cost of rural dispensing services. Specific access issues for remote and high-need areas are being considered by the Ministry and DHBs.

A further means of enabling access to pharmaceuticals in remote areas is the extended Medical Practitioner Supply Order list, which allows GPs in designated areas to provide a wider range of drugs than the standard physician’s emergency supply. However, GPs advise that they incur part charges on their Medical Practitioner Supply Order, which they cannot recover through charging patients. Some rural areas are already served by having medicines delivered to depots with telephone links to a base pharmacist.

Access to mental health services

Both international and New Zealand research suggests that around one in four people who present in general practice have a mental health disorder. There is some evidence to suggest that rural communities with geographical, professional and social isolation have high levels of alcoholism, marriage breakdown and depression. Addressing mental health issues in the rural context can help to stop the migration of people with mental illness away from their community and family supports to the city services (Mahmood et al 2001).

There is also evidence to suggest that New Zealand has difficulty in providing high-quality mental health services in rural and remote areas, and that rural psychiatric services suffer from the chronic shortage of psychiatrists throughout New Zealand. Rural communities are in as much need of specialist mental health services as urban populations. A study of Otago urban and rural GPs concerning mental health services identified that rural GPs considered they had limited time for consultations with people with mental health problems, and experienced poor liaison with psychiatric services. Rural GPs indicated they would like additional education for psychiatric conditions and better access to secondary specialist support and advice (Mahmood et al 2001).

A number of psychiatrists and rural health services have been actively involved in developing innovative models for delivery of specialist psychiatric services in the South Island of New Zealand. Central Otago utilises a three-tier model to address rural mental health services – the community mental health team, visiting specialist clinics, and tele-psychiatry clinics.
The development and expansion of primary health care models that integrate mental health service provision in a way that is effective for rural areas will require:

- recognition by funders that psychiatric consultation takes longer than the average GP consultation
- opportunities for rural primary health care workers, including nurses, to increase their knowledge and skills to provide psychiatric care to rural patients, particularly those people with mild to moderate mental illness
- better access to secondary specialist support and advice (Mahmood et al 2001).

**Rural hospitals and rural health centres**

Small rural hospitals containing hospital beds for continuing care, convalescence, medical observation and maternity services are a feature of some rural areas. However, consideration needs to be given to their role and service configuration in the context of ensuring equitable and effective access to an appropriate range of health services for rural New Zealanders, including older people. For example, consideration should be given to more flexible accommodation options for providing convalescence and/or oversight services for rural people whose homes are distant from the health services.

In some more populated areas, rural hospitals may employ a resident medical officer to complement the services of local GPs, and this presents an ideal training environment for rural GPs. There needs to be specific training and a career pathway for rural hospital generalist nurses and doctors.

In some rural areas older facilities have been replaced by purpose-built rural health centres providing an integrated range of services, including primary and community health services. Having a single site for all locally delivered health services will break down many of the boundaries between health professionals, and assist in reorganising services around the needs of patients. This streamlining of care between general practice, specialist health professionals, community-referred services and other providers such as the pharmacist will help eliminate communication barriers and allow for more teamwork across primary and referred services personnel.

Because the principal focus of this report is rural primary health care in rural New Zealand, the Advisory Group has not considered rural hospital services in detail. In a rural setting, all locally delivered services tend to be interdependent. We therefore propose a review of utilisation of rural hospitals and building on work already undertaken, such as *Roadside to Bedside*, to examine ways of improving integrated care across primary (including emergency, referred, older people’s, maternity, trauma and capacity) and community-based services.
Access to primary health care services for older people

The implementation of the Health of Older People Strategy will also make additional demands on rural primary health care services to deliver appropriate care to older people in community settings. The funding formula for PHOs will include recognition of the additional costs of providing services to older people.

While non-Māori tend to leave rural areas when they are older, older Māori are more likely to remain. Over one in five Māori living in rural areas of 1000 population or less are aged 60 years or more (see Appendix 8).

Many older people do not drive, or lack confidence driving, in rural areas to access secondary care. In some cases community-based services are not available in their rural area.

Key issues for older rural people are:

- access to community-based services such as podiatry, physiotherapy, optician, dental and audiology services
- more flexible options for intermediate care for people from more remote rural areas when discharged from secondary care services
- effective links with disability support services, co-ordinated ongoing care and palliative care.

Access to maternity services

Maternity services are provided in rural areas primarily by midwives and GPs acting as lead maternity carers, and by 59 rural hospitals. Retention and improvement of rural access to maternity services needs to be reviewed by a rural maternity group, including a GP and midwife who provide obstetric services.
2.7 **Recommended actions**

The Ministry of Health is asked to:

2.1 agree access standards with District Health Boards so that for 95 percent of the population they provide primary medical services and/or nursing services with medical back-up for:

- part of the normal business day within 30 minutes’ travel time
- after hours within 60 minutes’ travel time

Justification should be provided for shared practice areas that do not meet this standard (this standard does not include emergency services)

2.2 bring to the attention of the Ministry of Economic Development the linkages between telecommunications and health services delivery

2.3 review PRIME in conjunction with ACC, including consideration of legal protection, remuneration for medical emergencies and contracting arrangements

2.4 along with DHBs, facilitate better communication/problem-solving between local communities and regional ambulance providers

2.5 undertake further work on workforce issues for rural pharmacists and issues of access to rural pharmaceutical services

2.6 support the development and expansion of primary health care models that integrate mental health service provision in a way that is effective for rural areas

2.7 together with DHBs, review the utilisation of rural hospitals/rural health centres, and examine ways of improving integrated care across primary, emergency, referred, older people’s, maternity, trauma capacity, and community-based services

2.8 address issues of the retention of the rural maternity workforce and improvement of access to rural maternity services through a review by a rural maternity group, including a GP and midwife who provide obstetric services.
The District Health Boards are asked to:

2.9 work with PHOs so that for 95 percent of the population they provide primary medical services and/or nursing services with medical back-up for:

- part of the normal business day within 30 minutes’ travel time
- after hours within 60 minutes’ travel time.

Justification should be provided for shared practice areas that do not meet this guideline (this guideline does not include emergency services)

2.10 ensure the capabilities of the primary health care services match, as far as possible, the unique circumstances of rural communities

2.11 improve rural communities’ access to a comprehensive range of primary health care and community health care services, including health promotion, well child, mental health, disability support services and health of older people services.

Primary Health Organisations are asked to:

2.12 deliver programmes/services at a range of venues in the community, including taking services to more remote localities

2.13 develop intersectoral liaison with other key sectors; for example, housing, transport, Child, Youth and Family Services, which impact on the health of rural communities

2.14 encourage training of members of isolated communities in emergency first aid

2.15 ensure there is collaboration and an alignment of the skill mix of the primary health care workforce to the needs of the population they serve – teamwork needs to be encouraged to ensure appropriate matching of skills to tasks

2.16 encourage and fund providers to deliver services in rural communities that promote health/prevent disease

2.17 participate in PRIME

2.18 co-ordinate care and support for older rural people by liaising with community-based services (such as podiatry, physiotherapy, dental, audiology) and establish links with disability support services.
3 Rural Workforce

Aim 3: To develop, maintain and recruit a skilled, multidisciplinary rural workforce that works in partnership (that is, in a co-operative, co-ordinated and collaborative manner).

The achievement of the second aim of this plan concerning access to services for rural communities relies on the successful retention of the rural workforce. The rural primary health care workforce must be:

- sufficient in numbers, and sustainable
- multidisciplinary
- appropriately skilled and trained
- culturally competent
- have supportive working conditions, including access to appropriate leave
- enabled to work collaboratively
- made up of practitioners retained for adequate lengths of time to enable continuity of care and stable teams.

3.1 The rural workforce

The core rural primary health workforce includes doctors, nurses, pharmacists and ambulance personnel, although this may vary from region to region. Alongside these are Māori community health workers, midwives, allied health workers and community volunteers. All are valuable members of the primary health care team. Workforce data relating to rural GPs and some information on rural nurses is provided in Appendix 9. Workforce data relating to other primary health care workers is not available.
3.2 Focus on retention

Retention must be considered before recruitment of the primary health workforce to rural areas, because:

- the more we can keep primary health care workers socially and professionally fulfilled in their rural location, the fewer new staff need to be sought
- if rural primary health care workers are seen to be content with their lot, it sends a message to others that the work there is desirable
- a frequent change of primary health care worker does not enable continuity of care and the development of therapeutic relationships that are essential to holistic family and community health care
- high turnover of the workforce makes the development of effective primary health care teams more difficult
- as clinical education in rural areas is recognised as supporting the recruitment of primary health care workers, having staff who stay for longer periods enables their accreditation as rural teachers
- clinical teaching in rural localities exposes students and trainees to a career model, and what they see must be attractive
- recruitment of primary health care workers is often an expensive exercise and is a poor investment if the worker stays for a short time only and the exercise needs to be repeated.

Resolving the problem of retention significantly eases the problem of recruitment. Conversely, neglecting retention multiplies the challenges of recruitment.

3.3 Addressing heavy workloads

The uneven distribution of both GPs and the population means that there are areas where some GPs and their practice team carry very heavy workloads. For example, 38 GPs have ratios in excess of 1:2000, and 90 have ratios in excess of 1:1500. The average New Zealand doctor/patient ratio is 1:1200. This heavier patient load is compounded by a high seasonal influx of people to many rural areas. The poor health status of Māori and populations experiencing deprivation put greater demands on primary health care services in some rural areas, and rural GPs cover a broader work spectrum than most urban GPs.

Doctor to patient ratios as high as 1:2000 should signal the need for DHBs and PHOs to take action to avoid safety issues arising for the provider.
When referring to doctor-to-population ratios, the implication is that there is a practice team associated with the practitioner. Thus, responses to high doctor/patient ratios may include recruiting additional doctors or developing other members of the primary health care team to provide support. In areas of populations with high levels of deprivation or a high proportion of Māori, funding for PHOs that recognises these extra demands may provide an improved funding base to recruit additional primary health care workforce.

### 3.4 Reasonable rosters

In other areas the patient numbers may be low but the on-call demands are high. Onerous rosters are a significant source of stress for those doctors and nurses who experience them. They can lead to gradual but profound fatigue, which in turn adversely affects the health of the primary health care worker and the quality of care, with sudden decompensation and loss of service an increasing possibility.

With the exception of a very few very remote areas (which will need special consideration and assistance), the aim is for on-call rosters not to exceed 1:3, and with a clear preference for 1:4. These aims, while being a minimum for sustainability of high-quality services, are also likely to help recruitment.

Targeted assistance may need to be available to these areas to support effective strategies, such as:

- upskilling nurses
- sharing locums with other localities
- arranging with registrars/senior registrars in the nearest hospital Emergency Department to alleviate on-call rosters.

A further issue associated with on-call work is the isolated nature and possible security concerns arising. Where security is an issue for after-hours care, one response from primary health care providers is to seek assistance from the ambulance service, fire brigade or police to attend house visits alongside the primary health care worker.

### 3.5 Ability to take leave

It is important that all members of the primary health care team have opportunities to take adequate breaks. The locum services provided by the Northern Rural General Practice Consortium and the NZ Rural GP Network will provide around two weeks (20 sessions) of subsidised locum service for rural GPs, to enable them to take breaks for both continuing education and relief. In order to make rural areas more attractive to GP practice, support for longer leave arrangements will need to be considered.
Other members of the primary health care team, particularly nurses sharing on-call rosters or pharmacists undertaking similar out-of-hours services, also require adequate leave and support networks.

3.6 Increasing numbers of Māori primary health care workers

Demand for Māori primary health care workers is high and will continue to grow in the foreseeable future. There is a need to increase the number of Māori involved in all areas of the primary health care workforce.

The development of the role of the community health worker/kaiawhina has helped include Māori health care workers who usually belong to and/or have significant networks within the community they serve. Kaiawhina are usually employed by Māori organisations providing services according to Māori kaupapa and tikanga. The central belief of Māori care providers is that providing by-Māori-for-Māori services and following a holistic model of health as a basis for developing and delivering health services will result in positive health gain for Māori.

3.7 Creating opportunities to expand the scope of practice for rural nurses

A large number of rural nurses work in an advanced capacity. Some have undergone formal education and training for these roles, and others have developed skills and understanding over years of experience in the field, often driven by the necessity to provide services in the absence of other providers or organisations (Ross 1996). For those rural nurses who choose to do so, there need to be opportunities to expand their scope of practice within a primary health care nursing framework.

An expanded scope of nursing practice may enable nurses to participate in on-call rosters with GPs. In the South Island, approximately 35 rural nurses participate with rural GPs in on-call rosters. Not all rural nurses want to take on this responsibility, but those who do must have available the necessary professional support, back-up and access to training and education, and remuneration.

Expanding the scope of practice for rural nurses is not limited to preparing nurses for on-call work. The implementation of the Primary Health Care Strategy provides an opportunity for nurses to develop their scopes of practice within a framework of health promotion and disease prevention. The ways that nurses are contracted will need to allow for the expanded scope of practice.
3.8 Developing strategies in response to the ageing nature of the workforce

One feature of the rural primary health care workforce – particularly doctors, pharmacists and nurses – is that it is largely composed of people of mature age without an identifiable cohort of younger replacements for those considering retirement. A recent survey of rural GPs indicated that the average age is 44 years (Janes et al., 2001) and an unpublished study indicates an ageing rural pharmacy workforce with 26 (over 40 percent of the rural workforce) due to retire in the next 10 years.

Specific strategies will need to be developed to attract younger primary health care workers from all disciplines into rural practice. Some that have been suggested include:

- providing training places (for example, in medical schools) for students of rural origin, on the grounds that they are more likely to return to rural areas
- financial incentives to enter rural practice
- specific rural training before or soon after entry to rural practice
- reimbursement of student loans.

While some primary health care workers of mature age may be looking forward to retirement, others, with sufficient opportunity to renew and expand their skills, may be willing to practise for many years to come. For many women, for example, the mature years are a period during which they are freer of family responsibilities and have more opportunity to concentrate on their career and take time away for training. It is important to capitalise on this opportunity.

3.9 Supporting training and continuing education

All health professionals, including allied health professionals, require ongoing training and continuing education to maintain their professional standards. Acquiring, maintaining and updating skills for rural practice have added challenges in the rural setting.

The locum support scheme is expected to assist doctors to attend training courses, but will not meet the full cost of locum cover. The course fees, travel and accommodation are further costs. Clinical Training Agency funding for courses has occurred only on an ad hoc basis over the years, and some rural courses are not currently funded.²

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² A strategy for prioritisation and purchasing of post-entry clinical training is being developed by the Clinical Training Agency.
Rural practice demands a broad set of skills. For example, the distance from immediate clinical support exposes rural primary health care workers to the challenges and responsibilities of providing emergency care. The costs to patients of travel to access referral services puts an onus on rural primary health care workers to diversify their skills to accommodate some of these needs locally; for example, palliative care, minor surgery and mental health care. Further, the broad skill mix required for rural practice includes the skills of collaborative teamwork, community consultation and some special personal skills associated with living and working in the same small community.

Some specific rural training courses have been created. However, those who currently work in rural areas need flexible modes of delivery of training and education, including:

- more compact, funded packages for practitioners with greater pressure on their time
- rural-based training with clinical and personal supervision, supported from the main academic institutions
- distance learning and travel to learning off-site (however, internet access and other modalities of distance learning will require further development of information technology infrastructure in some rural areas).

PHOs could provide opportunities for primary health care team members to access study leave to attend refresher courses, or assist with accessing locums to enable extended leave for continuing education to be taken.

Pre-entry training should not be overlooked. Career considerations begin early during undergraduate training and are influenced by role models and educational experiences. Opportunities for members of the primary health care workforce who are interested in rural practice are needed to encourage them to undergo substantive placements in rural areas.

We endorse a number of the recommendations made by the Council of Medical Colleges in its Review of Medical and Health Workforce, Recruitment and Retention in Northland where they are relevant to rural primary health care services, and we have included them in our list of recommendations.

We acknowledge the recent initiative in developing a vocational pathway for rural doctors.

Consideration should also be given to improved co-ordination of rural professional development.
3.10 Improving collaboration

The aim is for all members of the primary health care team to have a working environment in which they feel valued, supported and able to develop professionally. Current service purchasing arrangements have not always encouraged the full use of everyone’s skills. PHOs will have the opportunity to apply different payment systems, which may enhance multidisciplinary team work and collaboration.

Multidisciplinary teamwork gives each team member the chance to develop their professional skills, and use time and resources creatively, and means they are more likely to provide an appropriate service. In the rural context, where workforce shortages are common, multidisciplinary teamwork and collaboration with neighbouring providers are essential to encourage retention of quality services.

It is important to maintain a good working relationship between Māori and non-Māori providers so that rural communities have well-integrated services and resources are used efficiently, with mutual professional support. Increasing collaboration with other community services, and across the primary and secondary care interface, is also important.

3.11 Competitive income

There is now a global marketplace for doctors, nurses and other primary health care workers, who are in short supply. New Zealand finds it difficult to compete against other countries offering attractive packages.

There are also extra costs associated with rural practice, including the costs of:

- travel and accommodation when sourcing continuing education, peer support, access to services, and access to educational and recreational facilities
- accessing and paying for locums
- subsidising services when there are no subsidies available (for example, acute medical and psychiatric care, counselling) to patients in rural areas, and no publicly funded service
- equipment, servicing, maintenance and consumables to provide a greater range of services at a distance
- diseconomies of scale – this is especially relevant to small rural practices
- telecommunications (toll calls, and other costs associated with setting up communication systems in areas with poor telecommunication coverage)
Implementing the Primary Health Care Strategy in Rural New Zealand

- freight
- providing community-based/out-reach services to rural areas
- perhaps most importantly, the hidden costs (family, social, cultural, health) of living and working in a rural area.

Strategies to consider are:

- marketing New Zealand as an attractive lifestyle option (and ensure there are sufficient opportunities to enjoy the lifestyle, through locum support for example)
- assistance with the costs of travel, accommodation and locums to enable all members of the primary health care team to undertake appropriate training
- continuing direct financial incentives for those practising in rural areas, including retention incentives
- offering salary packages or, in some situations, guaranteed minimum income.

### 3.12 Enabling ease of entry and relocation

Many pharmacies and general practices operate as small privately owned businesses, and for those serving areas with small populations, their business viability becomes increasingly marginal. While this is recognised to a limited degree by such schemes as the rural pharmacy bonus and the rural bonus for GPs having been redistributed in favour of the more remote rural doctors, some practices and pharmacies are still of marginal business viability.

Fear of becoming trapped through being unable to sell a practice is one reason GPs and pharmacists shun rural practice, as the inability to sell means loss of investment and having to start again on the lower rungs of a career ladder.

In some areas, community trusts and other community organisations own the premises, and employ the doctor as a means of easing entry to rural practice and avoiding the fear of being trapped. Communities may also consider offering premises at below-market rent, or instigate a buy-back option.
3.13 Recognising the importance of social factors

It is frequently family issues that lead to loss of the primary health care workforce, such as the stage in the family life cycle that demands relocation for schooling or employment. Key social factors identified include:

- employment opportunities for partners
- educational opportunities for children
- lack of privacy in small communities
- need for better facilities for child care and flexibility with after-hours commitments for those (usually women) with heavy child-care demands
- support for the spouse and children of rural health care workers, such as social activities and support networks.

3.14 Realising the potential of technology

Technological advances such as telemedicine increasingly make specialist expertise and continuing education more accessible to the rural primary health care workforce. It can be used for linking specialist services, the primary health care team and the rural patient to provide enhanced-quality services closer to where the patient lives.

However, as the Council of Medical Colleges in New Zealand points out, technology is a tool for clinicians in rural settings to overcome obstacles of distance and isolation, not a solution in itself. Realising the potential of technology requires careful service planning, training and technological support, and a reliable telecommunications network.

3.15 Recommended actions

The Ministry of Health is asked to:

3.1 develop a transparent rural primary health care premium so that PHOs are resourced to put in place effective workforce retention strategies and effectively support the primary health care team in rural areas

3.2 recommend a rural premium at a level that is sufficient to enable PHOs to support shared roster arrangements for out-of-normal-hours care towards achieving, as a minimum, a 1 in 3 on-call roster, with 1 in 4 as more desirable
3.3 support national initiatives for recruitment of primary health workers, encouraging them to work in rural areas on both a short-term and long-term basis; for example, through:

- nationally organised recruitment programmes, including the recruitment, placement and support of locums
- incentives for recent graduates to enter rural practice
- support for specific rural training of primary health care workers before or soon after entry into rural practice

3.4 work with the Ministry of Education to develop strategies that reflect current workforce needs as well as supporting and encouraging students from rural environments, particularly Māori, to consider a career in rural primary health care services

3.5 continue to support the development of rural nursing and assist those rural nurses who wish to make the transition to nurse practitioner status

3.6 encourage the Schools of Medicine and Schools of Nursing to move core clinical curricula and financially supported research into rural practices in a manner that is supported and appropriate

3.7 endorse the Council of Medical Colleges’ advice on improving the medical and health workforce in rural areas including:

- encouraging the Royal New Zealand College of General Practitioners to closely collaborate with other medical colleges and universities in the development of training modules to support the development of enhanced skill sets for rural GPs
- assisting DHBs to develop a mechanism for GPs to assume a secondary care role in rural hospitals and support the attainment of enhanced skills
- encouraging training institutions to support the identification and development of career pathways that enable the primary health care workforce to enter extended rural practice and maintain links with metropolitan tertiary centres
- supporting the Health Workforce Advisory Committee to liaise with the Ministry of Education, the Clinical Training Agency of the Ministry of Health, teaching hospitals, Medical Colleges and DHBs to advise on the right mix of specialist, generalist and primary care skills required for hospitals and health systems in provincial and rural areas.

District Health Boards are asked to:

3.8 monitor rural workforce issues and ensure strategies to address them are being implemented

3.9 maintain and improve support for rural primary health workers through providing specialist support (such as teleconferencing/telemedicine, visiting specialist clinics).
Primary Health Organisations are asked to:

3.10 promote retention of the rural primary health care workforce by creating favourable working conditions regarding:
- time off duty
- a supportive professional working environment
- access to continuing professional development and peer support
- adequate income
- the ability to enter and leave rural practice with minimal restrictions.

In particular Primary Health Organisations are asked to:

3.11 facilitate practical support (for example, provide medical locum cover or upskill nurses to share rosters) to enable the minimum 1:3 roster to be achieved and, as far as practicable, achieve a 1:4 or better roster as is the norm. (Existing 1:1 and 1:2 rosters are not acceptable. During a transitional phase where very small remote communities are served, the current 1:1 and 1:2 rosters need to be compensated for by either longer leave entitlement for salaried on-call team members, or, for non-salaried team members, subsidised and available locum cover to enable the practitioner to take longer leave)

3.12 facilitate locum cover for all members of the primary health care team to enable time off duty for recreation and continuing professional development and peer support

3.13 provide additional support, including in some cases income support for primary health care services whose viability is marginal in localities with small populations; options to explore include salaried or guaranteed minimum income packages

3.14 explore, either on its own account or with rural community trusts and territorial local authorities, ownership of practice premises and staff accommodation as a way of encouraging primary health care workers to practise in their area

3.15 support families of primary health care workers in order to aid retention of the primary health care workforce

3.16 promote collaboration among Māori and non-Māori providers in rural areas.
Appendix 1: Members of the Rural Expert Advisory Group on Implementing the Primary Health Care Strategy in Rural New Zealand

Bev Flavell, Katikati, nominated by Te Whanau Poutirirangiora a Papa

Chris Farrelly, Northland DHB, DHB nominee

Elizabeth Beresford, Otago DHB, DHB nominee

Howard Wilson, GP, Akaroa, nominated by Rural GP Network and NZMA

Joy Cooper, Wairarapa DHB, DHB nominee

Linda Brown, practice nurse, Te Anau, nominated by College of Nurses, Aotearoa

Pat Farry, Director of Rural Health for South Island, and Kim Gosman, Director of Rural Health for North Island (both nominated by Rural Health Directors of Aotearoa)

Peter Daws, Senior Locality Manager, Ministry of Health (Chair)

Reremoana Houkamou, Wairoa, Manager for Kahungunu Executive, nominated by Healthcare Aotearoa

Rewiti Ropiha, Manager, Turanga Health, Tairawhiti DHB nominee

Tim Malloy, GP, Wellsford, nominated by Rural GP Network and NZMA

Tony McKewen, Health Planning Consultant, nominated by Local Government New Zealand, Rural Women New Zealand and Southern Region Rural Health Trusts

Trish Crompton, Practice Nurse Manager, Dargaville, nominated by NZ Nurses Organisation

Floss Caughey, Ex-officio, Ministry of Health

Kate Garland, Ex-officio, Ministry of Health
## Appendix 2: Measures of health status

### Table A1: Comparison of life expectancy of total urban and total rural populations

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<tr>
<td>At birth</td>
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<td>At 65 years</td>
<td>15.4</td>
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### Table A2: Comparison of life expectancy of urban Māori and rural Māori populations

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<td>At 65 years</td>
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### Table A3: Comparison of life expectancy of urban non-Māori and rural non-Māori populations

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Source: Abridged Life Tables, 1995–97, Department of Statistics

Note: The rural population includes small towns of less than 10,000 population.
Figure A1: Comparison of standardised discharge rates for rural areas and towns with populations of less than 10,000 with the New Zealand average, 1999/2000

Figure A2: Comparison of standardised mortality rates for rural areas and towns with populations of less than 10,000 with the New Zealand average, 1999/2000
Appendix 3: General practice shared roster localities

General Practice Shared Roster Localities

Source: Public Health Intelligence, Public Health Directorate, Ministry of Health, 1 October 2001
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Appendix 4: Current initiatives/assistance in support of rural primary health care services

Rural bonus

The rural bonus was a 10% extra payment on the General Medical Subsidy for rural practitioners, part of the Rural Incentives Scheme of 1969. Over time, demographic changes caused many previously rural practices to become suburban, although they still retained their rural bonus payments. As a result, arrangements were made to redistribute the existing bonus away from the better-supported practices close to cities in favour of the more remote practices. This redistribution was based on the development of the rural ranking scale, which assigns points to the following factors:

- travelling time from the practice surgery to a hospital
- on-call duty
- on-call for major trauma
- travelling time to nearest GP at place of work
- travelling time to most distant practice boundary
- regular peripheral clinics.

GPs are ranked according to the 100-point scale from the minimum amount of $3000 for those scoring 35 points, up to a maximum of $21,000.

As well as relating directly to a financial incentive, the points a rural GP earns on the rural ranking scale can be accumulated over time so that the GP becomes eligible for a new Section 88 notice (based on need) in any single location of the GP’s choice. Thus those GPs serving in more remote or more difficult rural practice locations, and therefore earning high scores according to the rural ranking scale, can serve there for a shorter period to be eligible for a new Section 88 notice to practice in, say, an urban area.

Rural Locum Support Scheme

This scheme has made available $1,000,000 a year for two years to enable the establishment of a national scheme for the recruitment, supervision and subsidy of locums for rural practices. The scheme is due to start service delivery early in 2002.

The locum services to be provided under the Rural Locum Support Scheme and already provided by the Northern Rural General Practice Consortium provide around two weeks (20 sessions) of subsidised locum service to rural GPs to enable them to take breaks for both continuing education and relief.
**Directors of Rural Health**

A full-time director of rural health was appointed for the South Island in 1998 and in the year 2000 a North Island rural health directorship was established, being a full-time position shared between a rural GP and a rural nurse/midwife.

These directors have been involved in co-ordinating and ‘trouble-shooting’ roles, working towards the development of a consistent infrastructure to support rural health services. They have combined with the directors of the National Centre for Rural Health to form the Rural Health Directors of Aotearoa, working with the Ministry of Health on nationwide solutions to rural health problems.

**Rural pharmacy allowance**

The Ministry pays a rural pharmacy allowance in recognition of the need to assist rural people to have access to pharmacists and pharmaceuticals. The rural pharmacy allowance is paid to pharmacies that meet a number of criteria, including distance (at least 30 minutes) from the nearest other pharmacy, more than one hour from a major city where continuing education occurs regularly, and the number of pharmaceutical scripts processed each year.

**Rural practice support organisations**

Since 1994 the following rural practice support organisations have been established:

- the Centre for Rural Health, in Christchurch
- the Northern Rural General Practice Consortium
- most recently, the Institute of Rural Health, based in Hamilton.

These organisations have provided continuing professional development, locum services, personal support and organisational assistance to help maintain the effectiveness of rural practices. They have also engaged in national project work on rural health workforce and community initiatives, and work in collaboration with schools of medicine on training for the rural health workforce. These initiatives have been created and run by rural practitioners for rural practices, and have had close consultation with their clientele.

**Formation of rural health trusts and incorporated societies**

A number of areas have formed community trusts or similar corporate structures to run their rural health services. This has enabled the communities to recruit practitioners through negotiated working conditions and avoiding the need for the GP to buy into a practice with its associated risk of becoming trapped.
Some areas have expanded the concept of community health trusts to form organisations providing integrated services to defined populations. In the cases of Kaipara Care (Dargaville) and Clutha Health First (Balclutha), such organisations have emerged through active co-operation between health providers and support from the community.

In the cases of Hauora Hokianga and Ngati Porou Hauora, the development was based on the existing models of the Special Area Scheme, initiated in 1944 for regions unable to financially support their rural workforce due to small populations or high levels of deprivation. Both these providers now come under the umbrella of Healthcare Aotearoa Inc, a national network of primary care providers which is not-for-profit and community-controlled.

**PRIME**

PRIME (Primary Response In Medical Emergencies) services have been established in rural localities. This service is co-ordinated by St John’s Ambulance services and is funded by both ACC and the Ministry of Health. GPs and primary care nurses in designated rural localities receive specific training and equipment for emergency care, and work with the ambulance services to improve outcomes from rural emergencies. The PRIME GPs, primary care nurses and ambulances are represented on each of the five regional emergency care co-ordinating teams established as part of the Ministry’s Roadside to Bedside programme.

The services were first established in the South Island, and there are now 41 localities served by PRIME services in the South Island (17 in Otago/Southland and 24 in the northern half of the South Island). PRIME services are being progressively introduced in the North Island. Forty-seven North Island localities have been identified, and PRIME services have been established in 33 of those localities.

**Healthline**

The Ministry of Health is piloting a free, 24-hour telephone triage and health advice line in the following four regions – Northland, Tairawhiti, Canterbury and the West Coast of the South Island. Three of these areas were chosen because of their rurality, and two were chosen because of their large Māori population. The pilot was expected to end in May 2002, but it has been decided to continue the pilot for another year.
Appendix 5: Most disadvantaged rural communities

[Map showing most disadvantaged rural communities in New Zealand, with cities and towns labeled such as Gisborne, Kaitaia, Whangarei, Taumarua, Tauranga, New Plymouth, Balclutha, Greymouth, Ashburton, and Blenheim. The map highlights areas in different shades to indicate decile levels.]

NZDep96
- 8th Decile
- 9th Decile
- 10th Decile

Kilometres

July 2001
Appendix 6: Rural Māori population

Number of Māori per CAU
- < 364
- 364 - 1023
- > 1024

July 2001
## Appendix 7: Access to car and telephone

<table>
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<th></th>
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<td>Rural</td>
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<td>Minor urban</td>
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<td>2.6</td>
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<td>20.5</td>
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<tr>
<td>Total rural and</td>
<td>18.0</td>
<td>3.0</td>
<td>5.9</td>
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<tr>
<td>minor urban</td>
<td>12.3</td>
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<td>3.8</td>
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<tr>
<td>Total urban (secondary and main)</td>
<td>14.0</td>
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<td>4.3</td>
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<td>Total New Zealand</td>
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Source: 1996 Census of Population and Dwellings, Statistics New Zealand

Note: Values shown are percentages of total ethnic population within area type.
Appendix 8: Age structure of rural population

Figure A3: Difference in age structure between rural and urban populations, 2001

Note: Rural population includes areas with less than 10,000 population. Urban population includes towns and cities with populations of 10,000 or more.
Figure A4: Difference in proportion of Māori and non-Māori population aged 60+ living in rural, small town and urban areas

Percentage

<table>
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<tr>
<th>Rural</th>
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<th>Urban</th>
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<tbody>
<tr>
<td>Māori</td>
<td>Non-Māori</td>
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</table>

Note: Rural population includes areas with less than 10,000 population. Urban population includes towns and cities with populations of 10,000 or more.
Appendix 9: Workforce data relating to rural GPs and nurses

Note: Workforce data relating to other primary health care workers is not available.

**Rural GPs**
- Estimated total number of rural GPs: 528
- Estimated total full-time equivalent (FTE) GPs: 400

**Doctor/patient ratios**
- 14 localities (38 doctors) with doctor/patient ratios of >1:2000
- 12 localities (56 doctors) with doctor/patient ratios of >1:1750
- 14 localities (34 doctors) with doctor/patient ratios of >1:1500
- 15 localities (70 doctors) with doctor/patient ratios of >1:1250

- Number of rural practices: 212
- Number of shared roster areas: 116
- Number of shared roster areas where practitioners (doctors or nurses) are on 1:1 or 1:2 rosters: 34

Source: Centre for Rural Health Annual Rural Workforce Survey, 2000.

**Female rural GPs**
- Estimated percentage of rural GPs who are female: 28%

Source: Royal New Zealand College of General Practitioners survey, which also noted that 33% of female rural GPs worked five-tenths or less.

**Rural GPs**
- Of 338 rural GPs who responded to a recent survey (Janes et al 2001):
  - the mean age was 44 years
  - 72 percent were male
  - 93 percent were of New Zealand European ethnicity
  - fewer than 50 percent graduated from a New Zealand medical school
  - Britain and South Africa provided most of the overseas-trained rural GPs
  - 59 percent had received vocational training in rural general practice
  - 79 percent worked full-time
  - 78 percent owned their own practice
• 38 percent worked part-time as rural hospital doctors
• 21 percent provided intra-partum obstetric care
• two-thirds rated lack of locum relief, onerous on-call duties and rural GP shortages as ‘important’ or ‘very important’ problems
• one-third stated that more rural GPs were needed in their locality.

**Rural nurses**

There are 3868 registered nurses practising in rural areas (as at year 2000) compared with 28,808 nurses practising in urban areas. Nurses who have undergone specific training in rural health include 80 who have taken papers associated with the postgraduate Certificate and Diploma in Health Sciences (Primary Rural Health Care). Of these, 44 are expected to have completed the Certificate and 16 the Diploma by the end of 2001. (However, these programmes have not yet gone through the process of endorsement to be recognised as postgraduate nursing programmes by the Nursing Council of New Zealand).

The following localities listed receive their front-line primary health and emergency services from rural nurses: Moana/Otira, Haast, Stewart Island, French Pass, Hanmer, Fox Glacier and Tokanui. The rural nurses receive emergency back-up from doctors at a distance, who may also visit regularly to provide medical clinics. Only those at Stewart Island receive back-up from an urban GP.
References


