

	
Submission	<b>New Zealand Revised Health Strategy</b>
To	<b>Ministry of Health - New Zealand Health Strategy Team</b>
From	<b>New Zealand Rural General Practice Network</b>
Contact	<b>Linda Reynolds – Deputy Chief Executive</b>
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Thank you for the opportunity to provide feedback during this consultation on the revised New Zealand Health Strategy.

This submission is made on behalf of the New Zealand Rural General Practice Network (the Network).

The Network is a nationwide membership organisation representing the specific interests of rural health and the rural health workforce. Our membership of 1,750 includes rural GPs, nurses and other members of rural general practice teams.

### **Executive summary**

The revised New Zealand Health Strategy invites us to look at our current health service models, workforce skill mix and health outcomes and poses some challenging questions around how we will meet the complex and burgeoning health needs of New Zealanders, now and in the next 10 years.

Rural communities, despite continuing to be challenged by workforce shortages, may need to consider embracing new roles within their teams. This may mean a smaller number of well trained and well-resourced community service providers that have more generalist skills. Rural communities need to be enabled to deliver improvement in high quality and consistent health status.

Rural general practice needs to ensure that issues of access, sustainability and equity of outcomes are consistently addressed through training, support, investment and resourcing.

We support the direction which the government sets out in terms of working more closely across social service sectors to better achieve our goals for a healthier New Zealand that ‘stay well, live well and get well’. We also support the focus on investment to tackle the complex issues associated with age, race, and isolation including obesity, rheumatic fever, drug and alcohol dependency, dementia and mental health issues.

### **Rural General Practice**

#### **The challenge for rural communities**

The challenges of rural health care are twofold. Firstly, to ensure that rural people continue to have local access to sustainable, quality health services and secondly to actually improve the health of rural communities and to reduce the inequities in health outcomes and quality of life experienced by rural people.<sup>1</sup>

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 New Zealand economy. The rural community, tourism and those accessing rural-based recreational activities are particularly dependent on a limited number of health service providers and have reduced access to alternatives.

The Network acknowledges the direction of the government's health strategy in working towards improvements in these vital areas. We note the emphasis in the Minister's foreword: 'Some families find our current services hard to reach, and there are greater demands to address the social needs for the most vulnerable.'

In order for some of New Zealand's most vulnerable people to 'stay well, live well and get well' we need to address issues where rural communities are affected by a range of factors.

Rural communities face well documented, specific challenges around their access to equitable, appropriate and sustainable health care service delivery. These include physical access (limited access to transport; distance and cost of travel), affordability of the service (due to higher levels of deprivation in some rural communities), and sustainability of the available service (due to retention and recruitment issues for rural services and the increased difficulty ensuring quality of care received because of isolation of practices for peer review and educational opportunities).

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

**Low population density and /or isolation.**

- Rural people can be a long distance from services and communication hubs. This affects access to emergency services for communities and is often aggravated by poor broadband and cell 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 NZ Dep 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 experiencing shortages across the range of service providers, both in terms of retention of current providers and the development of future workforce.

Alongside these key characteristics we also acknowledge that a significant number of rural people face health challenges through ageing, poverty, mental illness and lower levels of health literacy. Rural people require advocates to speak up on their behalf and make a difference to the potential health outcomes.

The Network has established the following principles for use by health authorities (DHBs, PHOs and service providers) when planning health services to meet the needs of rural communities. <sup>2</sup>

1. 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.
2. Rural people should have the same health outcomes as people living in urban areas.
3. Rural people should have access to services that are equivalent to primary health services in urban centres.
4. 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.
5. Rural communities should be resourced at a level that enables providers to provide the services required.

6. Rural people should have access to primary care services that will be accessible into the future.

These principles can be acknowledged and acted upon through the following suggested process:

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

Rural communities require 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.

Providing equitable comprehensive services within rural communities requires a depth and breadth of skills, which may be limited when, across all professions, there is a reduced rural health workforce. This then impacts on sustainability of workforce and services, and on continuity of care.

Appointing “rural champions” within organisations, whose role is to ensure that rural issues are kept on the agenda at every level in the organisation, displays the “organisational 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 within these communities.

#### **Refreshed guiding principles for the system**

1. The best **health and wellbeing** possible for all New Zealanders **throughout their lives**
2. An **improvement in health status** of those currently disadvantaged
3. Collaborative **health promotion** and disease and **injury prevention** by all sectors
4. Acknowledging the **special relationship** between Māori and the Crown under the **Treaty of Waitangi**
5. **Timely and equitable access** for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay
6. A **high-performing system** in which people have **confidence**
7. Active **partnership** with **people and communities** at all levels
8. Thinking beyond narrow definitions of health and **collaborating with others** to achieve wellbeing

## General Practice - a key provider in the delivery of rural health services

Having reviewed the Ministry of Health's 'guiding principles' we note that the addition of the eighth principle, 'Thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing' broadens the reach to include collaboration with other services that may positively impact on people's well-being. This makes sense and is in line with the World Health Organisation (WHO) definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."<sup>3</sup>

The WHO definition sought to include social and economic sectors within the scope of attaining health and reaffirms health as a human right.

The revised health strategy is placing even more demands on rural practices, but is also offering greater opportunities for them to address health issues. Improving links between rural general practices, rural hospitals and other services, including other health providers is a good step. However, this will require more time commitments and will call on the on good relationships between the people leading these services. Retention of key health professionals is therefore key to this working well.

Retaining and recruiting to this workforce requires a context in which health teams feel that their work is meaningful, is professionally supported and is sustainable.

## Feedback on the Health Strategy – Five strategic themes

So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

### People Powered

The Network supports the strategic intention to involve people not only as users of health services but also as partners in health care.

In small communities, rural general practices are normally the focal point for the majority of health care, so this strategy is directly relevant. The concept of the natural healthcare home is already prevalent in rural areas with integrated social services and collaborative working practices being common.

The direction also aligns well with the principles of Mauri Ora (healthy lives), Whanau Ora (healthy families) and Wai Ora (healthy communities) incorporated within Pae Ora which is an approach that places families/whānau at the centre of service delivery, requiring the integration of health, education and social services to improve outcomes and results for New Zealand families/whānau.<sup>4</sup>

Much illness is caused by poor lifestyle choices. We need to keep looking for new ways to help people exercise more, eat more healthily, and avoid tobacco, drugs and too much alcohol. There are a high proportion of people in rural communities who are more vulnerable to these problems because of their low socio-economic status. Simply providing education is not the answer. Dealing with people's fears, problems that are overwhelming them, or just plain boredom or lack of purpose in life is hard to do, but we need to look further at how to offer appropriate emotional and spiritual input.

Rural health providers are very well placed to intimately understand the needs of their communities. The way in which services have evolved in rural areas has meant that there is a breadth and depth to

the service provision which extends right through to cross sector collaboration and inter agency working. Much can be learnt from the way in which many rural communities work together. However, much more could be done with the appropriate planning and funding of services and initiatives.

We applaud the adoption of the concept of '*investment*' (rather than cost) with its long view on the building of primary health services for future needs and we support the focus on such investment to tackle the complex issues associated with age, race, and isolation including obesity, rheumatic fever, drug and alcohol dependency, dementia and mental health issues.

We believe it is important to explore ways to work better across traditional boundaries. We need to look at ways for agencies such as MSD, Work and Income, Corrections, Education and Transport to work more closely with Health. Through closer working and finding common areas of concern we will be better placed to enable people to take responsibility for health and address the inequities that currently exist.

As we begin to consider the potential impact on health through this cross agency approach, we will identify other areas of significant influence on healthy communities such as environmental agencies, Local Government NZ, aged care sector, palliative care services etc.

### **Closer to home**

Again, the concept of health service provision being delivered 'closer to home' is a model which is already prevalent in rural areas. Indeed there are numerous examples of innovative and effective models around rural New Zealand such as the integrated family health centres in places such as Dannevirke.

The Tararua Health Group was established in 1999 in Mid Central DHB region and has developed a virtual integrated model through bringing together a group of smaller clinics in close geographic proximity. They operate as a team practice providing health care for a practice population of over 16,000 enrolled patients supporting GP and specialist nursing services for Dannevirke, Te Rongopai, Pahiatua and the large rural areas surrounding the towns. They operate from four sites including general practice, community health services and a rural community hospital. With eight hospital GP beds, three maternity beds as well as x-ray, ultrasound, visiting specialist clinics, community mental health and a lab collection service, the centre operates off a single networked patient management service and employs more than 100 staff.

The practice also works in partnership with the local community pharmacist in Dannevirke. They have established a model of shared clinical records through a direct link between the general practice clinic and the pharmacy via Medtech. This enables the delivery of better community services for the region's patients. The pharmacist attends the medical centre's clinical excellence group and is a part of the local peer review group. He is also involved in teaching on the rural medical immersion training programme.

There are many other examples of innovation and new models of care being developed across rural general practice which are achieving results in bringing care closer to home. However, there is much work needed to ensure that these models have the adequate level of investment to ensure equitable and clinically and financially sustainable services.

In more isolated rural areas, the importance of having health professionals who are known and trusted and who have become acquainted with the work required, know their patients and are able to recognise skills and encourage other people in the community who can contribute to the work cannot be overemphasised. Retention and recruitment (with that order of emphasis) therefore continues to be fundamental.

Healthcare in isolated rural communities is usually centred on general practices, with important input from community services. Allied health professionals and secondary or tertiary services are often distant. Services that travel to rural towns face difficulties including the time it takes them to get to the community, the suspicion they are sometimes met with by patients that do not know them if they are not visiting frequently and the waste of resources if patients they have come to see are unavailable during the limited hours that they can be there.

Rural communities may therefore need a smaller number of community service providers that have more generalist skills. They need to be able to see a greater range of patients and spend more time in the community, developing better relationships with both patients and the general practice providers. Time needs to be allowed for general practice and community service workers to meet together and build on what each other is doing.

### **Value and high performance**

Improved health outcomes that have meaning and value in improving peoples experience of life instead of 'counting measures' is a much better use of our health dollars. Consideration should be given to target funding to the individual 'health consumer' rather than the current model which focuses on contracted providers within a region.

Early indications from the feedback received by the general practice sustainability working party, led by GPNZ, point to a desire for a refresh of the current funding models and a move to not only increase funding for general practice but to also ensure it is fairly and equitably distributed on a needs basis.

We agree with the direction of the revised health strategy in looking to ensure that services are configured whereby:

- Population health management is improved through: looking at the population carefully and then focusing on high-risk individuals or other groups; developing multi-sector partnerships, using key stakeholder resources and aligning our policies to provide community-based support for all who wish to make health-related behaviour change; and striving for a fair system.
- Services are configured in a way that is more clinically and financially sustainable and equitable. Services are delivered in community settings where possible.
- Primary care services use teams to deliver core services; develop shared plans of care; better coordinate care with specialists and hospitals; improve people's access through better scheduling; and work with their communities.

When working towards these aspirational goals, where health service delivery is increasingly provided in the community setting, it will be important to plan for the health dollars to be directed to the appropriate point of care. Particularly in rural primary care, it will be essential to direct the adequate level of funding to enable many small, isolated providers to meet the challenges of increased workloads and extra compliance costs associated with these changes.

Smaller, rural practices do not have the benefits of the economies of scale afforded to larger health providers, therefore it is essential that as a minimum, the existing rural funding adjusters and rural premiums continue to be factored in to health budgets.

### **One Team**

'Primary health care, health promotion, enabling better self-management, preventative care, health literacy, the prevention of avoidable hospital admissions and working strategically to address the social determinants of health is the cornerstone of an optimised and efficient health care system'<sup>5</sup>

We believe it will be important to reshape our workforce to be flexible across primary, secondary and social care. To do this we will need to address workforce supply, distribution, retention and recruitment, and skills mix. This will enable us better to nurture talent; build leadership and capacity for interprofessional practice; and to find ways to integrate care across sectors.

In their study 'Nursing roles and responsibilities in general practice: Three case studies' Walker et al describe nurses as a 'vital resource'. They suggest that enabling nurses to work to the full extent of their scopes, along with adjustments to models of care, and with multidisciplinary cooperation and coordination, could contribute to improving access to health care.<sup>6</sup>

Their study highlights an example of this theory working in a small rural practice. They report that ‘the small size of the practice, commitment to frequent and regular clinical practice team communication and review meetings, and a positive, enabling approach to continuing education and the development of new initiatives in response to community needs has led to the evolution of a model of care. Such models, if scalable, could have an important role in addressing predicted workforce shortages and rising costs of health care – particularly in rural settings.’

We also need to urgently address the issues and challenges around educating, training and developing of a workforce to meet more adequately the needs of our population and health system. We need more focus on attracting ‘courageous doctors’ to study and train to be rural generalists and ‘innovative nurses’ to build on a growing, essential element of our rural health workforce.

New Zealand is currently 1,000 GPs short with rural areas severely affected (as at 30 November 2015, approximately 25% of rural practices have a vacancy for a rural general practitioner.<sup>7</sup>) Currently less than 2% of medical students indicate a desire to work in small communities and only 15% are looking to careers in general practice.

We strongly urge the government to focus on opportunities for health professionals to study, learn and work together in a collaborative style and in well supported contexts, which will ultimately encourage integration across sectors.

### **Smart System**

The Network agrees with the principle of working towards ‘unlocking the benefits of information and other technologies’ to improve delivery of health services to communities.

However, we would caution against relying too heavily on this, too soon. There are vulnerable groups of people who will have added challenges engaging with smart systems. For example, in communities with unreliable power source and weather challenges, there can be issues of an over reliance on smart services. Nevertheless, it is essential for appropriate levels of broadband access and speed to be available in rural areas to an equitable level with urban regions.

Also, a proportion of hard to reach patients will not have devices enabling them to connect to digital devices easily. (One rural practice recently conducted a survey of just over 12% of their registered patients and to their surprise found that as many as 62% of those surveyed have a computer or smart phone, and that 45% are interested in using a patient portal).

The aim for all people to be able to access their health information electronically is unrealistic, and not even wanted by some people.

Many of the hard to reach patients may not be motivated to use them. Reaching them through building relationships must not be forgotten when we focus on IT. Research is required to see how beneficial patient portals are for these patients. There is a risk that they will pamper the “worried well” while not helping the patients who most need help.

Areas where we see potential benefit from using IT more smartly are those where shared patient records can be safely and securely made available such as working more collaboratively with colleagues in Pharmacy through shared access to patient records.

**This submission is based on views of the NZRGPN Executive Board but may not reflect the full or particular views of all of its members.**

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## References

- <sup>1</sup> Successful Models of Rural Health Service Delivery and Community Involvement in Rural Health: International Literature Review. S Bidwell 2001
- <sup>2</sup> NZRGPN Rural Proofing Tool, 2011
- <sup>3</sup> World Health Organization (WHO). Primary health care—Now more than ever. Geneva: WHO Press; 2008.
- <sup>4</sup> Sir Mason Durie, Pae Ora: Maori Health Horizons. July 2009
- <sup>5</sup> McMurray A. Clendon J. Community health and wellness: primary health care in practice. 5th ed. Sydney: Elsevier; 2015 p 94-7.
- <sup>6</sup> Walker L. Clendon J and Nelson K, Nursing roles and responsibilities in general practice: three case studies, JPRIM HEALTHCARE 2015;7 (3):236-243
- <sup>7</sup> RGPN unpublished workforce data