

New Zealand Rural After-Hours Primary Care Provider Survey:

3. Finding workable solutions to providing rural after-hours care

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**Third of three reports from a survey commissioned by the New Zealand
Rural General Practice Network.**

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Executive Summary

Introduction

This is the third of three reports from a survey, commissioned by the New Zealand (NZ) RGPN and completed in August 2005, examining rural health practitioners' experiences of, and views about, providing rural primary care after-hours oncall. Web-based anonymous Internet questionnaires were used to survey general practitioners (GPs) and nurses providing first contact primary care after-hours oncall services in rural NZ. This report focuses on the experiences and views of these rural nurses and GPs regarding actual and potential solutions to improving rural oncall working conditions.

Summary of results

Eighty-one GPs and seventeen nurses completed anonymous Internet questionnaires. GPs reported a range of locality-based solutions that have reduced their oncall workload. These included educating patients to attend during daytime hours, extending daytime hours, more and better triaging of after-hours calls, improved ambulance services (including greater use of helicopter retrievals), nurses sharing the oncall coverage, paying locums to do oncall, combining oncall rosters within and between rural localities, combining primary care oncall with the local rural hospital roster, charging more for callouts to reduce demand, and arranging oncall coverage from nearby urban centres. As these changes are occurring piecemeal, many rural GPs may be unaware of

solutions being used in other rural localities. More isolated rural providers, including most rural nurses doing oncall, have fewer of these options available to reduce their oncall workload. The majority of both nurses and GPs in this survey wanted rural after-hours provision to be better remunerated, and to be a separate contract from the daytime work; with many wanting oncall to be optional as well.

Conclusions

This survey reveals that GP oncall workloads in some rural areas are being reduced in a variety of ways. This has been more easily accomplished by those rural GPs living close to urban centres. As these changes have occurred *ad hoc*, GPs and health managers in other regions will benefit from knowing what actually works to reduce rural oncall workload. Salaried rural nurses may have to use contract negotiations to improve their oncall working conditions and pay. The majority of both nurses and GPs in this survey wanted rural after-hours provision to be better remunerated, and to be a separate contract from the daytime work, with many wanting the after-hours contract to be optional as well. By adequately addressing this one significant rural issue (oncall workload), it may be possible for DHBs to improve both the retention and recruitment of rural nurses and doctors within their districts.

Introduction

Excessive after-hours oncall workload is a major issue for rural GPs in Australia, (1) Ireland, (2) and New Zealand (NZ), (3, 4) and is a major barrier to retention, recruitment and finding locums. In 2001, the NZ Rural General Practice Network produced specific recommendations for recruiting and retaining a skilled primary care rural workforce, and these included recommendations about oncall workload. (5) Despite a significant investment in rural health by the Labour Government excessive after-hours workloads continue to be an ongoing rural problem. Solutions need to be found now if the steadily worsening rural workforce shortage is to be addressed.

The New Zealand Rural General Practice Network (the 'Network') is keenly interested in supporting rural health practitioners, and promoting locally developed sustainable solutions to excessive after-hours workloads. In addition to providing the Ministry of Health with a written submission (6) on the After-Hours Primary Health Care Working Party Report, (7) the Network also wanted to obtain accurate, up to date information on locally developed solutions currently being used to reduce oncall workloads, and how providing after-hours primary health care was impacting on the rural workforce. The Network therefore commissioned a qualitative Internet-based survey of rural after-hours primary care providers, both nurses and GPs.

Methods

The Survey

Invitations to complete an anonymous Internet-based survey were sent to all NZ rural GPs in July 2005. The two-part survey requested self-reported information about individual demographics (six tick box questions) and provision of after-hours care (seven open-ended questions). Invitations to complete a separate anonymous Internet-based survey were sent to rural nurses known to be providing first contact after-hours primary care. The nurse survey was identical to the GP survey except for one less demographic question (Rural Ranking Scale score, which applied only to GPs) and one additional open-ended question asking nurses how they were paid for providing after hours care. The surveys were reviewed by a group of rural nurses and GPs, and feedback used to improve the final versions, which were then endorsed by the Network Executive.

Data Collection and Analysis

The Network, using its database of rural providers, invited all rural GPs, as well as rural nurses known to be providing first contact after-hours primary care, to complete the respective surveys. A 'rural' GP is defined by a score of 35 points or greater on the Rural Ranking Scale (8). A total of 81 rural GPs and 17 rural nurses completed the Internet-based GP and nurse after-hours surveys, respectively.

The demographic data of rural nurses and GPs was presented in the first report. (9) The transcripts of the typed responses were read and reread by the author, using an immersion/crystallization framework (10). Intuitive crystallizations emerged from repeated reflections on the data, which led to reportable interpretations. Identifying names of clinics, towns, cities and districts have been removed and replaced with either 'urban' (in brackets) for provincial or larger cities, or 'rural' (in brackets) for localities in which rural nurses and rural GPs work. This paper reports the themes and sub-themes emerging from five questions. The questions are provided within the results section (below).

Results

A total of 81 rural GPs and 17 rural nurses completed the Internet-based GP and nurse after-hours surveys, respectively.

1. Tell us about the current after-hours care arrangements in your rural locality: who is involved (GPs, nurses, rural hospital)? Is there a nearby urban after-hours centre or emergency department that does some of the oncall for you?

GPs' views

While the commonest oncall model for GPs was to have all of those in a locality sharing the oncall (without help from nurses, rural hospitals or urban centres),

there was tremendous locality variability and recent change in after-hours arrangements.

- Locality variability

GPs' after-hours care arrangements were varied, and related to a number of factors: proximity to urban centres, presence of a rural hospital, ambulance officer skill level, number of GPs available to share oncall, and availability of nurses trained to do oncall (with or without immediate GP backup).

- Change

In describing their current after-hours oncall provision, many respondents described how services had changed or were changing (also see Question 2, below). The following eleven quotes from GPs illustrate both the tremendous variability of after-hours arrangements between localities and the significant amount of change occurring in these arrangements.

D1. *"5 local GPs involved. From March this year [2005], we have had a nurse triage service after 7pm weekdays and 12 midday weekends and reduced local availability, with patients who require urgent care after those hours being advised to travel to (urban centre) or (rural town with hospital) or call an ambulance. We remain oncall for Prime."*

D3. *"one GP oncall 24 hours 7/7 doing second call, RNs between 2 and 4 in number rotating first call with differing levels of skill and experience."*

D15. *"Run from (urban centre), nearest large town. Oncall shared amongst GP's 2:17 FTE oncall ratio. At surgery from 6 till 8, by phone from 8pm to 8am, after triage from Healthline."*

D17. *"Combined GP after-hours roster between (rural town) and (rural town) practices during the week, with the addition of (rural town) on weekends. (Urban centre) Hospital ED < 30 minutes away - available 24/7 but not covering for us."*

D36. *"GPs do triage prior to consultations (though some patients think we run an A&E centre!), some weekends we have ACC-registered nurses doing clinics with us, resuscitation facility paid for by us, local well qualified paramedics, 60 mins to*

(urban centre), neighbouring practices refer through to urban after-hours centre so some of their patients call us in preference (but often get turned away by us)."

D42. "Currently we have an oncall roster for an after-hours clinic, that goes to 8 pm during the week and on Saturdays and Public Holidays, during the day. Outside these times we have a contractual arrangement for the provision of 24 hours care by (urban) A&M Clinic. The oncall roster is manned by GPs."

D52. "From December 2004, changed to GP roster group providing cover only 8am to 8pm on weekdays, and 8 to 12am on Saturdays. Outside these hours, emergency oncall services delegated to St John ambulance and (urban) Clinic (metropolitan doctors a/h co-operative). Prior to Dec 2004, rostered service 24/7 for 25 years - no longer sustainable."

D60. "GPs only - nearest ER 75 mins away. One surgery not providing any weekend cover - our surgery does but is unable to pick up the slack of their cover."

D71. "Only one Doctor in area - no nurses. Doctor always oncall when in the area, but community accept he has to go out of area sometimes. When not immediately available, answer phone advises patients they can leave a message for his return or call 111 which gets the local volunteer ambulance and that ambulance can also page the doctor (PRIME pager). If not available for some time, answer phone advises patients how to get medical advice from nearest centre, or to call 111 for emergencies. Nearest hospital is 1.25-1.5 hours away. Nearest centre is 1 hour away."

D82. "Our geographical area is divided into three areas. The top bit, the nurses do a 1:2, the middle bit the doctors do a 1:2 and 2 other nurses do back up with us, or cover us if we want to hide somewhere. I also do 1:1 for X-rays and other specialised work. The bottom bit of the practice is covered by an emergency nurse but the doctors get involved with him also."

D88. "We have been providing full after-hours care 1:5, and more recently 1:6, until March 2005. At that time we got together with all other (district) practices and signed on with (urban) After-hours service and for a payment of \$2,600 per month are now no longer oncall after 10.00 pm at night. There are no nearby 24 hour clinics. Triage advice is given by a nurse and may lead to the sending of a car with a doctor as a house call. May take an hour to get there and fee usually \$110 dollars (we used to charge about \$65-\$75)."

Nurses' views

The themes of variability of after-hours care between localities and changing after-hours arrangements were also evident in the rural nurses' descriptions of their oncall services. Factors affecting oncall arrangements in these localities included availability of other nurses or GPs to share oncall, and availability of volunteer ambulance officers. Nurses were almost all employed, and almost all commented on their medical backup arrangements.

N1. *"6 nurses sharing call 24/7. All are PRIME trained. Nearest hospital is 1.5 hours away. We are a rural area with no regular GP, so most of our back up is by fax and phone."*

N6. *"Rural nurse does 24/7 PRIME and 111 call week on, week off - i.e. there is a nurse oncall for 111 and PRIME every day/night - 365 days/year. Doctor does 4 nights 'GP type call' (no 111/no PRIME) a week and 1:3 weekends 'GP type call'. If nurse sick or unavailable, St John volunteers pick up 111 calls."*

N8. *"We have 5 registered nurses who are PRIME trained, but only two do oncall shared roster with our GP."*

N11. *"I am oncall 24/7 for 10 days. I am the only person in the area. At weekends I cover an area of 300kms. During the week there is a GP available by phone, and at the weekend, hospital doctors can be phoned. These doctors are often junior staff, who are not always helpful. The nearest hospital is 3 hrs away. Air transport is limited to fine weather and daylight hours. There is frequently no ambulance service due to a lack of volunteers."*

N19. *"We have recently gone from a 1:3 to a 1:6 due to finally being accepted for an amalgamated roster with 2 practices 20 minutes away."*

2. Tell us how after-hours care in your rural locality has changed in the last 5-10 years: Has it gotten better or worse - how? How has nurses or GPs taking on expanded roles, or the recent introduction of HealthLine, impacted on your oncall work?

GPs' views

After-hours care had changed in most rural localities. From the GPs' descriptions there were a number of factors affecting after-hours workload, both increasing and decreasing it.

- Population

Factors that had improved the after-hours workload included fewer motor vehicle accidents, and the tendency of some rural people to now seek care during office hours so as to avoid the need for after-hours care.

D7. *"Fewer MVAs, probably due to tougher policing of speed and DIC."*

D27. *"I am lucky enough (?) to be the sole practitioner in (rural town). The people take that into consideration and only really call for urgent matters (ie. sick children, older people with chest pain, fevers, etc). It was like this when I arrived and at times I must speak loudly to patients who should have called me at night!!"*

D30. *"If anything, the night time calls have reduced, as patients understand the need to be seen during the day if they're sick, rather than waiting."*

Population factors perceived to have increased the after-hours workload included greater patient expectations of access to after-hours care and increases in a rural locality's population.

D11. *"In the last 10 years the oncall has become more onerous because people have become more demanding and less able (inclined) to look after themselves (eg. getting called to people with the flu who have been sick for 5 days then decide they need to see a doctor, or whose child has had a fever for 30 minutes)."*

D26. *"Majority of people expect 24 hour access to health care for minor problems. The out of hours expectations continue to get higher"*

D45. *"Population increased 3% in last 5 yrs. Increasing local population, declining doctor population = increased after-hours load."*

D62. *"Deteriorating oncall situation; 24/7 mentality, growing population, increased expectations"*

- Ambulance services

Better ambulance services were cited as reducing the oncall workload of rural GPs. This included advanced paramedic providing services in some rural areas close to urban centres, and a greater use of helicopter retrievals for rural road accidents and other emergencies.

D25. *"the workload has improved - the helicopter now retrieves most road traffic accidents and other serious injuries/medical problems directly to base hospital that, before we had the helicopter, would have been brought to our rural hospital."*

D85. *"Paramedic support and air evacuation also much more fluent."*

A fall in rural ambulance volunteers has increased the workload of some rural GPs, and even some ambulance officers.

D25. *"Our ambulance service is staffed by Level 1 Paramedics (the new name for ambulance officers), with a volunteer if they are lucky."*

D27. *"I also work closely with the local St John but due to shortage of volunteers we often have weekends with NO local cover - then we have to wait for an ambulance from (rural town) (35km) or (rural town) (72 km) - Difficult!"*

D59. *"Due to the excessive demands that St John places upon their volunteers, we have had for several years a dwindling pool of volunteers, and there are sometimes holes in their roster."*

- Triage

For a number of years, some rural localities have used urban-based nurse telephone triage services, including Healthline. At the time of this survey, Healthline had been a national, free to the patient, government-funded telephone triage service for less than one year. Many GPs felt that a triage service reduced

their after-hours calls, while others said it made no difference or even increased their callouts.

D36. *"a few inappropriate or misinformed referrals from Healthline"*

D41. *"nurse triage and Healthline have really helped, I live out of the area and stay overnight to do my oncall and could not participate if I had to field the phone calls our nurses get."*

D46. *"Healthline has worsened calls as patient nearly always told to see GP! Healthline has no idea what rural GPs do, all think there is an 'after-hours centre' as in urban areas."*

D69. *"Chief change is the introduction of Healthline 3.5 years ago - this has reduced the number of calls out of hours - there are occasional gripes about having to talk to a 'nurse in Wellington', but so far without significant clinical harm to anyone."*

Triage by nurses working the night shifts at rural hospitals was seen by GPs as very positive in reducing after-hours callouts. These nurses provide a local telephone triage service, but can also ask patients to attend the hospital to be personally assessed by the nurse before a decision is reached to involve the oncall GP.

D6. *"For 5 yrs the DHB nurses have been taking and triaging calls which has made a huge difference to the after-hours, and without which we couldn't have survived 1:3 call."*

D25. *"our rural hospital nurses are now doing more and better triage after-hours, so we aren't being woken at night for non-urgent problems that can reasonably wait til the morning. These patients are frequently kept at our hospital, under nurse observation, til assessed in the morning."*

D61. *"Greatest help is from local hospital registered nurse who can triage attendees and decide whether the duty doctor needs to be called out or not."*

But not all local rural hospitals or nearby provincial hospitals were as cooperative.

D17. *“(Urban) Hospital ED < 30 minutes away - available 24/7 but not covering for us.”*

D19. *“No help or support from local rural hospital, which is staffed 24 hours.”*

D26. *“There is a rural hospital but no emergency centre and they do not see any walk-in patients - the GP gets phoned.”*

D37. *“There is no after-hours clinic in the rural hospital, the MOSSs do not do GP oncall, and I do not want to work out of the hospital anyway.”*

- Nurses

Besides triage by rural hospital nurses, GPs cited examples of where they are sharing rosters with rural nurses. These nurses, by taking on first oncall roles, are reducing the GP after-hours workload.

D3. *“Changes have been more related to continuity of staff and development of RN first oncall, so this had been a huge improvement for the GP.”*

D27. *“Approximately a year ago we got extra funding to pay the 2 RNs for oncall at night - this allowed me to have a bit of a life although I am still at the end of a phone, but at least I can go to CME meetings in (urban centre) and nearby towns. Both RNs have completed PRIME.”*

D53. *“Nurse practitioners were introduced 2 yrs ago approx, to help with weekend rota and have been successful - well received by local community and supported over phone by GPs.”*

There were no examples given where nurses were felt to be increasing the workload of GPs, with the exception of nurses working the Healthline triage service.

- PRIME

The PRIME initiative was only mentioned by a small number of GPs, but was seen as an improvement in training, equipment and remuneration for after-hours callouts.

D71. *"Workload much the same, but now better equipped, and trained due to PRIME."*

D84. *"Funding for accidents through Prime has made huge difference to attending these accidents while being paid."*

- GP workforce

Obviously the number of GPs available to share the locality's after-hours roster impacts on their workload. Areas fortunate enough to experience an increase in GP numbers had an improvement in their oncall roster.

D5. *"Our call has gone from 1:3 (occ 1:2) when I first started, to now 1:6 as the practice has expanded and more doctors have joined the practice."*

A few localities used GP locums to supplement the after-hours roster, however this was sometimes seen as an expensive option.

D30. *"The actual amount of call is no better, possibly worse as it is very difficult to employ anyone to do the weekends - we sometimes get a locum, pay them \$1000 (GST incl), and on average, run at about a \$400 loss. It is very hard to compete with the sort of locum fees the DHBs can offer, and the rural locum scheme fees are just prohibitive."*

One rural GP simply opted for a salaried position, which included minimal oncall.

D15. *"On choosing my recent rural position, I selected a salaried role and ensured minimal after-hours, before accepting the contract."*

While another simply stated that he had opted out of oncall.

D22. *"Have given up providing PRIME and local access oncall. Now there is no local oncall as it was so depressing and exhausting; effectively took a \$28,000 pay cut to go from a 1:1 situation, where patients had excellent cover, to current situation where they have no local cover - no GP at all after-hours and no ambulance service after 10pm."*

Loss of GP numbers in a rural locality, or GPs not participating in the oncall roster, obviously had a negative effect on the oncall workload of those remaining, not to mention a possible increase in the daytime workload.

D6. *"10 yrs ago we had 1:6 oncall and a full rural hospital. 5 yrs ago we had 1:6 oncall and no hospital. For 4.5 yrs we have been oncall 1:3. But at 1:3, there is no leeway for illness, holidays etc, and we have all at times done 3 weekends in 4, in addition to very full working weeks, and one gets a bit frazzled at the end of that."*

D18. *"Really has got worse - used to be 1 in 4 but are at least one GP short and no applicants and no locums that will do call available."*

D41. *"Fewer GPs, and some existing ones not doing community call."*

D60. *"Worse - because there is no Section 51 and the other surgery in town has been 'allowed' not to cover weekends."*

- Split weekend oncall

The strain of being oncall over an entire weekend (Friday 5pm to Monday 8am) was improved for some GPs by splitting up the weekends.

D14. *"Now do only one day in a weekend, as too onerous to do two in a row."*

D88. *"We have been burnt out by call - 19 years in my case, 1:4 to mainly 1:5. It became better when we split Saturday from Sunday."*

- Urban cover

Many rural localities close to cities have significantly reduced their oncall workload by making arrangements for some, or all, of it to be provided from the

urban centre. Some mentioned having to pay for this coverage. While this had improved their lifestyle, it was acknowledged that patients had to travel further for assessment.

D2. "A few months ago changed from 24 hour availability by direct phone call, to not being available to general public on nights and after midday weekends. Reasonable acceptance by public, less strain for GPs, and hopefully more likely to retain/recruit new ones. Overall service for patients has deteriorated."

D6. "There is no rural hospital here now, but a DHB run Health Centre with 6 beds and a 24hr RN. The RN takes all after-hours calls and triages, simple advice, call back later, that's ok till tomorrow, you need to see the GP, you need to present at ED in (urban centre), you need an ambulance, or you need the emergency helicopter. GP's are called in Mon to Thurs nights, and do a Sat and Sun clinic, aiming to see 80% of those who need to be seen. Fri night to Mon am, the GP is available for the dire emergencies and for the Sat and Sun clinics"

D22. "No longer locally provided, but by a town cooperative 55kms away of which I was forced to take part, now on 1 in 13 instead of 1 in 1."

D39. "There are three doctors working at the Health Centre. Each doctor is oncall every 3rd day and weekend. Very occasionally, when the rostered doctor has another important commitment and neither of the other two are able to cover, we pay (urban) after hour service for cover."

D54. "Calls go to urban AH centre and patients encouraged to seek help there."

For one locality, a trial of overnight oncall cover provided from a distance was not considered a success, highlighting the problem of patients having to travel further for assessment.

D48. "Had a trial last summer for 2 weeks when 10pm-7am cover was provided by a hospital 50km away. This was relaxing, but did throw up a couple of incidents where risks were raised, in addition to a couple of unnecessary trips by ambulance to hospital."

For some rural GPs, the ability of a nearby urban centre to take some of the oncall load was seen as a negative.

D39. *“With the opening of the after-hours centres in (urban centre), which is about 20 miles by car, patients have started using those services, bypassing us. So what happens is, that even though we have given up our weekend or evening to be oncall, we receive very few calls. Most of these calls are either 111 calls or house calls. The total number of patients seen has gone down drastically and it is a financial loss. As a result, it is not feasible to employ someone else to do the after-hours work and in any case, nobody wants to work for us and take on the after-hours work as well.”*

Some urban areas were either not willing to support nearby rural localities, or were just simply not being used.

D41. *“We have tried to get formal arrangement with a city practice to cover this but they are all full.”*

D45. *“Urban A/H previously reluctant to assist in after-hours cover.”*

D72. *“There are private A & M clinics 30 mins away, which close from 10pm to 8am, and 1 other 24hr A & M clinic 40 mins away. They do not cover our call.”*

- Clinical safety

The issue of clinical safety when GPs are oncall for 3 days over a weekend, was mentioned by number of doctors.

D5. *“It is absurd that a truck driver cannot work more than 8 hours but there is no problem with a GP working all day, after having had as little as 2 hours sleep the previous night.”*

D40. *“Nights oncall become much harder to cope with and potentially produce unsafe working environments.”*

- Patient co-payments

Charging significantly higher patient co-payments was also cited as a way to reduce after-hours callouts, but this strategy can simply lead to higher unpaid accounts in lower socio-economic localities.

D45. *"Patients aware of after-hours fees in urban centre and seem more reluctant to call doctor."*

D86. *"Better due to after-hours price hikes."*

- Combining oncall rosters

A number of rural localities reduced their oncall burdens by combining their rosters, either within the locality or among nearby localities, thereby reducing the number of nights each GP was oncall, albeit increasing the workload when oncall.

D17. *"Combined GP A/H roster between (rural town) and (rural town) practices during the week, with the addition of (rural town) on weekends. Has had to change in order for GPs not to burn out and so current combined roster is an improvement on the situation > 5yrs ago."*

D37. *"In the last 5 years I have been part of a larger roster involving the next town instead of doing 1 in 2 in my practice. My oncall work has become more frustrating because I am dealing with a larger, more demanding population. I am busier when oncall and do about the same travelling or perhaps a bit more."*

D44. *"Our after-hours roster has expanded from the town to the local district and now includes doctors from neighbouring towns in the district. This has improved the oncall frequency from 1 in 9, to 1 in 13."*

D49. *"Has improved: sharing weekends with others has made a huge difference to life (1 in 12 weekends, instead of 1 in 3) and split Sat & Sun, so do either Sat or Sun every 5-6 weekends."*

Another example of combining rosters has been where the GP oncall has been combined with that of the local hospital, thereby improving everyone's roster.

D28. *"GPs from the After-hours Care roster also run the local DHB Accident & Emergency Dept. in (provincial city)."*

But this innovative approach was not being used in other localities with rural or nearby provincial hospitals.

D44. *“Shared district-wide after-hours roster for >20,000 people - 13 doctors on the roster. Local rural hospital also sees urgent/after-hours patients at their ED. When oncall we work from our own rooms.”*

Nurses' views

Most of the rural nurses were either the only health care provider in their locality or were in a team with only other nurses. For these nurses, medical support was provided by phone, fax or helicopter. Although their job was mainly looking after small stable rural populations, increasing tourist numbers were adding significantly to the workload in some localities. A number of the nurses did 10 consecutive nights oncall before getting time off.

N1. *“6 nurses sharing call 24/7. All are PRIME trained. Nearest hospital is 1.5 hours away. We are a rural area with no regular GP, so most of our back up is by fax and phone. The area has 1500 registered patients at the health centre, but this doubles in the summer for the 'kayak' season.”*

N11. *“The after-hours callouts have increased due to increasing population and large numbers of tourists in the area.”*

N14. *“(Rural locality) is VERY remote. I am oncall for 10 days, 24 hours per day. The nearest colleague is 160km away, either another rural nurse in (rural town) or the GP groups in (rural town).”*

N20. *“Oncall for (rural) area, 10 days out of 14, 24 hours per day. Oncall 1 weekend in 2, and on that weekend cover (rural town) as well. Hospital is 2.5 hours north via road, or 35 minutes via helicopter, if in daylight hours and weather permits. I am the PRIME responder for the area. My community only has a population of approx 400 people, however has over 2,200 tourist beds and runs at 80-100% occupancy for summer season, which now stretches October to April.”*

Having nurses do more of the oncall work was mentioned as a way of enticing GPs to work rurally.

N9. *"I am 1 of 4 nurses who cover the (rural town) Medical Centre's after-hours service on weekends so the Doctor does not have to. It is one way of attracting Doctors to rural areas."*

Nurses also mentioned the difficulties of finding sufficient local volunteers for ambulance crews.

N5. *"We sometimes have no ambulance cover during the 'oncall' period, but recently there has been a drive to obtain more volunteers and so the situation will improve. We have no paramedic personnel within this ambulance crew."*

N11. *"There is frequently no ambulance service due to a lack of volunteers."*

Nurses commented that reduced numbers of GPs and fewer GPs doing oncall, have increased the workload of rural nurses, but this has also improved the availability of PRIME-trained providers to some rural populations.

N2. *"I believe that the lack of GP oncall availability has increase the work of the RN greatly."*

N5. *"the previous GP covered the whole area on his own for 15 years, and the rural nurses covered the weekends for the last 2-3 years of his tenure. He was not PRIME trained. From what is presently in place [PRIME-trained nurses doing oncall], I would think that there have been some improvements."*

N8. *"After-hours care has improved, there is now 24hr, 7 day a week cover, provided by our service. My role has extended to meet demand, and has been backed up with PRIME course and postgraduate papers."*

Nurses also complained about unpaid patient debt. No nurse mentioned

Healthline reducing their workload.

N13. *"Healthline just makes it worse for us. The nurse says they should get a GP/Nurse out and they have not triaged very well at all, creating extra work for us - also the people who generally call Helpline are low socioeconomic and we never get paid for the evening calls!!"*

N17. *"Unable to tell if Healthline has stopped any of our phone calls, but Healthline does ring us for advice on where to send patients."*

3. Tell us who you think should be financially responsible for ensuring that rural New Zealanders have adequate after-hours medical care (Ministry, DHBs, PHOs, GPs, others) and why? What should a rural GP/rural nurse earn for being oncall for a weeknight, or for a weekend?

- Responsibility

Overwhelmingly, GPs stated that financial responsibility for ensuring that rural communities have access to after-hours medical care should not be theirs, but should rest with the Government, or one of its main agencies such as the Ministry of Health or the local District Health Board (DHB). A few GPs thought Primary Healthcare Organisations (PHOs) should be responsible, while others specifically didn't want them to be responsible. A number thought that provision of after-hours care was everyone's problem, and therefore required a joint effort to improve.

D4. *"The bottom line lies with the MoH to ensure adequate funding is provided for ALL aspects of primary health care needs."*

D5. *"This issue is at a Government level but no doubt would be devolved down to DHB. It is becoming a significant impediment to getting doctors to work in rural general practice, either as locums or partners long term. This is affecting health care for rural communities."*

D11. *"I believe that the MOH/DHB have a responsibility to fund oncall better. We are finding it harder to get locums who are willing to do oncall. We also find that 'younger doctors' who have been through the hospital system are not happy to be oncall for 48 hours over a weekend (they don't have to do this in hospital) and they expect to get paid handsomely."*

D15. *"Ministry. Should follow UK system. GPs should no longer be obliged to cover out of hours and those interested should be contracted to do so. Pay should be a retainer for being oncall and then have a scale depending on how busy it is."*

D17. *"Everyone's problem and everyone needs to participate in working toward a solution. Funders need to recognise that this service is being provided and that there are 'costs' to those who provide it - stress/burnout, etc. It needs to be remunerated."*

And a number of GPs questioned whether the capitation formula included adequate payments for providing oncall.

D48. *"I have noted that the Ministry have declared no further money will be available for after-hours care - I still haven't managed to work out where the after-hours component is in my capitation; it must be microscopic."*

- Oncall payments

Historically, rural GPs provided this service for minimal payment as part of their commitment to the local community.

D67. *"So far the oncall work has always been a 'service' commitment to be in a small town and has never been compensated adequately."*

D71. *"GPs often (or used to) feel ethically responsible for providing care for their patients and for emergencies in their area. They have provided after-hours care as a service to their community."*

However, the majority felt strongly that after-hours care should now be adequately remunerated.

D6. *"Realistically, a night oncall should be worth several \$100's and a weekend more."*

D7. *"Ministry should be responsible - weeknight \$150, weekend \$1000."*

D14. *"The call should be paying a GP at least \$1000 for 24 hr period oncall with patient co-payment supplementing this."*

D30. *"I think that we should be employed by the DHBs on the same conditions as the hospital based specialists. There should be no fee to patients, and remuneration for oncall should be factored into the annual salary/leave etc package."*

- Market forces

Put simply, they wanted to earn the same as what they would have to pay a locum to do the same work.

D10. *"A locum would cost me about \$1000+ per weekend. If this is a national 'going' rate, then why should we not be paid it?"*

D40. *"Remuneration is more difficult, but should be sufficient so that if the responsible GP does not wish to provide oncall, the money that they would have earned during that call period should be sufficient to pay another provider to provide that oncall. I would think that a retainer plus patient co-payments would be appropriate so that a busy oncall will be paid more than a quiet oncall but with some adjustment for frequency of call also."*

Current rates being paid for rural hospital oncall were also mentioned.

D25. *"Our hospital contract pays us \$225/night during the week, and \$500/day for each of Saturday and Sunday when oncall (eg. hospital weekend oncall from Friday 5pm to Monday 8am pays \$1225, plus any primary care earnings). The hospital oncall payments basically subsidise the primary care oncall, which is uneconomic."*

D82. *"When you see what the DHB pays their GPs, it makes you realise your own value."*

- Rural premium payments

These were seen as partial compensation for the oncall burden, and could be lost if choosing not to provide oncall services.

D6. *"what I earn oncall for the time commitment is a pittance relatively. The Rural Premium is at least an acknowledgement of that commitment, and comes from the MOH to the DHB to the PHO and then to us. I get no pay for being oncall unless I see someone, but don't get the premium unless I am oncall."*

D45. *"Rural retention funding linked to rural ranking. Rural ranking linked to oncall. No oncall = no rural funding. If we say the DHB/Ministry is responsible, then we wave goodbye to our rural funding."*

Some were using the rural money specifically to reduce their oncall workload.

D88. *"We are paying our assistants using all our retention and recruitment money: \$700 for working 8.30 am until 10.00pm oncall plus 55% of any earnings. When the retention and recruitment money runs out we will have to think again."*

Trying to find a funding formula that will be fair to all rural localities was an issue.

Some saw a salary package as being the most equitable, but transparency of being paid was the important issue.

D29. *"The payment should be per patient/year for night care with clawbacks. When oncall we may get 5-10 calls after 6pm while other areas may only get 1. At a weekend I might see 60-70 patients and be busy all day and a good deal of the night. In a quiet rural area a doctor may be working 1:2 but rarely be called. The payment should be per patient per year with a weighting toward practices with onerous oncall rosters."*

D61. *"Personal belief is that income from after-hours care in the primary sector should be totally separated from daily work (as is now happening with our hospital contract)."*

After-hours care highlighted the inequity between rural and urban people. Those living in urban centres are able to access fully funded urban hospital emergency room services without being charged a co-payment.

D79. *"It pains me to read in GP mags about 'free' visits to urban Emergency Departments after-hours instead of writing 'fully funded' as it stands by default."*

D84. *"Financial responsibility for after-hours should be funded in the same way it is in cities. In cities, emergency departments pay staff for being oncall rather than GPs. As we effectively are the emergency staff we should be equivalently funded."*

Nurses' views

The majority of nurses placed the responsibility for after-hours care clearly with the Ministry and DHBs.

N11. *“Ensuring adequate rural health is ultimately the responsibility of the MOH, through the DHBs.”*

N13. *“The local DHB should be responsible, the PHO can't even get their act together!”*

While a few nurses didn't comment about payment for after-hours work, the rest were unanimous that it was inadequate and needed to be increased.

N1. *“A rural nurse with only phone back up should earn a lot more than the \$2.67/hour currently being paid. \$22/hour is more like it.”*

N13. *“Rural nurses oncall require a salary, NOT wages, of approx \$80,000 – \$100,000 per annum.”*

N16. *“Adequate remuneration is essential (eg. weekend - \$700-800). The more remote the nurse is, the more remuneration there should be for the extra responsibility”*

4. Should rural GPs be able to 'opt out' of oncall - why or why not? Should rural oncall work for both nurses and GPs be a separate contract to the daytime clinical workload - why or why not?

GPs views

- No opting out

Many of the rural GPs responding to this survey felt strongly that opting out of oncall should NOT be allowed, and they gave a number of reasons for this view. First, some stated that their very identity of being a 'rural GP' required an oncall commitment – it was part of what made them rural, and therefore different from urban GPs.

D28. *"GPs who wish to opt out of oncall will always do so by choosing NOT to work in rural practice. I feel flexibility of approach is most useful - one size/contract does not usually fit all."*

D41. *"in the end though I do it out of a sense of responsibility to the patients I care for, and wish others would too - my most rewarding medicine happens at 2 am. I don't think medicine is a 9 - 5 career, but I do think that this should be acknowledged in our pay, and that is certainly not the case currently. Someone is abusing my sense of responsibility."*

D67. *"If a GP chooses to live and work in a rural community then part of that commitment should be accepting that there is an oncall commitment. I don't feel you can have it both ways."*

Second, others expressed an ethical responsibility to provide this essential service to the communities in which they lived.

D7. *"Like it or not, being a rural GP means being part and parcel of the community. I feel better chatting to locals in the supermarket knowing that I am there after-hours for them - it wouldn't feel so rewarding if I were only there 9-5."*

D45. *"Rural communities do not have an A&E they can pop into if a GP is unavailable. Opting out therefore is difficult. It would be great if we could opt out, but it is our community that suffers."*

D70. *"No, I believe oncall is part of our job, it just needs to be remunerated properly. It is unacceptable to expect our rural communities to be put at risk because of not having a local GP oncall."*

Third, others feared that if opting out was an option, then too many GPs would stop providing oncall.

D12. *"Would be nice, but a nightmare as everyone would!"*

D37. *"Impractical, even though I would like to opt out."*

D83. *"If rural GPs can opt out of oncall, everybody will opt out, me included. It would be wonderful, and I know all my colleagues will jump for this opportunity as well. We are all older and sick of after-hours."*

- Yes – allow opting out

Those in favour of an ability to 'opt out' stated that it was already happening in some rural localities, and the requirement on rural GPs to provide oncall is the main reason for the workforce shortage, affecting both recruitment and retention of rural GPs. They argue that by removing this requirement, younger doctors (and especially women working part-time) will be more likely to try rural practice.

D15. *"Yes. This is the only way to ensure rural practice is appealing. Few other occupations work a full week and then have no choice about working overtime or not."*

D25. *"YES: it should be a separate optional contract! Only then will the true cost of providing this service be made visible, and will force DHBs and GPs to negotiate reasonable cover and to consider other options for cover (nurses oncall, shared oncall regions, utilisation of nearby urban centres, etc)."*

D88. *"I think they should, because oncall is the killer that ruins your life, and prevents any desire to wish to work in a rural area for many years. There are amazing doctors who still do this, but not the younger generation."*

Others would allow this option, but only for older GPs.

D10. *"in a perfect world older GP's should not have to work excessive hours, as it will damage their own health and life expectancy."*

D61. *"Attending out of hours emergencies helps maintain those clinical skills necessary for rural practitioners. But the workforce is growing older and I can recognise that some GPs can be approaching that stage of their professional life that nights/weekends oncall can become increasingly arduous (if not dangerous). So if medical manpower permits, then Yes, our 'senior' colleagues should be offered an opt off clause."*

Some would only allow opting out, if another system were in place for providing oncall services.

D39. *"Rural GP's should be allowed to opt out only if another service was able to cover."*

D48. *"I do not see it as ethical or morally supportable to opt out without adequate alternative arrangements in place."*

However, it is highly unlikely that another system will be put in place, as long as GPs are prepared to work for minimal payment. It was conceded that giving up oncall could mean a lower income, presumably by losing special rural funding.

D2. *"Oncall is essentially PART of rural GP. However, younger doctors seem to not see it that way, an extra financial incentive is obviously now necessary. If opt out is allowed, income should reflect this (IE. reduced rural incentives)."*

D22. *"Yes, should be able to opt out for a pay cut (?)."*

D57. *"Yes, because it should be the DHB's or PHO's responsibility for providing the out of hours cover, but there would be a cost penalty for opting out."*

- Separate contract

Whatever opinion rural GPs had on 'opting out'; the majority were in favour of making the cost of providing after-hours care more visible by having it as a separate contract. Those in favour of an ability to opt out argued that it was the ability to choose that would ensure that proper rates were paid, as otherwise people wouldn't be prepared to do the work. Also it would address the inequity of those GPs who had already opted out, but were still collecting rural payments.

D11. *"It should be a separate contract because oncall commitments vary from place to place and capitation payments do not cover it. Because oncall visits are 'emergencies', patients can't be turned away which means user pays does not work. We have about a 25% bad debt ratio for after hour visits so effectively they are being done for free (or almost free)."*

D40. *"There should be a separate funding stream for after-hours care as GPs have subsidised the service for too long, and MOH can realise the true cost (financial and social) of after-hours care which is currently born by GPs and their families."*

D84. *“Funding for after-hours needs to be separately funded, as it is effectively already in cities.”*

D85. *“Separate contracting might bring the issue into clearer focus and get the MOH to realise the true value of what they are buying. Properly funded it will cost more but the spin-off of retention and high quality services will be even more valuable.”*

Nurses' views

Nurses were similarly split over the issue of their being able to opt out of oncall.

N1. *“I think we should have a choice instead of being made to feel that we are letting the team down if we don't want to do much or any call. By making us feel obligated to do call we are starting to feel used and many are leaving just so we don't have to do it, even though we love the rural nursing scene.”*

N11. *“I believe that health professionals have an ethical and moral responsibility to use their knowledge and skills. In a small rural community, everyone helps each other and the health professional would find that they were not accepted into the community if they refused to help others for urgent care after-hours.”*

5. Do you have anything else to tell us? - other comments, suggestions or solutions regarding rural after-hours care?

GPs and nurses mentioned a range of ideas and solutions to reduce the oncall workload, and to make it more manageable and sustainable. Those solutions currently being used are summarised in Table 1.

Table 1: Current Strategies/Solutions for reducing after-hours workload.**-Better use of daytime hours:**

- educate patients to attend during regular hours
- extended 'regular' hours

-Better triaging of after-hours calls:

- telephone triage services (e.g. Healthline, ProCare)
- telephone triage by rural hospital nurses
- in person triage by rural hospital nurses

-Better emergency services:

- more and better skilled ambulance officers
- more and better skilled volunteer ambulance officers
- increase use of helicopters to transport patients with serious accidents and medical problems directly to base hospital
- PRIME: nurses/GPs with better training and resources

-Nurses with expanded clinical roles:

- up skill nurses to provide first line primary care oncall services

-Better salary negotiations with less oncall:

- one GP negotiated a salaried rural position with minimal oncall

-Add more doctors to the roster:

- recruit more GPs to a practice
- pay GP locums to do oncall
- combine oncall rosters within and between rural localities
- combine oncall rosters with the local rural hospital

-Use of urban-based services:

- use nearby urban centre to do some or all oncall

-Charge more for after-hours callouts:

- use higher callout fees to deter patients calling

In addition to these solutions currently being used, nurses and GPs also made a number of suggestions for improving after-hours working conditions. They clearly felt that without better after-hours working conditions (hours and pay), the rural workforce would continue to struggle with both retention and recruitment.

D40. *“After-hours care is THE ISSUE for all rural GPs and the next generation of GPs will not be willing to work for nothing, especially as they have large debts.”*

D42. *“Rural after-hours care is stressful, incredibly tiring, financially totally unrewarding, sacrificial, not understood at all by patients ('well, you wanted to be a doctor, didn't you') and unsustainable in modern society.”*

N6. *“we have supported GPs in practice - are also concerned at their drop out/burnout rate - but are also very fearful that the same is happening to nurses - there are some incredibly dedicated health professionals in rural NZ - we must value and nurture what is in danger of becoming an 'endangered species' - yes, nurses and doctors!*

Adequately addressing the after-hours issue will eliminate the inequity between urban and rural general practice oncall, and also the situation where some rural GPs are opting out of oncall, thereby increasing the after-hours burdens on others in the same locality, or nearby.

D25. *“Each rural locality needs to come up with local solutions based around an agreed national framework. The current situation of urban GPs being able to opt out of oncall, while rural GPs are forced to do it, is simply not fair or sustainable. Also, having some rural areas opt out, putting stress on other nearby rural areas, isn't fair either.”*

Suggested strategies for improving rural after-hours working conditions and reducing after-hours workloads included both local and national initiatives.

Local initiatives should be encouraged:

D1. *"I doubt that one blanket will cover every bed. Local solutions will be required. Our local solution has been successful because numerous influential local people were supportive of the change and were involved in convincing the community that limited oncall cover is better than no local doctors at all, which seemed very likely to be the other possible outcome."*

Local solutions need to involve everyone affected.

D2. *"Each area/DHB/PHO needs to develop local solutions, with discussions between GPs, nurses, DHB, ambulance service, local rest homes, and community. Innovative solutions need to be funded."*

D80. *"The DHB and PHO should be willing to assist local solutions, including the combination of nursing, ambulance and GP expertise, providing strategic funding where necessary."*

Localities need to look at their geography and population, and see what resources are available to help. Urban areas (close to rural localities), rural hospitals, rural locums, rural nurses, and rural ambulance services (including volunteers) will all be important resources to make oncall manageable.

D19. *"Would be nice if we had more support from the local rural hospital."*

D57. *"All rural hospitals should have a Casualty Unit, primarily run by (appropriately-trained) nurses, but with doctor backup."*

D66. *"I think it is time for a paradigm shift and that rural communities must realise that the luxury of having their GPs oncall and available 24 hours a day is unsustainable and unhealthy, and that after-hours care needs centralising."*

National initiatives suggested:

- Adequately remunerate rural after-hours work

Nurses and GPs were explicitly asked what they thought would be reasonable remuneration for oncall work (question #3, discussed earlier). The need for adequate pay was re-iterated in this section.

D34. *“Adequate remuneration for after hours work would make rural general practice more attractive for younger doctors, and so improve our workload and current GP shortages.”*

D70. *“We have been performing after-hours care as a free service to the rural population we serve - the time has now come for the government of this country to recognise and realise that, and pay us a reasonable fee for providing that service.”*

- Separate contract for after-hours oncall (optional?)

Nurses and GPs were explicitly asked in question 4 about having a separate contract for oncall. The majority supported this, and it was further mentioned in this section.

D22. *“Should be on a totally separate appropriately funded contract.”*

- Incentives to spend time in a rural practice

Falling in love with a rural practice and lifestyle takes time. Therefore, incentives are needed to get nurses and GPs into rural localities to experience the positives of living and working rurally.

D41. *“the government needs to really work to get young doctors into rural areas - the practice I work in lured me with student loan repayments and it worked - I love it, feel committed to it and am staying. I think the government should be funding this rather than individual practices, our pay is dramatically less than in*

other countries and we have to get young people out here to fall in love with real medicine.”

Providing health care students with significant amounts of rural exposure and experience is used extensively in Australia, and this strategy was suggested for NZ.

D68. *“Increased medical student attachments should also be looked at to give up and coming doctors a taste of rural medicine.”*

- Redistribute rural funding to pay for oncall contracts

It was conceded by a number of rural GPs that rural premium funding (Rural Bonus, Rural Workforce Retention Funding) might need to be re-allocated. This funding could allow DHBs to adequately pay those still providing rural oncall, while those opting out of rural oncall would lose their rural premium funding.

D2. *“Oncall is essentially PART of rural GP. However, younger doctors seem to not see it that way, and extra financial incentive is obviously now necessary. If opting out is allowed, income should reflect this (IE. reduced rural incentives).“*

D42. *“After-hours call should be managed separately to regular working contracts and employ people just for the purpose - funded by the Ministry and DHBs and ? rural retention monies.”*

D88. *“We should refuse to be required to be oncall. I don't care if government subsidies are reduced to compensate. It would be worth it.”*

- Industrial action

Most of the current models of after-hours care, involving both nurses and GPs, pay very little for what is an essential emergency service.

D10. *“Good luck on getting anything changed, as we are too cheap to change financially for any Government.”*

Because the current model is very inexpensive, industrial action was mentioned, to get the attention of Government, Ministry of Health, and DHBs, so as to enable change to occur.

D40. *“Firm, united response from all GP representation groups, even to the extent of planned industrial action, if necessary.”*

D62. *“Our experience, after meeting with one or two politicians, is that they are keen to hush and placate; health care is a 'nuisance' and that as long as it's outside of the public arena, they are happy.”*

D72. *“As was mentioned at the RGPN Conference, some form of Direct Action may be necessary to make the Government, Ministry, and DHBs wake up & really listen to us; it certainly worked for the hospital nurses, the bus drivers, and combined general practice (over the 18-24yr subsidy).”*

Table 2: Suggested Strategies/Solutions for improving after-hours working conditions.

- Local initiatives

- Involve everyone locally in finding solutions

- National initiatives

- Adequately remunerate rural after-hours work
- Make after-hours oncall a separate contract (optional?)
- Incentives to spend time in a rural practice
- Redistribute rural funding to pay for oncall contracts
- Industrial action

Discussion

This is the first NZ national survey of GPs and nurses providing rural after-hours primary care. It asked about their experiences of providing rural oncall, and for their views on improving rural oncall working conditions. The first paper in this series examined the impact of providing rural after-hours oncall on the providers and their families. (9) The second paper examined the experiences and views of rural providers on the PRIME scheme. (11) This paper examines and discusses actual and suggested solutions to making the oncall workload of rural providers reasonable and sustainable.

“The future is already here. It is just not universally distributed.” William Gibson

GP respondents described a range of local solutions and strategies that have been implemented in an attempt to reduce oncall workload and make it sustainable (Table 1). These changes have occurred *ad hoc* around the country and it is probable that many rural providers will be unaware of all of them. This highlights the need for a national framework to correct and avoid inequities between localities, and to share information on successful models for reducing oncall burden with those rural areas still struggling to cope with high workloads.

A very successful solution for rural areas close to urban centres has been to offload oncall, either partly or fully, to an urban after-hours provider (e.g. weeknight [8pm – 8am] and weekend [noon – 8am]). Some localities with rural hospitals have combined their after-hours oncall roster. Those GPs in rural

areas unable to take advantage of these two options, should consider the other options in Table 1, such as greater use of rural locums or having rural nurses join the roster. A redistribution of rural premium funding, from those enjoying significantly reduced oncall workloads to those continuing to provide oncall services in more isolated rural localities, seems logical, especially if no new government money is to be allocated to this problem. The redistributed rural funding, potential supplemented by Services to Improve Access (SIA) funding, needs to be sufficient to ensure that in rural localities where daytime providers opt not to be the after-hours provider, there is enough funding to attract and pay after-hours providers. Nurses working alone with small rural populations commented that the community would always call on them in an emergency, whatever the shared roster. For those isolated solo nurses and GPs, redistributed funding should be used to hire locums to ensure they have sufficient and regular breaks away.

Respondents also suggested other strategies and solutions to reducing rural oncall workloads (Table 2). Specifically, that DHBs and PHOs should be the agencies responsible for ensuring after-hours care is provided, and that this is made transparent by using separate contracts for after-hours care. It was suggested that contract negotiations would ensure that responsibilities are clearly defined for all parties, and that providers are adequately remunerated and have clinically safe workloads. For GPs, this approach would allow those who wanted to provide oncall to continue and be adequately paid; younger and especially female GPs to experience rural general practice and rural living with the option of

doing minimal if any oncall (improved recruitment); and allow senior GPs to reduce their oncall commitment as they got older (improved retention). Retaining these experienced, vocationally trained older doctors is critical for rural health services stability, as they are needed not only for patient care, but also to supervise the younger doctors and trainees. For nurses, the majority of whom are on salary, the same issues will need to be addressed with the help of their union by renegotiating their employment contracts. By having DHBs (and PHOs) clearly responsible for sourcing any additional workforce needed to cover the oncall roster, rural providers will be protected from having to work unsafe hours, and funders (Ministry of Health, DHBs, PHOs) will have greater motivation to address the worsening rural workforce shortage.

Regarding ultimate responsibility for providing after-hours care, respondents to this survey were in agreement with the Report of the After Hours Primary Health Care Working Party (7) that clearly recommended that DHBs and PHOs be held responsible. Recommendation 1c to DHBs states *“DHBs, in collaboration with PHOs and after hours service providers: develop and implement a planning and funding strategy for after hours primary health care for their district, including rural communities, that enables accessible, effective and resilient after hours primary health care services for all service users within current resources.”* While recommendation 5 to PHOs states *“Accountability for 24/7 primary care health care service delivery should remain with PHOs. PHOs must demonstrate to the DHB that they have 24/7 arrangements in place for all service users: (a) by establishing subcontractual arrangements with their*

member practices that make their after hours obligations clear and/or (b) by contracting with another provider to provide after hours services.” DHBs have until February 2007 to supply the Ministry with their District After Hours Planning and Funding Strategic Plans.

The actual and suggested solutions mentioned by respondents to this survey are very similar to many of those in the recently released report of the South Link Health (SLH) After Hours Working Party. (12) The After-Hours Working Party was appointed after the passing of a motion at the SLH annual general meeting of November 2005: *“South Link Health notify all relevant District Health Boards that Members will no longer provide out of hours care after 31st December 2006 and that they wish to enter into negotiations to improve members’ current 24 hour care contractual obligations.”* (12) The South Link Health report recommends a separate optional after-hours contract, adequate and realistic remuneration, better integration of primary care services with hospital services, reasonable workloads, enhanced involvement of nurses, and locality specific solutions for rural areas.

Deciding on reasonable remuneration for rural after-hours work will not be easy, as the workload between localities varies tremendously. However, by making after-hours primary care an optional separate contract, each DHB will be able to work out for itself the cost of providing oncall services in each of its rural localities. Besides the various rural premium funds, Services to Improve Access (SIA) funding could also be used to ensure adequate remuneration for after-

hours services. Many rural GPs in this survey appeared willing to give up some rural premium payments in exchange for less oncall.

It is clear from the comments of many rural GPs and nurses in this survey, that they are prepared to continue to provide oncall services to their communities for minimal pay because they see it as both an ethical obligation, and necessary for their self-identity as a 'rural' provider. This attitude, while laudable, is deterring younger doctors and nurses from choosing to work in rural areas, thereby perpetuating current high rural oncall workloads and with it, the workforce shortage. There is little incentive for DHBs and PHOs to change the current inexpensive arrangement, as the alternative will involve the difficult task of redistributing rural payments, and may well cost more. For that reason, a number of GPs mentioned that industrial action (or the threat of it), may well be required to facilitate change. However, this will be difficult to organize as many of those rural GPs close to urban centres have already reduced their oncall workloads, and many of those in more rural localities, who see oncall as both part of their identity and as an ethical responsibility, may not participate in industrial action.

Doctors in training at DHB hospitals are paid for oncall work and have strict criteria around reasonable rosters. Increasingly, the medical model for hospital nighttime work is that of night shift doctors (similar to the nursing model) which means these young doctors have no experience of being woken from sleep to urgently attend an emergency. These recent graduates, with their high

debt loads, are therefore reluctant to take up rural GP positions seen as having large, poorly paid, oncall workloads that will significantly disrupt their sleep.

The Ministry of Health continues to argue that the primary care capitation funding formula includes payment for oncall primary care services based on historical utilisation rates. (7) The problem with average utilisation rates is that it entrenches minimal pay for rural oncall work where historically the actual number of patients seen (and income generated) while oncall was low in relation to the number of oncall hours worked.

Studies of rural GPs in other countries also indicate that oncall workload is considered one of the most stressful aspects of the job. (1, 2) In this survey, many rural GPs, as well as a few nurses, indicated they were planning to leave rural practice principally because of the stress of the oncall workload. Surveys of NZ rural GPs (3, 13) have included questions about intentions to leave rural practice, however there have been no NZ follow up studies to determine whether rural GPs do what they say they are going to do. In a 10 year follow up of 91 rural GPs in Western Australian, Kamien (14) found that 51% (23/45) of those intending to leave rural practice had in fact left, while another 24% (11/46) of those intending to stay had also left.

As some rural GPs divest themselves of most or all of their after-hours oncall, it may be timely that the Rural Ranking Scale is being reviewed. (15, 16) A discussion needs to occur regarding GPs' continued entitlements to special rural funding if they are not actively participating in a rural oncall roster. Reducing the rural oncall workload is required to improve both the retention and

recruitment of doctors and nurses in rural New Zealand, but this may well require a new version of the Rural Ranking Scale.

Strengths and limitations

These were fully discussed in the first paper in this series (9).

Conclusion

Rural after-hours oncall is a significant barrier to the recruitment of young doctors and nurses, causes experienced providers to consider leaving rural practice, and makes it difficult to find locums. Many rural providers work long hours oncall for little pay because they feel an ethical duty to their communities and because oncall forms part of their self-identity as a 'rural' provider. Rural GPs across NZ have used a variety of ways to reduce their oncall workloads. One effective solution, available to rural GPs living close to cities, is to offload oncall onto the urban centre. As these after-hours changes have been occurring *ad hoc*, GPs and health managers in other regions may benefit from knowing what actually works to reduce rural oncall workloads. Rural nurses and GPs also suggested that if after-hours oncall was a separate optional contract to daytime work and was fairly remunerated, it would attract more young graduates to work in rural areas. By adequately addressing this one significant rural issue (oncall workload), it may be possible for DHBs to improve both the retention and recruitment of rural GPs and nurses within their districts, thereby providing stable rural health services with better continuity of care.

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