Rural health
– a barometer of the health of New Zealand

Pat Farry has been a general practitioner in Queenstown for 30 years and is now Director of Rural Health for the South Island.

The economic reforms of the early eighties brought New Zealand into the 21st century. The flourishing of corporate New Zealand and big business, we were promised, would have a 'trickle down' effect, resulting in all New Zealanders being better off. However, it has been more of a 'flow out' than a 'trickle down' as the large fortunes amassed by a few have often been transported off shore.

Fortunately now, some 20 years on, we are seeing a boom in our agricultural-based industries. Farming and the rural sector in New Zealand are currently 'on a roll' and, if you want to see a real 'trickle down effect', watch the next few years and you will see all New Zealanders becoming a little better off. All of this is because we are a rural, agricultural-based economy and everything else, even tourism, is icing on our economic cake. Rural New Zealand is the barometer of our economy and the barometer which indicates the well being and standard of living of the majority of New Zealanders.

Likewise, I believe that rural health care is an indicator and predictor of the future of health care in New Zealand generally. Because rural health care systems are the most vulnerable, the most expensive and the most difficult to provide equitably, it follows that these are services which will be the first to have problems when health needs are ignored or inadequately funded. This has been the case for nearly 40 years in New Zealand and it's time for change.

If we look at what is needed to rectify rural heath care we see that little has been achieved by successive governments to strengthen rural health care in New Zealand over the last 30 years. It is quite incredible, for example, that the rural bonus scheme introduced in the late 60s has not changed since then, except for redistribution. So the general malaise, low morale and anger which developed first in the rural health sector, is now spreading to include our urban-based colleagues.

The workforce

In this editorial I would like to look at some of the things which need to be further developed, or developed as new initiatives for rural health care in New Zealand. These developments will need to take into account changes in the graduating workforce. It seems less likely, to me, that young general practitioners will be keen to buy a practice and settle down to continuity of care in the same town for thirty plus years. Furthermore, the recruitment efforts of other countries are now attracting our graduates to work off shore where they know they can earn a lot more than they can in New Zealand. It must be realised that there is an international market place for health care providers so they will need to be attracted to, or encouraged to stay in, New Zealand by appropriate incentives and work conditions. For rural health services and rural general practice to flourish in New Zealand over the next 30 years, we will need a brave government to bring about a number of changes for our workforce and these changes will need to happen simultaneously.

- Realistic and humane working conditions so that no rural doctor or nurse is on call more than 1 in 4.
- Financial support (perhaps an extension of the Rural Practice Support Scheme) to allow additional extra doctors and nurses to work in areas where the rate of on-call is currently more than 1 in 4.
- Ensure the provision of locum cover for rural general practitioners for both study leave and holidays.
- Introduce scholarships which will encourage doctors to enter rural general practice and also reward them when they continue to work in the same town over a number of years.
- The PHO system of integrated care, I believe, has been largely based on our existing rural health model, which has been functioning successfully in a number of areas for some years. If communities and health providers embrace PHOs, there could be positive effects on health care and, at the very least, should have an unburdening effect on the level of administration and paper work which takes up the professional time of our rural GPs. It will be important that PHOs' development is not detrimental to the IPAs, which have built up a strong foundation of information systems and expertise in primary health care. Good will and co-operation will be required.
- Rural general practice needs to be represented on the Health Workforce Advisory Group because of the fact that we are des-

perately short of rural general practitioners in New Zealand.
- Changes to the maternity regulations have resulted in rural general practitioners opting out of maternity care. In many areas we now have midwife-only services in an area of health care where teamwork is absolutely essential. The system will need to change in the future to strongly encourage rural general practitioners to recommence the provision of maternity services.

Many of these improvements will take place if the plan for the implementation of the Primary Health Care Strategy in Rural New Zealand is fully funded and properly administered. Then rural practice will once again, as in the late 1960s, begin to be perceived as an exciting and professionally satisfying career in medicine. One thing about getting older is that you see 'the wheel rotate a few times' and if I was a young general practitioner now I would be taking my pick of one of the choice rural practice locations which at present you can walk into for free. The wheel will continue to turn, as always, and I believe that these rural practices, which have no saleable value at the moment, will escalate in value over the next ten years. Let me give an example.

When I bought my practice from Bruce Todd in 1971, my total payment to Bruce was $25 (for his oak desk). When I sold the practice 25 years later the price had escalated 400 000%. There are opportunities out there at present for keen young doctors.

Finally I should say that general practitioners have always provided about 95% of primary care in New Zealand so it would have been nice if 'general practice' could have been named specifically in the Primary Health Strategy. To quote Goffman: *'There seems to be no agent more effective than another person in bringing a world for oneself alive, or by a remark or a gesture shrivelling up the reality in which one is lodged.'*

Rural health education

The next requirement for rural health in New Zealand is increasing input into medical education. Back in the 1980s Julian Tudor Hart[1] said that the world of medical education should be 'turned upside down', by which he meant that medical students should be based in communities and visit universities rather than based in universities and visit communities.

When I think about vocational education for general practice I am reminded of the 'Sutton Principle'. This principle came from a now famous quote from the American Bank Robber named Willy Sutton. Willy was asked during a media interview, 'Why do you rob banks?' and his reply was, 'Because that's where the money is!' If general practice registrars are to be expected to practise in rural New Zealand, then that's where their training should take place for both the Intensive Year and for Advanced Vocational Education.

If general practice registrars are to be expected to practise in rural New Zealand, then that's where their training should take place for both the Intensive Year and for Advanced Vocational Education

There are many advantages of rural placements for both undergraduate and post-graduate education.
- Rural health care is generalist in nature and traverses primary, secondary and tertiary care.
- Community and social structure and their influence on health are more obvious.
- The 'person' of the patient and the 'context' of their lives are more readily defined and understood in a small community.
- Care is more likely to be integrated and continuous.
- An integrated team approach to patient care is more obvious.
- Students and registrars have more encounters with patients with chronic illness.
- Patient interventions are more accessible to the trainees.
- More patient procedures are experienced by trainees.
- The general practitioner who will have a single student present undertakes the initial management of all emergencies and trauma.

At the Dunedin School of Medicine the students now spend a quarter of their clinical training in rural Otago/Southland and there are now moves towards a trial of a Rural Medical School in which a group of eighteen students will be based in urban and rural teaching centres for three years of training. Students will have all the above advantages while developments in web-based teaching, video-conferencing and telemedicine will create a virtual academic environment in the country. Students can see the same patients from the earliest presentation of illness through secondary care and travel with them when patients needs tertiary care in the teaching hospital.

We have diplomas in rural health and rural and provincial hospital practice as well as a trial of rural practice rotations in post-graduate year II. We do not yet have specific rural vocational training and this must be developed soon.

During the past two years we have seen the development of collaborative efforts by the Directors of Rural Health, The Centre for Rural Health and the recently established Institute for Rural Health. I hope that the collaboration and cooperation will continue on a national basis, as there is so much work to be done and so few to do it. We cannot afford to be inefficient or duplicate our efforts in education or research.

Reference

1. Hart JT. George Swift Lecture. The world turned upside down: proposals for community-based undergraduate medical education. J Roy Coll Gen Pract 1985; 35:63–8.