



NEW ZEALAND RURAL GENERAL PRACTICE NETWORK

RURAL PROOFING YOUR PRIMARY HEALTH SERVICES:

Rural proofing – ensuring that impact of new services or service reconfigurations on rural communities are considered up front.

When developing any new services DHBs/Alliance Leadership Teams should specifically consider how rural populations can access that service and the effect upon rural populations.

Why is rural proofing primary health services important?

The rural sector is an important part of the New Zealand community. The New Zealand economy is highly dependent on rural-based businesses.

Industries based on the agriculture and forestry sectors generate about 70 percent of our merchandise exports and rural-based tourism makes a significant contribution to the rural economy.

The rural community is particularly dependent on a limited number of health service providers and has reduced access to alternatives.

Living rurally has a negative effect on access to services, the sustainability of those services, increased difficulty ensuring quality of the care received because of isolation of practices from peer review and educational opportunities.

Rural communities are affected by a reduced workforce across all professions, the necessary breadth and depth of workload required of those in the rural workforce.

Although health outcomes are to some extent preserved in the current system this is despite the combined effects of distance from services, areas of high deprivation and the risks associated with ethnicity.

What makes rural New Zealand different?

Several key characteristics of rural New Zealand could influence the effectiveness of primary health services:

- **low population density** and /or **isolation**.

Rural people are a long distance from services and communication hubs – this affects access to emergency services and affects cellphone coverage.

-deprivation ethnicity and poor socioeconomic status.

Socioeconomic deprivation is closely linked with poor health outcomes, a larger proportion of Maori in rural areas are in NZDep quintile five than urban Maori, compounding poor access to services through distance, with deprivation and ethnicity places some rural communities at very high risk.

-workforce issues

The rural primary care workforce is recognized to be in crisis across the range of service providers, both in terms of retention of current providers and the development of future workforce.

What are the underlying principles?

- All people, no matter where they live, should have a reasonable ability to live, work, and to contribute to and be part of New Zealand society.
- Rural people should have the same health outcomes as people living in urban areas.
- Rural people should have access to services that are equivalent to primary health services in urban centres.
- Primary care services in rural areas should be comprehensive, sustainable, provide continuity of care by the right person, at the right time, in the right place.
- Rural communities should be resourced at a level that enables providers to provide the services required.
- Rural people should have access to primary care services that will be accessible into the future.

How to Rural Proof your Primary Health Services.

Recommended steps for rural proofing new health services –

1. Consider local rural communities when planning every new service.
2. Consult appropriately with rural communities.
3. Develop solutions that enable equity across rural and urban communities and health providers.
4. Ensure implementation plans include a review of how rural communities are impacted by / access the service and make appropriate and necessary adjustments to ensure outcomes are equitable across urban and rural communities.

Step 1 :

Consider local rural communities when planning every new service:

Questions:

What are you proposing?

1. What are the objectives of your proposed new service? - What is the problem? - What are the intended outcomes?
2. Is there currently disparity across urban / rural communities?
3. What is your proposed method of delivery?

What is the state of your current rural health service?

4. Do you know who your rural communities are?
5. Is there a comprehensive list of who lives where in your district?
6. Do you know where people travel to access services within and outside of your area?
7. Do you know where enrolled patients live in relation to their preferred general practice?
8. Do you know how rural communities access out of hours services?
9. Do you know if there are sections of the rural community who have more difficulty than others – Maori, migrant workers, single parents?
10. Do you have a record of what services are available at practices providing care for patients living in rural communities?
11. Do you know who your rural health workforce are ? Do you know how long they have been working in your rural community? Do you know what their career aspirations are? Do you know how long they plan to stay? Do you know what would help to make them stay?
12. Do you know what would encourage more people to come and work in your rural communities?

Solutions :

- a. Develop a definition of rurality – the RGPN Rural Ranking Score is an accepted definition in relation to NZ health services.
- b. Consider combining this dataset with other statistical definitions of rural population such as that illustrated in the NHC document – Rural Health etc...
- c. Comprehensively survey your rural communities and workforce every 2 years.

Step 2:

Consult appropriately with rural communities.

Questions.

1. Is your engagement with rural stakeholders affected by their ability to receive information, participate in consultation and provide feedback?
2. Have you identified how your policy will impact on different sectors of the rural population, for example Māori or the elderly in rural areas?
3. Does your communication plan ensure you have given the rural community the opportunity to engage with the policy process?

Solutions:

- a. Hold consultation meetings and hui in rural areas at appropriate times, recognising the distances and time rural people have to travel, and seasonal work constraints (for example calving).
- b. Allow sufficient time for rural people to participate. Recognise any extra communication lags (for example, postal delivery timeframes). Recognise the time required for organizations and iwi to contact members.
- c. Make printed copies of documents readily available.
- d. Modify delivery methods (for example, minimising the electronic size of documents to ease transmission, using Māori media to communicate with rural Māori).

Step 3:

Develop solutions that enable equity across rural and urban communities and health providers.

Three areas relevant to health service provision are especially influenced by population density and isolation:

Connecting people: Efficiently and effectively connecting rural people with health services and health services to each other and to the world.

Access to services: Providing sustainable, expert, comprehensive and accessible primary health services to people in rural areas.

Costs of service provision: Recognising the practical implications of complying with legal, ethical and registration requirements, continuing medical education, and involvement in clinical governance in rural areas – considering the smaller population size and increased workload inherent in providing comprehensive services.

| Questions: (Not a comprehensive list – how does your service impact rural communities – positive and negative?) | Solutions: (intended as a guide to prompt innovative solutions.) |
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| Connecting People Are service providers in rural communities able to access internet and telecommunications support and power in the same way urban providers can? | Many rural people do not have cell phone coverage, a reliable internet connection or access to public transport Fund appropriate infrastructure in rural practices to ensure high speed broadband is available, provide support for infrastructure required to ensure sustainable services in times of need, for example power generators. Encourage shared service provision across government agencies and health service delivery providers – for example in shared fibre-optic installation costs. |
| Access to services Providing sustainable, expert, comprehensive and accessible primary health services to people in rural areas. How will your primary care service affect the availability, quality or cost of accessing services in rural areas? Are there significant travel distances or times involved in providing or accessing the service in rural areas? Are there any particular implications for the safety and security of rural primary health care providers given their isolation? Will providers be able to access appropriate | Some rural people live over an hour by road from the nearest medical centre, secondary school, hospital and/or service town. Ensure new services do not impact negatively on the current provision of primary care service, but enhance and build upon it. Subsidise travel, provide free transport or set up temporary service centres in rural community buildings (for example, funding emergency helicopters provide mobile clinics, linking in with other rural events or coinciding appointment times with transport timetables). Encourage sharing premises or staff with other agencies (for example, Community Link & Heartland Centres) Fund appropriately time for education, travel, and local infrastructure to support providers accessing necessary learning opportunities. Ensure training opportunities are integrated |

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| support mechanisms to ensure their ongoing competence and continued quality improvement? | into all new service provision, to encourage learning and education in rural communities and expose young people to rural areas. |
| <p>Costs of service provision:</p> <p>Will the delivery of services be more expensive or more difficult to achieve in rural areas?</p> <p>Will your new service have a disproportionate affect on small rural isolated practices?</p> <p>Are there significant differences between the costs of compliance with contractual obligations of providers in rural areas compared to urban areas?</p> <p>Will rural providers find it more difficult or expensive to comply?</p> | <p>Recognising the practical implications of complying with legal, ethical and registration requirements, continuing medical education, and involvement in clinical governance in rural areas – considering the smaller population size and increased workload inherent in providing comprehensive services.</p> <p>Take services out into rural areas (for example mobile delivery of surgical services).</p> <p>Provide funding, per practice, in recognition that some costs are relatively constant regardless of scale</p> <p>Modify funding formulas to take into account higher per capita costs of delivery in rural areas (for example, modified population-based funding of rural practices).</p> <p>Target funding to assist or encourage provision in rural areas or improve access for rural people.</p> <p>Encourage combined servicing of several providers of similar services (for example, one administration provider for two or more practices).</p> <p>Require delivery of education and training in isolated rural areas</p> <p>Provide exemptions or concessions in particular situations. (For example allowing rural nurses to request tests, develop standing order processes).</p> |

Step 4:

Ensure implementation plans include a review of how rural communities are impacted by / access the service and make appropriate and necessary adjustments to ensure outcomes are equitable across urban and rural communities.

Questions :

1. Can you measure outcomes and compare rural and urban dwellers in your audit process?
2. Do you measure rural population health outcomes when you audit?
3. Do you have the organizational will to ensure equity across communities?

Solutions:

- a. Appoint a rural champion within your organization tasked with ensuring equity and ensuring rural issues or addressed in every agenda item.
- b. Ensure your management services programme can identify rural and urban addresses and use these as filters in assessing access and outcome measures.
- c. Include rurality when performing health outcome audits.
- d. Require regular reports including outcomes based on rurality and plans to address equity gaps from providers.
- e. Ensure rurality is reported in all evaluations of access to services.

CONCLUDING SUMMARY :

Rural communities require a focused attention to ensure equity of access and outcomes.

DHBs, Alliance Teams, and PHOs should ensure their current and future services acknowledge the needs of rural communities and their health service providers.

Appointing a “rural champion” within the organization, whose role is to ensure rural issues are kept on the agenda at every level in the organization displays the “organizational will” to take rural issues seriously.

The issues and solutions discussed above are not comprehensive, rural communities vary from region to region, their needs vary, and the solutions to those issues will often be developed from within those communities.

The intention of this rural proofing tool is to enable health funders and planners to demonstrate that in the process of development, implementation, assessment, evaluation, and restructuring of health services, they acknowledge the needs of their rural population.

Appendix 1:

Solutions Checklist

| Solution | Who is responsible | When will it be achieved | Actual achieved date. | Comments for review. |
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| Appoint a “rural champion” | | | | |
| Develop a definition of rurality | | | | |
| Survey your rural communities and workforce | | | | |
| Enable a management services programme that can identify rural and urban addresses | | | | |
| Require regular audits based on rurality and plans to address equity gaps | | | | |
| Ensure funding enables equity of services | | | | |
| Ensure adequate access to education services for providers | | | | |