

Anne Duncan  
Ministry of Health  
PO Box 5013  
Wellington

29 September 2006

Dear Anne

### **Submission on the Ministry of Health review of the Rural Ranking Scale (RRS)**

The New Zealand Rural General Practice Network (NZRGPN) has consulted widely with its members on the Ministry of Health review of the RRS and the following issues have been identified as needing to be considered and addressed. The issues we raise relate to the process of the review itself and to issues specific to the RRS.

The NZRGPN has a number of concerns related to the way in which the review has been conducted. We have raised a number of these issues with the Ministry previously and summarise them below.

#### **Ambiguity around the purpose of the review**

We are concerned about the ambiguity in relation to the breadth and scope of the review. In its communications with the NZRGPN the Ministry indicated that the review was concerned with issues related to the RRS. We understand however that in communications with other organizations, the Ministry has noted that the assessing of the definition of rurality is the initial phase of a review "of the entire funding of rural health services".

We have somewhat "after the fact" been provided with a project plan for the review. We do not believe that this is a proper process for a review, which could have significant impact on rural practitioners and their patients. We request that any future reviews impacting on the delivery of rural primary care be based upon processes which engages the Network and sector at an early stage in determining terms of reference, developing a consultation plan and data gathering process and establishing a robust process for gaining expert advice.

#### **Concerns about the review process**

There have been unnecessary mistakes made by the Ministry in the initial gathering of data from rural practitioners. For example; soon after the MOH RRS Review letters were received by rural GPs, the Network identified that less than 50% of eligible rural GPs had been sent the RRS survey by the Ministry. If not informed by the Network the Ministry would have remained blind to its error.

Feedback to the Network from rural GPs indicates concerns about the way in which the MOH has approached the review and the potential impact of the review on rural funding.

These concerns particularly relate to recruitment and retention of the workforce. One rural GP noted, “the little remaining surety and confidence (in the sector) will be eroded if this approach continues”.

Feedback also indicates that there is concern amongst rural GPs that PHOs have been asked to comment on the RRS and that this could potentially lead to “division, minimization and/or fragmentation”.

A rural GP has also noted

“I am perplexed that the Ministry of Health has thrown the issue of the rural ranking scale open to almost public discussion, as it really is a sector issue that should be negotiated between general practice and the DHBs. It is prescribed in the Health and Disability Services Act and reiterated in the contract currently held by GPs. It is a negotiated agreement reached now between GPA (now NZMA), the Rural GP Network, and the RHAs (now DHBs). I believe that it is not for the Ministry of Health to change and is only changeable by the three parties mentioned.”

### **Issues addressed by the review**

#### **Definition of “rurality”**

Rural is a perspective, dependent on person, place and context. As such, the definition and meaning of "rural practice" will vary considerably, depending on whether the person is a rural patient trying to access care, a rural doctor, a nurse, another rural health worker, a researcher or a government planner.

In general terms, rural practice can be defined as practice in non urban areas, where most medical care is provided by a small number of general practitioners/family doctors with limited or distant access to specialist resources and high technology health care facilities.<sup>1</sup>

A paper by Eugene Leduc ("Defining rurality: a General Practice Rurality Index for Canada") presents a preliminary model that measures 6 community variables in an effort to quantify rural practice. These variables are distance from the closest advanced referral centre, distance from the closest basic referral centre (or advanced referral centre if closer), drawing population, number of GPs, number of specialists and presence of an acute care hospital.

Other rural practice indices have been developed. The 1997 British Columbia Northern and Isolation Allowance Program measures 5 medical isolation factors (number of GPs, number of specialists in the geographic area, distance from a regional referral hospital, exceptional circumstances, and doctor to population ratio) and 2 living factors

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<sup>1</sup> “In search of a definition of "rural". James Rourke, MD, CCFP(EM), MCISc, FCFP, FFAFP Rural General Practitioner/Family Physician, Goderich, Ont. Can J Rural Med vol 2 (3):113

(remoteness from a major population centre and size of the community) (Dr. Geoffrey Appleton, Terrace, BC: personal communication, 1997).

The New Zealand Rural General Practice Network Rural Ranking Scale measures 7 variables: travelling time from the office to the base hospital, availability of ambulance services, on-call for motor vehicle accidents, travelling time to nearest GP colleague, travelling time to visit most distant patient, on-call duty and number of regular peripheral clinics.

In reviewing the RRS we would suggest that any future index of rural practice should reflect where rural doctors live, what they do and what degree of professional isolation and support they have. When looking at any detailed index, it is useful to see how it examines the depth and variety of rural practice under the 3 headings of community and lifestyle factors, the nature of practice, and professional isolation and support. It is also important to see how these factors are weighted in any index.

## **Community and lifestyle factors (where rural doctors live)**

In the smaller, more distant communities, educational facilities, spousal job opportunities, religious and cultural access, and the potential mate pool for unmarried physicians are all less available. Transportation for these activities is both time-consuming and expensive. Any index of rurality therefore should include both the size of the community and the distance from or ease of access to larger urban centres as key markers for these important social and family considerations.

Some communities are more difficult than others to attract staff to because of their remoteness, the perception of achievable lifestyle and social standing of the community when compared to others. Whilst it is difficult to measure these factors, for these communities an additional rural bonus helps with recruitment and retention.

The Network's Rural Ranking Scale does not include distance or ease of access to larger urban centres for issues around lifestyle, but does include travelling time and distance to major hospital for professional support and additional discretionary points that can be added when areas have difficulty with recruitment or retention of staff.

## **The nature of rural practice**

One of the major differences between rural and urban is access to a range of services across health issues and across types of service providers e.g. urban areas have enough services to cover most issues and, especially with more generic services, a range of service providers to enable the service to be delivered effectively in the eyes of the patient. Rural areas typically have a very limited range of services locally, meaning many services need to be accessed regionally, thereby severely impacting on accessibility for the patient.

Furthermore, if a service is available there is usually only one provider and often a one size fits all approach because of lack of options. This results in general practice being required to deliver a wide-ranging service in the context of a high level of dependency.

This in turn, leads to difficulty in recruiting and retaining staff, and gaining locum cover to enable attendance at education and or other meetings.

#### A rural GP notes

"For health care, the impact of rurality on patients comes through distance from health services, communication and travel difficulties, poverty, exposure to agrichemicals and other work conditions and quality of housing. For health care workers the impact of rurality comes through distance from services, lack of collegial support, difficulty getting holidays and breaks for CME, workload (out of hours, secondary and social support services – e.g. poor mental health support, inability to refer eye problems locally, poor dermatology services locally, lack of access to minor surgery, no A+E services locally). These and other complex issues need to be taken account of.

I hear that in my area, the pharmacies in Whakatane have been defined as rural – there is evidently a ranking scale for pharmacies, as there is for the police, and schools and dentists and vets, these scales should all be specific to the needs of the differing services, there is no one definition of rurality that will fit all."

A practical definition of rural practice, used by the Faculty of Rural Medicine, Royal Australian College of General Practitioners, is "medical practice outside of urban areas where the location of practice obliges some general/family practitioners to have or acquire procedure or other skills not usually required in urban practice."

Each rural setting has its own special challenges. In the smallest, most remote settings, help is a long time and distance away. This places immense strain on limited local resources and on the rural GP, particularly when serious emergencies occur. In larger rural communities and those equipped with a small active hospital, the rural general practitioner's scope of practice, in addition to office-based family practice, house calls and rest home visits, sometimes includes hospital-based medicine. Acquiring and maintaining the necessary knowledge and skills can be a challenge.

The rural health care context has only recently begun to be considered at academic and government levels. The population served by rural practitioners has distinct characteristics and determinants of health. In low socio economic settings or those with a high Maori population, public health activities take on special importance for rural doctors.

The Network believes that rural nurses who are providing 24/7 and emergency skills in a role similar to their GP colleagues, should be assessed and funded in the same way as rural GPs.

In order for this to occur the RRS will need to be extended and there will need to be an increased level of funding to cover all rural eligible rural nurses and sufficient to ensure that the existing rural general practice infrastructure and services to rural communities are not destabilized.

## Professional isolation and support

Although all rural areas suffer from professional isolation relative to urban practice, the smallest, most remote communities pose particular challenges in terms of both professional isolation and lack of resource support. This factor must have particular weighting in any index of rurality. Even though the nature of practice may be similar in two very different geographic settings, the distance to referral sources may be dramatically different.

The presence of a local hospital and its level of resources, including any specialists, and the distance to more advanced referral care and specialist support services are factors affecting professional isolation.

The Network's Rural Ranking Scale allows for the various shades of rural isolation with questions around; travelling time to nearest GP colleague with a weighting of 0 – 10 points and the travelling time and distance from the practice to a Major Hospital placed in a large urban centre with weighting from 0 – 20 points.

In Canada, Australia, United Kingdom and United States, most definitions of rural are based on geographical classifications. Territory is classified by: population size and density; level of urbanization; relationship to urban centre; principal economic activity; or indices of rurality (United States Rural Policy Research Institute, 1999; Welch, 2000; Pitblado & Pong, 1999; Bollman, 1994).

## On Call (24/7)

The number of doctors available to share the workload and on-call duty is an important variable contributing directly to the sustainability of working conditions. Balancing on-call and case-load can be problematic, especially for emergency work.<sup>2</sup>

The NZRGPN believes that on-call service represents a significant burden for many rural general practitioners. The Network has recently completed a survey on rural practitioners' experience of on call, which informs this view. (The survey can be located on [www.rgpn.org.nz](http://www.rgpn.org.nz))

Key findings from the Network survey on the impact of on-call on providers and their families:

- o Providing on-call has significant negative personal consequences for GPs, nurses and their families
- o On-call workload is a significant barrier to recruitment
- o On-call workload is a major reason providers leave rural practice

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<sup>2</sup> "Defining Rurality: A general practice Rurality Index for Canada" Eugene Leduc, MD CCFP *Can J Rural Med* vol 2(2):125

- o Practices face difficulties attracting locums who are prepared to do on-call work
- o On-call is remunerated very poorly in relation to day time work provided by GPs and nurses – despite being an essential service
- o Solutions to this one key rural issue (on-call workload) would be a significant step to improving both retention and recruitment of rural nurses and doctors in New Zealand

Workforce surveys are clearly indicating what we have been advising the Ministry for a number of years: that the NZ rural GP workforce is ageing and new graduates are unwilling to consider rural practice with its heavy on-call workload. The Network foresees a serious predicament. We would hope that the Ministry of Health is giving genuine and earnest consideration to this matter within their proposed 10 year plan, and that sector engagement and consultation forms part of the Ministry's plan.

On-call responsibilities are currently recognized as important criteria for the RRS. It is essential that this onerous part of rural general practice, which requires special knowledge and skills, is adequately recognized. On call for major trauma and medical emergencies is a major contributor to rural general practitioner stress and clearly distinguishes rural from urban practice. On-call is also a significant deterrent in the recruitment of general practitioners into rural practice and financial compensation, reasonable workloads, and incentives need to be in place.

#### A rural GP commented

“Having worked as a single-handed rural GP for coming up to 20 years, I would say that the single most important issue is after hours service. This is the burden that is hardest to bear and is the single most important reason for young doctors avoiding rural practice. If you really want to encourage young doctors into rural general practice this is your answer. Remove from general practices the need to supply an after hours service, without punishing them financially and young doctors will flood into it.”

Rural GPs have identified concerns around the way in which on-call duty is calculated with the description of the “roster area”, not being well defined. They note also that the calculation of the eligible number of GPs to participate in a roster area does not make allowances for the arrangements around part-timers and GPs who commute to an area.

Some discretion in this area would assist, with the current description standing, but practitioners being able to negotiate recognition of the usual contributors to on-call rosters and the appropriate ratio. A part-timer should be considered pro rata e.g. in accord to actual FTEs, a resident but non-working GP should not be included and consideration should be given to GPs who commute to an area but don't contribute because of particular circumstances.

An inherent danger in changing the way rurality is defined is that this could disenfranchise GPs who are living and working rurally but who have used the RRS and its benefits to develop other supports for their on-call commitments. This could result in the “catch 22” of their having decreased their on-call work, they then lose points and the ability to sustain those supports.

The Network agrees that there are many factors that determine the true rurality of a practice which need to be considered. These include but are not limited to:

Geographical location and landscape features (e.g. Ruatahuna is close to Whakatane but you need to drive around the Urewera range to get there).

- Access to regional and local services
- Service level of local and secondary service providers
- Prevalence of transport to measure the true geographical spread e.g. It may be 7km by car but if there is no car, how long will it take?
- GIS mapping to determine patient geographical spread
- Socio-economic deprivation of the practice population

It is important to remember that the Network's Rural Ranking Scale was designed specifically for rural GPs by rural GPs.

### ***Other indices of rurality***

Rousseau, in a review of various definitions of rurality in the United Kingdom, concluded that the term "rural" encompasses a wide range of communities: affluent, deprived, agricultural, industrial, stable, mobile and others. She summarized that "it is difficult to choose any one feature which captures the essence of rurality."

The Montana State University Rurality Index showed that only 2 variables were needed to produce results comparable to those of other, more detailed rural health care indices.

These 2 variables were distance to nearest emergency care and population. Distance was given twice the weight of population, which was given a negative value.

## **Practice profiles**

Hays and associates,<sup>3</sup> working in Queensland, Australia, developed a "sampling framework" for rural and remote doctors, and surveyed 311 of these doctors to compare their training and practice profiles with those of 142 city doctors. They found that doctors

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<sup>3</sup> "A sampling framework for rural and remote doctors" Hays RD, Craig ML, Wise AL, Nichols A, Mahoney MD, Adkins PD, Aust J Public Health 1994;18(3); 273-6

who were more than 80 km or 1 hour's travel time from the nearest, most frequently accessed hospital and support services were significantly more likely to practice a wide range of clinical and procedural skills, use a wide range of procedural clinical equipment, and were more likely to have restricted access to health and community services. They also found differences in the practices of "remote" doctors, those more than 300 km or 3 hours' travel time from support services. Local area population was a better predictor of these differences than individual town population.

A more statistically rigorous study was that by Britt and colleagues,<sup>4</sup> who surveyed 231 full-time Australian general practitioners. The practices were randomized and stratified in advance according to location in metropolitan or large (population greater than 15 000), medium (population 5000 to 15 000) or small (population less than 5000) country towns. The doctors recorded the details of all patient encounters in two 1-week periods separated by an interval of 6 months. Small country town general practitioners were more likely to be older, male and in solo practice. Access to medical specialists and other support services decreased in proportion to population. Doctors in the smallest, most remote towns wrote fewer prescriptions, requested fewer tests and made fewer referrals.

## List of possible variables

There are numerous differences between rural and urban medical practices that could potentially be measured. Some of these are described here in 6 broad categories.

### Health care facilities, staff and equipment

The type of healthcare facilities can vary significantly. It might be important to know if the community has a laboratory service, a medical imaging service (X-ray, ultrasound), or a rural hospital offering inpatient care, as well as the appropriately trained staff to provide services in these facilities.

### Remoteness and availability of transportation

The distance from higher-level medical services (secondary and tertiary) and educational, social, political and cultural centres are obviously very important factors. Access to air, road and water transport is closely related to these factors.

### Travelling time

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<sup>4</sup> "A comparison of country and metropolitan general practice" Britt H, Miles DA, Bridges-Webb CD, Neary S, Charles J, Traynor V. Med J Aust 1993; 159 (suppl):S9 –S64



The Network believes that “travelling time” is an important measure of rurality and needs to be retained. Travelling time to the nearest GP colleague is an important determinant of isolation for a rural general practitioner, as is travelling time to the nearest hospital. Also important is travelling time to the most distant practice boundary. For some GPs in large rural practice areas, huge distances need to be covered in doing home visits for seriously ill patients.

Peripheral clinics are essential to isolated communities and GPs need to have recognition for the difficulty of getting themselves, data and equipment to these remote clinics. Geographical isolation in relation to coping with natural disasters should also be considered.

A rural GP notes in relation to these issues

“Travelling time is a very significant issue. Consideration also needs to take into account the quality of roading (e.g. half an hour on a dirt road equals 20 minutes on a secondary road, equals quarter an hour on a main highway).”

## **On Call Paramedical/Ambulance support (0 –15 points)**

The presence and level of training of non-physician health care professionals in the community constitute an important variable.<sup>5</sup> A nursing triage system can reduce the disruption caused by phone calls and the frequency of emergency call-outs for rural GPs. Rural Nurse Specialists who share the on-call roster are an important part of the rural health team contributing greatly to improving the on-call workload and ratio. The capabilities of the ambulance service are often volunteers who live in rural communities and their skill-set can vary enormously.

The Network’s Rural Ranking Scale takes into consideration the issue of on-call and links it to assistance provided by paramedic or ambulance arrangements with a weighting of 0 – 15 points. The name changes that have occurred with ambulance officers also needs to be taken into consideration. Ambulance officers are now called ‘basic paramedics’, and ‘paramedics’ now called ‘advanced paramedics’.

## **Social factors**

Social factors are varied and are not adequately addressed by research. Many family and social opportunities are not available in rural and remote centres. Housing is likely to be less plentiful and less marketable than in urban centres. There will probably be fewer school and course choices for students. Postgraduate educational facilities may be absent or very limited. Continuing medical education opportunities for physicians are likely to be infrequent. There may be fewer employment options for a doctor's spouse, as

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<sup>5</sup> Hays, Craig, Wise, Nichols, Mahoney, Adkins et al

well as fewer child care options. The local retail and service industry may be limited and relatively expensive.

## Population

Population appears to be inversely related to the availability of many of the services mentioned above. Rural populations are more scattered, may have lower average incomes and may have significant subpopulations with specific health care needs.

## Remoteness from closest advanced referral centre (0 - 20 points)

A measure of remoteness first necessitates a standard definition of the urban community with which the rural community is being compared. Only then can distances be measured.

In their sampling framework, Hays and associates<sup>6</sup> used 80 km or 1 hour's surface travel time from support services as the minimum distance to qualify as rural. Thompson and McNair<sup>7</sup> for Canada used 50 km or 30 minutes' travel time because "multiple trauma patients should be taken directly to the nearest hospital for stabilization, unless a higher level of care is available within 30 minutes by ground." Communities were considered "remote" if they were outside the 200-km limit of a helicopter air ambulance service or were at a minimum distance of 300 km or 3 hours' travel time by road. This distance would also be reaching the limit of a comfortable 1-day return trip by road for elective services.

While New Zealand is more compact than either Australia or Canada, the concept of time and distance in relation to rural and remote practices is important.

It would be logical to use actual travel time to the referral centre, but this cannot be easily or objectively measured. An alternative is to use road distances, but not readily apparent on maps are significant hazards such as road surface, terrain, weather and wildlife, which can greatly increase rural travel time. Some rural communities may have a road link, which becomes unreliable in winter. GIS mapping software can measure traveling times over roads, and take into account the type of road traveled (e.g. metal, paved, divided highway). Consideration should be given to incorporating GIS measurements into the RRS.

## Drawing population

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<sup>6</sup> Hays et al

<sup>7</sup> "Health care reform and emergency outpatient use of rural hospitals in Alberta, Canada" Thompson JM, McNair NL, J Emerg Med 1995;13(3):415-21

There is no agreement as to what population size qualifies as rural. General practitioners usually provide primary care for people outside the statistical town boundaries. For this reason, the concept of a drawing population or local health area should be used, rather than just the population of the town. This would allow for consideration of the numerous rural practices throughout New Zealand who have a seasonal or transient tourist population.

The availability of many services is directly related to population, but too much weight on this variable would diminish the more important role of remoteness. Some small communities may be within a short commuting distance of large cities, so should be relatively lower on the rurality scale than bigger, more remote places.

The Network believe that it would be inappropriate to limit definitions of a “rural” population to those living outside settlements of 1000 or more as many rural areas concentrate some part of their population for safety without improving their access to services or their ability to facilitate access. Many practices service a wide geographical spread of patients and we need to enable choices of health professional in order to allow people to feel comfortable and confident with the services they access. This fosters a proactive approach to self-management of health.

## **Number of general practitioners – On-Call Roster (10- 40 points)**

The number of doctors working in a given community determines the workload and on call-sharing potential, as well as the general feeling of isolation. Surveys have shown that isolation and sharing call with only 1 other GP were significant factors in the consideration of GPs planning to leave rural practice. This variable may be independent of remoteness and population.

## **Population to doctor ratio:**

The Network has always maintained that the ratio for rural practitioners should be 1:1200 as opposed to the Ministry of Health’s ratio of 1:1400. The 1:1200 ratio takes into account the varying degrees of providing rural general practice services.

## **RURAL PRACTICE**

The Network believes that as guiding principles, rural and remote GPs need to be recognized in three ways.

### **1) Degree of isolation:**

- from other general practitioners
- from specialist backup (secondary and tertiary)
- from professional and academic opportunities
- from social opportunities for spouses/partners
- from social and educational services for their families
- from work opportunities for spouses/partners and other family members

### **2) Level of Responsibility:**

- on-call emergency duties
- on-call obstetrical duties (if this is now or becomes in the future a reality for rural GPs)
- on-call gp-anaesthesia / special skill duties (this should be factored in as future proofing any RRS review)
- being accessible when in the community even when not on-call for emergencies (e.g. multiple traumas, terminal patients)
- in-patient care and critical care - which is often consultant-like in nature due to the lack of sub-specialists (this should be considered for inclusion as future proofing any proposed RRS review)
- involvement in multiple hospital committees
- special skills, NZ police contracts, psychotherapy, crisis intervention, house calls
- maintaining an office practice despite those other duties listed above
- managing resources and triaging ambulance or paramedic services
- deciding which patients require secondary/tertiary care services and arranging transfer of care
- having social contact with patients for whom they provide care, on a daily basis

### **3) Duration of service**

- Physicians who acquire the special skills and knowledge base that rural and remote medical care requires are a valuable health care resource. Industry would find it unthinkable that we do not reward a person with this skill set and try to keep them in place, providing care for years to come.

### **Importance of the rural ranking scale**

The rural ranking scale is a tool, which gives a measure of rurality as it applies to general practitioners. The Network's Rural Ranking Scale gives consideration for the various characteristics of rural. Rural and remote are a continuum. It is a lot harder to recruit for a solo practice 100 Km away from the next doctor, than for a hospital at a closer distance to an academic centre.

Since its inception in 1999, the RRS has been used for allocating other rural funding: Rural Workforce Retention Funding, Reasonable Roster Funding, the ACC Rural Contract, PRIME and the Rural Bonus payment.

The RRS is important to rural GPs because it defines eligibility to crucial rural funding and as well as the level of funding they receive. In doing so it is an indicator or measure of a GPs rurality, and the difficulties and challenges they face. One of these difficulties is professional isolation from colleagues, both socially and professionally. This professional isolation also limits the number of general practitioners available to share the on call roster.

The RRS has also played an important part in creating an identity for rural practitioners and for rural general practice and has become an invaluable tool for research about the rural workforce.

The RRS is also used by the Clinical Training Agency for the placement of House Surgeons in RNZCGP rural general practice/PGYII teaching attachments and for the allocation of rural scholarships for registrars training in the RNZCGP general practice vocational education programme.

Any review of the rural ranking scale needs to take into account the degree to which the current ranking process underpins the identity, viability, stability and effectiveness of rural practice and its impact on general practice vocational education.

The NZRGPN believes that the RRS has proven itself to be an excellent functional definition of a rural GP that takes into account measures of isolation and workload, and has provision for DHBs to provide discretionary points for special circumstances. Having said this, the Network is not opposed to examining how our RRS could be improved.

## **Other possible measures of rural ranking**

### **Statistics NZ measure of “rurality”**

The Ministry has raised the possibility of using other measures to define rurality. One suggestion has been to use the Statistics NZ definition of “rural” as those populations living outside concentrated communities of 1000 people or less. The NZRGPN believes that the Statistics New Zealand definition of rurality is not appropriate as a means to determine rural ranking of healthcare professionals, and specifically not GPs. This definition does not take into account the range of issues which impact upon the delivery of health care: traveling time from the surgery to secondary and tertiary services, on-call duties and emergency care arrangements, the degree of isolation, dispersion and deprivation of rural populations and the distance between rural GPs and their secondary and tertiary colleagues.

Rural GPs’ comments in response to the suggestion that the Statistics NZ measure be used include the following:

“Almost no general practices would then be defined as rural and you would have solved the problem wouldn’t you? What are you then going to call the problem of getting GPs to work in towns with populations of between 1,000 and 30,000? That is what this move would achieve and would have given the same problem a different name”.

“It seems to me that the definition needs to be based around clinical safety for GPs – NOT population densities. Where a GP has a roster of 1 in 3 (or thereabouts); where his/her closest hospital backup is greater than one hour by car; where there are no colleagues within, for example, 20 minutes drive – these are the sorts of criteria that make additional funding important. Also a GP moving from an area where there is a ‘reasonable’ population will create issues for the remaining GPs and that will increase clinical risk as a result. Levin would be an example”.

### **Deprivation index**

The Network is very supportive of the Ministry attempting to meet the needs of communities who have high health needs. Social deprivation is already considered in

the loading of capitated funding for this demographic parameter. The Network does not however see the deprivation index as providing a useful measure of the attributes of rurality. As previously noted, the RRS was devised to reflect isolation and the difficulties inherent in providing health care to rural communities under these circumstances.

## Rural Premium Funding

### Allocation of the rural premium

The NZRGPN has previously noted its concerns that the allocation of the rural premium funding lacks transparency and accountability (see [www.rgpn.org.nz/papers.htm](http://www.rgpn.org.nz/papers.htm) Premium Funding, November 2005).

In this paper the Network identified significant indications that Rural Premium funding was not reaching its intended source. Prior to the introduction of the PHO contract Rural Workforce Recruitment Funding was explicitly allocated. Over subsequent years the allocation of this funding appears to have been inconsistently applied.

The Network identified situations where some DHBs and PHOs are not only top slicing the Rural Premium under the pretext of 'flexible funding' but also determining how the Rural Premium will be utilised. The decisions are often made with limited or no rural GP involvement. This has significant implications for the stability of the rural health workforce and the impact of service delivery to rural New Zealanders.

From the evidence gathered, what was very clear was that the allocation of the Rural Premium funding lacked and continues to lack transparency and accountability.

The Network made the following recommendations to the Ministry of Health in 2005:

The Network strongly recommended that:

- The current approach to allocation of all Rural Workforce Recruitment Funding is reviewed. This will require the establishment of a sector working party.
- Where funds are allocated against a GPs Rural Ranking Score and his/her enrolled population, then any such funds received (either by the DHB or PHO) should be transparently applied with a clearly defined process for determining utilization, and that any such process be contestable by the GP whose RRS and enrolled population is the basis for the funding in the first place. This will require an amendment to the DHB-PHO Contract, Schedule F5.
- That a robust and transparent approach to ongoing monitoring of the Rural Premium allocation is established and maintained.

The Network continue to note that it is questionable whether this important funding for supporting recruitment and retention of the rural workforce is reaching the target for which it was intended.

## **RRS Discretionary points**

The Network believe that discretionary points are important to enable DHBs to recognize local variants e.g. large swings in seasonal population, recruitment and retention issues, particularly difficult travel/access, having to get there by boat, etc.

## **In conclusion**

The NZ Rural General Practice Network is of the view that in recent years that there has been a growth in the level of confidence and morale in the rural sector which needs to be supported and strengthened. Initiatives that acknowledge and support rural general practice, under the current Government, have played a key role in the upswing in confidence of New Zealand's rural general practitioners.

However, the Network are concerned that recent Ministry actions may result in the introduction of uncertainty in the sector and this could impact negatively upon the stability and development of the workforce, particularly in relation to retention and recruitment. The Network would like to see these issues considered and managed with effective Network and sector consultation.

We look forward to being engaged by the Ministry to ensure that all rural general practitioners and rural nurses are kept informed of the process and progress of the review and are consulted with and have their views reflected in the outcomes of the review.

Yours truly

A handwritten signature in black ink, appearing to read 'Adrienne Steele', with a stylized, cursive script.

Adrienne Steele  
Chief Executive