

## **New Zealand Rural After-Hours Primary Care Provider Survey:**

### **2. Rural general practitioners' and nurses' views on PRIME**

#### **(Primary Response in Medical Emergencies)**

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**Second of three reports from a survey commissioned by the New Zealand  
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## **Executive Summary**

### **Introduction**

This is the second 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 experience and views of these rural nurses and GPs regarding the PRIME (Primary Response in Medical Emergencies) scheme.

### **Summary of results**

Eighty-one GPs and seventeen nurses completed anonymous Internet questionnaires. GPs could be divided into three groups: currently contracted to PRIME, previously contracted, and never contracted. Most current PRIME providers felt the system was working reasonably well. While PRIME was working well in many areas, GPs commented there were still a number of important outstanding issues that need to be resolved. These issues included poor triaging of calls leading to inappropriate callouts, inflexibility in contracting, and poor remuneration for non-accident callouts. All but two rural nurses were currently contracted to PRIME, and nurses shared the concern about poor remuneration for non-accident callouts.

**Conclusion**

While PRIME is working well in many areas, there remain the unresolved issues of poor triaging of calls leading to inappropriate callouts, inflexibility in contracting, and poor remuneration for non-accident callouts. These issues were identified in 2001, and raised again in 2004. For PRIME to be successfully implemented across rural NZ, these unresolved issues need to be addressed.

## **Introduction**

The Southern Regional Health Authority (SRHA) developed the PRIME (Primary Response in Medical Emergencies) scheme in 1995, as part of its regional Trauma Service Plan. Pre-hospital emergency care in rural areas was to include trained and equipped rural general practitioners (GPs) and rural nurses as part of the first response team. Jointly funded by the SRHA and the Accident Compensation Corporation (ACC), the scheme was successfully trialled in the southern region in 1998. A year later it was extended to the rest of New Zealand (NZ), as part of the 'Roadside to Bedside' strategy. (1)

PRIME providers must complete an ACC-approved PRIME training course within two years of signing a contract, and an ACC-approved PRIME refresher course every two years thereafter. PRIME providers are paid a \$30/day retainer for being available for PRIME callouts, are paid fee-for-service by ACC for all callouts to accidents, but receive no additional payment for non-accident callouts. They are provided with a PRIME emergency kit, which is replenished (free of charge) by St John ambulance services.

In December 2001, NZ rural GPs were surveyed 'to ascertain the level of acceptance of the PRIME scheme'. (2) Of the 224 GPs who responded (42% response rate), 41% were contracted to provide PRIME, while 59% were not. While there was overall satisfaction with the training and equipment, PRIME providers expressed concern about the inflexibility of the scheme, the poor quality of triage information, and the inadequate payment for non-accident

callouts. These same concerns were also expressed by those GPs choosing not to provide PRIME. (2)

In a jointly prepared discussion paper released in 2004, the NZ Rural General Practice Network, the Royal NZ College of GPs, the NZ Institute of Rural Health and the NZ Medical Association expressed further concerns about the PRIME scheme. (3) Provider dissatisfaction with PRIME was noted to include insufficient numbers of training and refresher courses, difficulties attending the 5 day training course, and disparities between payments for accident and non-accident emergency callouts. These national organisations also expressed concerns about the poor uptake of PRIME on the North Island, the poor support for providers due to the absence of functioning PRIME committees in some parts of the country, and the lack of transparency of PRIME funding revenue in St John's annual financial statements. (3)

In December 2004 the Ministry of Health established the After-hours Primary Health Care Working Party. The purpose of this project was *"to develop and recommend a national policy framework as it relates to after-hoursafter-hours primary health care that: provides clarity to practitioners, PHOs, DHBs and the Ministry of Health about their respective responsibilities for the provision of after-hoursafter-hours primary health care, and creates an environment that promotes locally developed solutions to the provision of services overnight."* (4) The working party produced its report in July 2005 (4) and the Ministry of Health released it for comment in October 2005.

The NZ Rural General Practice Network (the 'Network') is keenly interested in the issue of after-hours primary care, specifically as it relates to the rural workforce (IE. GPs and nurses providing the service). In 2001, the Network made specific recommendations regarding after-hours oncall workload (5) after it was clearly identified as a major issue by NZ rural GPs. (6) To obtain accurate, current information on how providing after-hours primary health care is impacting on the rural workforce, the Network commissioned a qualitative Internet-based survey of rural after-hours primary care providers, both rural nurses and GPs. As the PRIME scheme is unique to rural NZ and involves after-hours work, rural GPs and nurses were asked their views about PRIME as part of this survey.

## **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. (7) 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.

(8) The transcripts of the typed responses were read and reread by the author, using an immersion/crystallization framework. (9) 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 the question:

***Are you, or others in your rural locality, contracted to provide PRIME (Primary Response in Medical Emergencies)? If 'Yes', how is it working; If 'No', why have you decided not to participate?***

## **Results**

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

## **GPs' views**

GP respondents could be categorised into one of three groups by their response to whether they held a PRIME contract: currently contracted, previously contracted, or never contracted.

### **- Currently contracted**

The majority of GPs in this group felt the contract was working well. The factors that influenced this positive assessment included not being called out too frequently or inappropriately, a desire to support their local volunteer ambulance crews, and receiving improved remuneration for accident callouts that were historically done for minimal or no payment.

D1. *"Yes. Working reasonably well, although we do not often get called out."*

D3. *"Yes. We have always done the work anyway (had to do it as there is no-one else apart from volunteer St John's)."*

Despite working well, current PRIME providers identified problems regarding payment (IE. patients resenting or refusing to pay GP charges for an emergency ('111') service, and inadequate Government payments for non-accident callouts), and communication issues (IE. poor triaging of PRIME callouts, and poor interactions with funders).

D43. *"The local community also seems to object strongly to the charge that is imposed when PRIME attends (a service which they feel they have not asked for) - I can understand this."*

D45. *"Yes. Very variable. Issues regarding determining what is or isn't PRIME are unresolved. Variable responses from ACC: payments declined, hostile actions, etc. Non-accident related PRIME visits not funded. Expensive 'pro-deo' work and costs not covered by 'PRIME retainer' of circ \$30/oncall day. Patients not prepared to pay GP costs. Basically, generally unsatisfactory. Lots of talk, no support. If it were not to the benefit of the community, it is very doubtful that I would continue to participate."*

D70. *"Yes. Working reasonably well - too many calls for trivial conditions, funding a nightmare for medical conditions."*

- **Previously contracted**

These GPs had previously held a PRIME contract, but had since chosen to stop providing the service. They cited inappropriate callouts to non-emergencies or even to places outside their coverage region, disruption to their daytime workloads, and lack of specific payments for non-accident callouts. Many felt the system needed better triaging of calls, or even having the ambulance officers at the scene make the decision about responding the doctor.

D5. *"Were contracted to PRIME but had too many trivial call outs at inconvenient times. Found that the calls were not triaged sufficiently for us to make a determination as to level of urgency and need for us to attend. It was highly disruptive to our surgery and an added stress when oncall."*

D11. *"No one else in our area does PRIME. We used to, but pulled out because of frustration with St John's inability to give us basic information (eg. the age of the patient with chest pain). This made triaging & prioritising impossible. Being called to accidents where there were no injuries (or people), or collapsed people in cars who were simply resting because tired, didn't help either."*

D12. *"No - used to but got called to inappropriate places outside our area."*

D48. *"We are not currently contracted - too much extra work for too little reward. We do have an advanced paramedic available at times - part of his salary was diverted from what would have been our PRIME payments."*

D88. *"No. We were part of PRIME but withdrew after three months. My average oncall day used to include 2 PRIME calls a day. These were often for trivia, like fainting, etc. I would rush out and find the ambulance already there and nothing to be done, and did not feel that I could charge any fee, because the patient initially only called 111 and not the local doctor. This was all unnecessary duplication of service. Better to have the ambulance officer call us up rapidly when he/she had analysed the situation."*

- **Never contracted**

GPs in this category had either chosen not to take on the PRIME contract, were unaware of the contract, or had been declined a contract. Many of the GPs in this category stated they had done the PRIME training course (to meet ACC rural contract requirements). Reasons cited for choosing not to take on the PRIME contract were similar to those cited above (see 'previously contracted'), as well as not wanting to do field emergency work, not wanting the additional work, or having a competing commitment (eg. rural hospital contract). St John's apparent disinterest in contracting in some localities and their inflexibility regarding only contracting for PRIME if all GPs in an area participated, were mentioned. Despite not holding a PRIME contract, many stated that they still attended emergencies when requested by the local ambulance or fire brigade.

D6. *"No. We have chosen not to be, as we are too busy anyway and none of us wish to chase ambulances. But we are available for the ambulance staff to call us."*

D14. *"No. St John has contract but never has a GP been sub-contracted. We respond anyway to calls by ambulance control."*

D25. *"No: we must be within 15 minutes travel time to the rural hospital (according to our hospital contract) when oncall. If we contracted to do PRIME, either the hospital would have to relax this requirement (which they won't do) or we would have to have a second oncall for when the duty doctor gets a PRIME callout or have 2 separate oncall systems (hospital and PRIME). Both of the last 2 options would effectively double our GP oncall to 1 in 3, which is unacceptable. The possibility exists to incorporate nurses into the PRIME callouts, but St John has only visited our area once in the last few years to discuss PRIME with us."*

D26. *"No. No one does PRIME in the area as far as I know. I have been here 2 years and no one has asked me and I have read nothing about it. I am PRIME-trained, as I used to work in the South Island."*

D60. *"No. I have contacted St John to get myself on (and am PRIME-trained) but the other surgery won't do it, so St John aren't interested."*

D72. *"I am also oncall for road trauma, etc - not under PRIME (we don't qualify) but via the local Volunteer Fire Brigade's pager system."*

### **Nurses' views**

All nurses, except two, stated they held a PRIME contract. One of the two nurses not doing PRIME had a conflicting hospital job, similar to D25's comment above.

N17. *"No. We have decided not to participate. Because we are physically on site, we are not able to leave the premises, therefore unable to do PRIME."*

Of those doing PRIME, most stated it was working well. Being paid for accident callouts, that had previously been unpaid, was a positive factor, but the extra oncall workload was an added negative stress.

N1. *"We are all contracted to provide PRIME. This works well, but as we provide 24/7 cover we get very tired, and burnout is a factor, as is no life to speak of."*

N15. *"Yes, the team is contracted to provide PRIME. This is working well. The extra payment to do what we already did was much appreciated!!!"*

Similar to GPs, nurses complained of the lack of payment for medical callouts,

N13. *"we are called out to medicals, which we do not get funding for at night, like ACC do!!! This needs to be addressed urgently."*

Nurses had specific issues relating to being PRIME providers in isolated rural localities: such as telecommunications difficulties and limited support at the emergency scene.

N8. *"Telecommunications is a real issue, paging system often inadequate, does not always function."*

N20. *“Often attend accidents with no police presence, as there are only 3 policemen to cover 250km, so usually am expected to direct everyone at a scene. Volunteer fire brigade is improving and starting to supervise scenes. With major injuries, I try to get the (rural) nurse (30 minutes south) or the GP (30 minutes north) to attend as well.”*

## **Discussion**

This is the first survey to ask both GPs and nurses providing rural after-hours primary care oncall for their views on the PRIME scheme. While many current PRIME providers were positive about the way the scheme functioned in their area, it was also very clear that issues previously identified with PRIME in 2001 (2) and 2004 (3) have still not been addressed. While GP PRIME providers in 2001 were satisfied overall with the training and equipment, they expressed concern about the inflexibility of the scheme, the poor quality of triage information, and the inadequate payment for non-accident callouts. (2) These concerns were also expressed by those GPs who chose not to be PRIME providers, (2) and were similar to the comments made by ‘previously contracted’ and ‘never contracted’ GPs in this survey.

The major issue of lack of remuneration by the PRIME scheme for non-accident ‘medical’ callouts remains unresolved, with GPs being placed in a position of having to bill patients directly for attending non-accident PRIME callouts. There are issues of equity that need to be urgently addressed: patients should not be expected to pay for emergency services which they did not request, and GPs and nurses should not be expected to provide essential emergency services without being fairly remunerated.

Other issues related to PRIME which were raised in this survey, and which also need to be addressed, relate to poor communication. Respondents were concerned about the poor triaging of some PRIME callouts. Being called out urgently to trivial problems, that did not require their emergency skills, was both frustrating and annoying, especially when unpaid. Respondents commented that better quality triage information would enable them to make a more informed decision about attending, and that in certain cases decisions about responding the PRIME GP or nurse would be better made after the ambulance officer had made an initial assessment. Some respondents noted that St John had only once, or never, made contact with them about becoming a PRIME provider, suggesting a lack of interest in contracting GPs for the PRIME scheme by St John in some regions.

It is clear from this survey and previous work (2, 3) that the PRIME scheme would benefit greatly from an independent and comprehensive review. This would ensure that the needs and concerns of PRIME practitioners are not only heard, but also addressed. While respondents noted that it was satisfying to serve their communities by providing PRIME services, they also noted that PRIME involved significant additional work and this was a factor in fatigue and burnout.

This survey did not differentiate between those providers working in localities with only volunteer ambulance officers and those working with salaried ambulance officers. It also did not attempt to document where PRIME services were and were not being provided. These are areas for future research, as the

emergency skills of GPs and nurses will be most in demand in those rural localities with only volunteer ambulance services.

### **Strengths and limitations**

These were fully described in the first paper in this series. (8)

### **Conclusion**

While the nurses and GPs currently contracted to provide PRIME stated that it was working reasonably well in their localities, they expressed a number of concerns about the operation of the scheme, as well as stating that it was an added stress on top of their regular daytime job. The main concerns of currently-, previously-, and never-contracted GPs were inappropriate callouts, inflexibility in contracting, and inadequate payment for non-accident callouts. These issues were previously raised in 2001 (2) and again in 2004 (3). These concerns need to be urgently addressed if the PRIME scheme is ever to be a national service, working successfully in all rural areas.



## **References**

1. Ministry of Health. 1999. *Roadside to Bedside: Developing a 24-hour clinically integrated acute management system for New Zealand*. Wellington: Ministry of Health. (Available in PDF format at <http://www.moh.govt.nz> [accessed 6/9/06])
2. Hore T, Coster G, Bills J. Is the PRIME (Primary Response In Medical Emergencies) scheme acceptable to rural general practitioners in New Zealand? *NZ Med J* 116 (1173); 9 pages, 2003.  
URL: <http://www.nzma.org.nz/journal/116-1173/420/> [accessed 6/9/06]
3. Rural General Practice Network. *Primary Response in Medical Emergencies (PRIME): System and Delivery - a discussion paper prepared jointly by The New Zealand Rural General Practice Network, the Royal New Zealand College of General Practitioners, the New Zealand Institute of Rural Health and the New Zealand Medical Association*. NZ Rural General Practice Network (Inc), Christchurch, December 2004. (Available in PDF format as 'PRIME – NZRGPN recommendations' at <http://www.rgpn.org.nz/papers.htm> [accessed 6/9/06])
4. After-hours Primary Health Care Working Party. 2005. *Towards Accessible, Effective and Resilient After-hours Primary Health Care Services: Report of the After-hours Primary Health Care Working Party*. Wellington: Ministry of Health. (Available in PDF format at <http://www.moh.govt.nz> [accessed 6/9/06])
5. Rural General Practice Network. *Recommendations for recruiting and retaining doctors to work in rural New Zealand*. Rural General Practice Network (Inc), Christchurch, March, 2001. (Available in PDF format as

- 'Recruitment and Retention' at <http://www.rgpn.org.nz/papers.htm> [accessed 6/9/06])
6. Janes RD, Dowell A, Cormack D. *New Zealand Rural General Practitioners 1999 Survey - Part 1: An overview of the rural doctor workforce and their concerns*. NZ Med J 114: 492-5, 2001.
  7. *Variation of Advice Notice Pursuant to Section 51 of the Health and Disability Services Act 1993 (Schedule 2, Appendix 11)*. 1999, Health Funding Authority: Wellington.
  8. Janes RD. *New Zealand Rural After-Hours Primary Care Provider Survey: 1. The impact of oncall on providers and their families*. NZ Rural General Practice Network (Inc), Wellington, September 2006.  
Available from: <http://www.rgpn.org.nz/papers.htm> [accessed 17/9/06]
  9. Borkan J. Immersion/Crystallization. In Crabtree BF and WL Miller (Eds): *Doing Qualitative Research*, 2<sup>nd</sup> Ed. Sage, London, 1999, pp. 127-143.