

Rural General Practice in New Zealand: has the situation improved?

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Introduction

Rural general practice is an important area of health care in New Zealand with approximately 530,000 people living in rural areas, 13% of our population.¹ Many people feel that there is already a shortage of rural health care workers and this situation is likely to deteriorate as the effects of the aging population and the retirement of the baby boomer workforce come into play. Currently 40% of rural North Island GP's and 35% of rural South Island GP's are over 50 years old.² One recent study found that 34% of respondents were intending to leave rural practice within the next five years.³ Another report estimates that by 2021 New Zealand will require 40-69% more registered medical professionals, assuming the workforce turnover and number of trainees remains constant.⁴

The Primary Health Care Strategy, published in 2001, notes that retention and recruitment can be a problem for rural areas: 'the difficulties of attracting and retaining basic health services in rural communities have not lessened over recent years.'⁵

These statistics show that retention of our existing rural practitioners and recruitment of doctors and graduates into this area is important to ensure the stability of the rural health care workforce. Previous research has demonstrated a number of the negative aspects of rural general practice which included frequent on-call, heavy workloads and difficulty in getting time off.⁶ It follows that improvements to these areas may help to improve rural workforce retention and recruitment.

Since 2002 the Government has introduced a number of initiatives aimed at improving the situation of the rural general practice workforce.

- Rural Workforce Retention Funding- a flexible resource for supporting and retaining the primary health care team
- Reasonable Roster Funding-a targeted resource aimed at supporting those experiencing onerous on call arrangements
- Rural Innovations Fund
- New Zealand Locum Scheme

The Rural Workforce Retention Fund (RWRF) and the Reasonable Roster Fund (RRF) were introduced together in 2002 as a package worth \$32 million over three years. This was continued \$10.9 million per year in 2004.⁷

The Rural Innovations fund has \$300,000 available annually with a maximum of \$50,000 available for any one project. These awards are designed to support practices in developing innovative approaches to health care delivery. The first round of funding was distributed in November 2006.

The New Zealand Locum Scheme is a government subsidized locum recruitment scheme, run by the New Zealand Rural General Practice Network and set up in 2002.

These initiatives have targeted some of the main problem areas identified by rural GPs in previous research. The aim of this project is to explore the views of a range of rural GPs and assess how well they feel these initiatives are working to alleviate some of the challenges facing rural general practice. Understanding the impact of the recent efforts is important for informing both policy makers and future research.

Method

Participants were selected in an attempt to canvas a range of viewpoints on the issues facing rural general practice. The sampling framework included gender, rural ranking score and geographic location (North or South Island). Seven interviews were carried out via telephone, recorded and transcribed for analysis with identifying references removed.

These transcripts were then read repeatedly to identify the themes of interest and quotes illustrating these themes were collated. Quotes were edited for clarity with repetitions and um and ah's removed.

Results

This study had seven participants, five male and two female. Three participants were from the North Island and four from the South Island. The age of participants ranged from 46-56 and the number of years practicing medicine (not exclusively rural general practice) ranged from 22-30 years.

Rural Workforce Retention Funding (RWRP)

There was a consistent view that RWRP has been a positive change in rural general practice although the degree of impact it has had on practitioners varies. For some it has been a decisive influence keeping them in rural general practice, whereas for others it has been useful and a 'nice bonus' but hasn't made a huge difference to them overall. Those who felt it had had the biggest impact also had the highest on call burden and were eligible for reasonable roster funding. Other initiatives that were felt to have had a major impact on rural general practice were the general increase in funding, the rural ACC contract and the PRIME contract.

'whether they gave me the funding or not I'm not planning to go, now there may be other practices where people are teetering on the brink and that may have made a huge difference to whether they are staying or leaving'

‘I would say that was a clear decisive influence that stopped us leaving (rural centre). The funding up until then had become so tight that it was verging on the ridiculous to stay in this area...Ah the rural retention fund, the reasonable roster and joining the PHO giving us access to capitation turned that financial reality around and it settled us.’

‘PRIME, and the ACC rural contract, have made a huge difference to rural practice incomes. So rural GP income is actually quite good now I think.’

A number of respondents expressed frustration with the system through which the funding is provided citing a lack of transparency, lack of control as to how the funding is distributed and frequent contract negotiations.

‘the DHBs and everyone wanted to put their little grubby claws on it and decide what it should be used for instead of the people it was meant for’

‘we had a year where we received about 50% of the allocated money and the rest I don’t know what happened to it, no one saw it or was allocated elsewhere. We had a year where we didn’t get any money at all and it went to some other town or small hospital that someone else had done a deal with and no one would tell us why we didn’t get any money. The last couple of years it’s actually been quite helpful, we’ve received I think 50% on a per patient basis of the money’

‘one area of irritation is that there’s so many unnecessary contracts’

Reasonable Roster Funding

The reasonable roster funding, available to practitioners on a roster of 1:1 or 1:2, was very well received as having made a big difference although serious concern was expressed over the need to adjust the funding level to reflect cost increases such as nurse’s wages and locum fees.

‘I’ve got the opportunity that I can throw my lot in with (urban centre) I can do a 1:35 on call ...you know kind of at the moment I’m financially neutral by paying the nurse and doing the oncall for nothing. But if the nurse rates go up and the reasonable roster funding doesn’t and I find I’m actually paying out of the practice the oncall well then at that stage it’s a bit of a no brainer’

‘the concern is that it needs to be inflation adjusted I mean we’re still giving the same rates as we were five years ago. We’re still getting people coming over although we did struggle at the end of last year to find people for a couple of weekends.’

New Zealand Locum Scheme

The majority of participants considered the New Zealand Locum scheme to be very valuable, and very good at getting locums provided they were given enough notice although some still had trouble finding locum cover at times. There still appear to be issues getting locums on short notice, for example if a doctor is sick, which can leave practices in a difficult situation. One participant raised the point the other service the New Zealand Locum scheme provides is a marketing role, raising the profile of New Zealand overseas.

‘It’s a very professional service they have managed to get me locums the vast majority of times I’ve needed a locum, the main factor there is giving them enough advance warning’

‘They have been able to create in reality a cooperative service to rural general practice in New Zealand which individual GP’s could never have achieved. Great idea put into action really well’

‘Give them 100% marks’

In a follow on to comments made by some respondents in the RGPN after hours survey⁸, participants were asked whether they considered the fees for the New

Zealand Locum scheme to be reasonable. Most respondents felt they are reasonable; acknowledging that it was an internationally competitive market and if rates were any lower it would be difficult to attract locums to work in rural New Zealand.

‘Locums are charging a significant amount for their services and they’ve got to match that if they want to have locums to be able to be able to support rural practice with.’

‘You know if I was a locum I wouldn’t work a weekend for less. However when I work a weekend as a GP I get about a third as much that’s just the name of the game.’

‘We have to be realistic about what locums expect, they’re having to put up with transitory work, they’re moving from practice to practice, it’s not easy to do that kind of thing and we’re competing on the international market, particularly Australia, for all the same guys’

Cost can still be a problem for on call work as locums are less likely to generate enough revenue for the practice to cover costs and the locum fee during an on after hours session, making it expensive for practices to hire locums to do after hours work. Another point raised was that locum fees are reaching a stage where it may be more profitable to be a locum than a full time doctor, something which may act as a deterrent to people going into full time practice. Some practices deliberately didn’t use locums during busy times due to a sense of responsibility to the community, causing the practice to run into the problem of making a loss on after hours when they did go away.

‘it’s not the sessions we have a problem with it’s just the on call... often we don’t go away during the busy times because we feel sort of committed to supporting our local community and our local ambulance staff so there’s not people who are unknown to the area, so when we go away it’s quiet or quieter and it’s very expensive paying \$300 a night’

'If they work a weekend um it costs \$3000 plus GST I think in the fees and the last few weekends we've had to get a locum to do it they've actually generated about \$1500 and if you think half the money you generate is bad debts which is much worse at weekends, the doctor's out of pocket usually about \$2000 just to have a locum do the weekend'

Mobile Surgical Services Bus

The mobile surgical service bus began in 2002, and travels the country on a five week rotation providing low risk elective day surgery procedures.⁹ Opinion on the bus was divided, with some saying it was a 'great system' where others felt it was more of a 'publicity stunt'. A number of respondents were uncertain of the economics of the service and how patients were selected. A positive theme was the reduction in patient travel time. Lack of interest from some DHBs and issues around who would provide post operative care were issues that prevented some areas from accessing the surgical bus. Some felt the major benefit of the bus for GPs lay in the teleconferencing and IT facilities it brings with it.

'I think it's much more efficient sending people to hospitals and having things done there or allowing general practice to do certain other things that they are doing.... if you take a look at what they spend on that I don't think it's efficient and how do you decide who gets what and it's really a bit of a publicity stunt'

'I think it's value is in the other possibilities it creates and the fact it is innovative in terms of IT and that it drags with it the need for IT networks to be established in rural areas.'

'The other positive and we haven't quite realized it yet is the mobile surgical bus has teleconferencing facilities...they may be able to put on education or do specific training.'

I was very disappointed because I actually canvassed my DHB saying well hey why have it come here to (rural centre) we've got a kind of a car park that would be ideal...

However we gave them the number of people we felt would likely benefit from the surgery and they felt it was too small to warrant pursuing any further so that was the end of it.'

Difficulties applying for funding

An important theme raised both in context of the Rural Workforce Retention Funding and the Rural Innovations Fund, was that the effort required to apply for funds was at times more than doctors or practices could manage. This is important as it is often those having the most difficulty that these funds are targeted to help, but the application process may mean they are missing out due to a lack of time and energy. For these initiatives to reach their full potential, support with the application process may be required.

'I think a problem with all these funds it's worth saying and is actually quite important: those practices which are in good heart and have got plenty of good energy say "Here's some more money we could get; lets put our minds to it, come up with a really well worded proposal and we could get some more money." which they do. With a struggling practice which is on its knees, the doctors are usually tired and maybe depressed. They can't get their heads around new things. It's just another piece of paperwork they can't get their head around, they fail to apply for the new funding and they miss out.'

The following quotes are in the context of applying for the Rural Innovations Fund.

'From my perspective I don't have the mental energy to do anything novel, I'm busy enough trying to keep the balls in the air and have a family life'

'we've already got a huge paper load to deal with without a practice manager and to actually sit down and have to apply for funds is just a little bit too hard'

‘sometimes actually applying for these things can be more of a burden than it’s worth to be honest, when you’re filling out all the applications and the endless forms and strategies and huge amount of time and effort can go into those’

Barriers to entering rural practice

Participants were asked what they felt the major barriers were for doctors entering rural general practice. A strong theme was the lack of exposure during training years. Others talked about the isolation, difficulties with locums, lack of privacy and the workload and a lack of knowledge as to the positive side of rural practice.

‘One would be the actual workload. Two, the lack of privacy that you do have that 24/7 accessibility. Three, I think people find it quite intimidating that they are on the frontline and they are relatively isolated.’

Undergraduate Education

A strong theme that came up throughout the interview was that many practitioners felt that there was not enough exposure of undergraduate students to rural practice during their training. Many felt that this exposure was important in helping to address the workforce issues in rural practice. One viewpoint was that the Government is currently ‘tinkering’ with other things and hoping to avoid this issue as it will be more difficult to organise and implement.

‘We get students who go through our place and most of them are delighted and amazed at what they are seeing and doing.’

‘You cannot expect people to go to Auckland for six years, never leave Auckland, go into the hospital system for two years in an urban centre and then at the end of eight years think I want to be a rural GP. They’ve had no role models, no exposure, they don’t know what it is to live in a small town’

‘New Zealand seems to be tinkering with these little funds [Rural Innovations Fund] and projects and not getting off their butts and addressing what needs to happen which is what Australia is doing. I mean we’re picking and choosing and trying a little bit of this and a little bit of that and the workforce shortage is just getting worse and worse and worse. And we need to actually really focus on getting a rural undergraduate training programme and a rural career pathway in place’

Generational Expectations

One participant pointed out the difference in the system in which current doctors are training to the system which was considered normal twenty years ago. Junior doctors now have contracts which include paid overtime. Training systems in the past have required doctors to work long hours with little or no overtime pay.

‘we did long periods of on call, 24 hour call, weekends on call I can still remember my A&E run in (urban centre) which comprised of a morning shift followed by an afternoon shift followed by a night shift followed by my day off and then I started again and that went on three months... I guess we didn’t know any better and there were no alternatives...the pay for the extra hours was minimal so we grew up just saying well that’s the way it is, that’s what doctors do and that group have gone into rural general practice and sort of tolerated the on call. I think these days the junior doctors have got much more prescribed working hours... so they don’t do nearly as much on call and when they do the on call they get well paid for it, so the thought of doing long periods of on call in general practice for next to no money doesn’t appeal at all so they go and look for something else.’

The situation compared to five years ago

Although most respondents felt that rural general practice was in a better position financially now than it was five years ago, this was combined with a concern that it would be easy to slowly lose the gains of the past five years if RWRF and RRF were not adjusted for increasing costs, and that there still didn’t appear to be

enough replacement doctors coming through to take over for the cohort who will be retiring in the next 10 years.

‘Definitely in a better position in so far as the funding streams, the capitation has definitely improved the income within rural general practice which is a very positive thing. As far as workforce goes it is no better.’

‘If you are going to look at the demographics we are all getting older and we are not getting replaced by younger people’

‘I think it’s certainly better than what it was in 2002 but costs have gone up, I’ve increased my hourly rate to the nurses significantly and they deserve it and they earn it, but it’s that level of increase that we haven’t seen in the rural retention fund or the reasonable roster funding’

‘ I think most of us who are in our fifties now are looking around and thinking well where are all the replacements for this great cohort of people who are fifty and over ... that are going to take up the reins when we when we leave and the answer is I don’t see them anywhere’

Participants were given the opportunity to make a ‘wishlist’, the three things which would improve their situation working in rural general practice. These answers showed that after hours funding is still seen as an issue, and so is the amount of paper work required. Other wishes included less political interference, teleconferencing facilities to reduce travel time, more doctors in rural general practice and better funding for rural academia, research and a rurally oriented undergraduate curriculum.

‘properly funded after hours care funding to develop an academic teaching and research centre in this rural locality and ... third thing, it’s around the workforce, I guess a medical undergraduate rurally oriented curriculum to address the workforce shortage.’

‘it would be more the paperwork that puts the pressure on me rather than the sleepless nights... if I’ve got to do 2 ½ 3 hours paperwork on average on a weeknight just to keep everything afloat it just means if I want to play with my children I go to bed later... they go to bed at 8 and I’ve got paperwork to do till 11 half 11’

‘we might have found one, we’ve got a long term locum coming...So that would be wish number one, wish number two, let me think I’d like the Ministry of Health to keep their nose out of it, I’d like their politicians to stop trying to dominate general practice and deal with things they really don’t understand and deal with things in a totally political way which really pisses the doctors off’

Discussion

Rural general practice is an important area of health care provision in New Zealand, serving approximately 13% of our population.¹ It is important that we understand and address the challenges that face this sector in order to maintain delivery of quality health care to the rural population.

Previous research has found that some of the negative aspects affecting rural general practice include frequent on-call, heavy workloads and difficulty in getting time off.⁶

Responses in this study indicate that the Rural Workforce Retention Fund and the Reasonable Roster Fund do appear to have had a positive impact on rural general practitioners, and in some cases has led to people remaining in rural practice who would have otherwise left. However, this funding has remained at the same level for five years, in which time many nurses have received a substantial pay increase and locum fees from the New Zealand Locum scheme have also gone up. Clearly the value of this funding is being eroded by increasing costs and needs to be adjusted to maintain its value.

The New Zealand Locum scheme was very highly regarded and appears to have made a difference to the availability of locums, a highly positive change given previous research showing that the lack of locums has been viewed as a major negative aspect of rural practice.⁶ Overall practitioners felt that fees were reasonable, although the session fee for on call work was often higher than the revenue generated for the shift, causing the practice to run a loss for on call work. Although the New Zealand Locum Scheme has improved the availability of locums there still appears to be a shortage which can cause some doctors to miss out even when they have given a lot of notice, and making it very difficult to get a locum on short notice if this is required.

There still appear to be a number of issues in rural general practice that are not being addressed by the current initiatives. The paper work burden has been a negative aspect of rural practice both in previous research⁶ and this study. A number of respondents spoke about the need for rural exposure at the undergraduate level to attract young doctors into rural practice. This is supported by a study of Dunedin medical students which showed that students were more likely to plan on entering rural general practice after their rural general practice attachment.¹⁰

The variety of GP's spoken to in this research is a major strength of this study, with location, rural ranking score and gender included in the sampling framework. This increases the chances of achieving good cover of the range of views held in the rural general practitioner community about the initiatives looked at in this research. Interviewing a greater number of GP's would have increased the strength of this study as it would decrease the chance that other opinions were missed.

There have been some other major initiatives introduced over the past few years which were not looked at in this study, including the rural ACC contract and the PRIME contract. One major issue facing rural general practice that was also not

examined in great detail in this study is the provision of after hours care, although this did come up during the discussion of RWRF, RRF and locum cover. This appears to be an area which causes significant problems for rural general practice.

There have been some initiatives have been introduced recently which have not yet had time to filter through into the workforce, but should be acknowledged.

- 2002 - a three month rural general practice attachment was introduced for 10 post graduate year 2 and 3 house surgeons, which has since been extended to 20 funded places per annum.
- 2004 - 20 extra places were made available at both medical schools for students from a rural back ground.
- 2006 - An increase of 15 funded places per year on the general practice registrar training programme
- 2007- A pilot rural immersion programme for six University of Otago fifth year medical students

Overall it appears that the rural GPs in this study feel that although general practice has reached a better financial position over the past five years, the workforce situation is the same or worse than five years ago. This indicates that although the initiatives introduced over the last five years may have produced some benefit, they may not be enough to ensure that there are enough people entering rural general practice to deliver a health care service that can adequately address the rural population's needs.

There are some issues facing rural practice which do not yet seem to have been adequately addressed, include the paperwork burden and the issue of after hours provision.

An interesting area for future research would be generational expectations and the effect of the system in which medical students and junior doctors train on what they consider acceptable working conditions later in their careers. This may provide useful information to workforce planners when looking at how rural general practice should be structured in the future.

References

- [1] Statistics New Zealand. Defining Urban and Rural New Zealand. 17 January 2006 [cited 2006 December]; Available from: <http://www.stats.govt.nz/urban-rural-profiles/defining-urban-rural-nz/default.htm>
- [2] Royal New Zealand College of General Practitioners 2005 RNZCGP Membership Survey General Practice in New Zealand Part III; 2006.
- [3] Ministry of Health. The 2005 Rural Health Workforce Survey. Wellington: Ministry of Health; 2006.
- [4] Medical Reference Group Health Workforce Advisory Committee. 2006. Fit for Purpose and for Practice: Advice to the Minister of Health on the issues concerning the medical workforce in New Zealand.
- [5] Ministry of Health. The Primary Health Care Strategy. 2001; Available from: <http://www.moh.govt.nz/moh.nsf/c43c7844c94e08cd4c2566d300838b43/6627a8d08100ba41cc256b6c00749f32?OpenDocument>
- [6] Janes R, Dowell A, Janes R, Dowell A. New Zealand Rural General Practitioners 1999 Survey--Part 3: rural general practitioners speak out.[see comment]. N Z Med J. 2004 Apr 2;117(1191):U815.
- [7] Ministry of Health. Funding for rural primary health care workforce retention and recruitment. Available from: <http://www.moh.govt.nz/moh.nsf/0/E38591402F6277E4CC256BC90078836B>
- [8] Janes R. New Zealand Rural After-Hours Primary Care Provider Survey: 3. Finding workable solutions to providing rural after-hours care: New Zealand Rural General Practice Network; 2006.
- [9] Mobile Surgical Services. [cited 2006 December]; Available from: <http://www.mobilesurgical.co.nz/the-service/day-surgery/>
- [10] Williamson M, Gormley A, Bills J, Farry P, Williamson M, Gormley A, et al. The new rural health curriculum at Dunedin School of Medicine: how has it influenced the attitudes of medical students to a career in rural general practice? N Z Med J. 2003 Aug 8;116(1179):U537.

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