Guest Editorial

Rural health care needs incentives

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Rural communities face considerable difficulties in achieving equitable health care. Central to this is general practice which is struggling to recruit and retain health professionals. Rural GPs have onerous call rosters, must provide emergency and terminal care, and lack allied support services. They have difficulty accessing CME and are vulnerable to burnout.

Without a stable work force, patient confidence is eroded, quality is compromised and health prevention and education is neglected. The centralisation of hospital services puts further demands on general practice. To make a significant difference, changes need to occur as a "package", as outlined below.

Encourage interest in rural health work before students graduate. Students need to experience the deeper relationship rural GPs have with patients and the satisfaction of utilising a range of skills.

Provide further training to give graduates confidence and skills for working in rural areas. The GPVTP now requires participants to spend half their time in rural practices, but there are funding restraints.

Attract health workers to areas currently having difficulty in recruitment and/or retention. Many rural areas are quite depressed, resulting in greater difficulty attracting GPs, a different spectrum of illness and a greater sense of isolation.

Encourage teamwork and cooperation between rural health workers. Health professionals in rural areas work closely together, with less defined boundaries.

Consider the needs of health workers' spouses and families. Many spouses have a role in the practice itself as well as being the GP's main support. Providing grants to spouses to assist them network and develop their skills would impact significantly on morale.

Provide ongoing education for rural health workers including the management of emergencies. ACC and the HFA are developing a scheme (PRIME) to enable this, as well as providing emergency equipment and coordination with St John's.

Improve the availability of locums. Incentives include better pay, measures to help cope with emergencies, and promotion of rural practice. Mentoring and training should be provided along with accommodation and travel allowances and points towards a Section 51 contract.

Protect rural practitioners from having to work dangerously long hours. Areas where there are only one or two GPs or nurses need special attention.

Provide a career pathway to alleviate fear of rural entrapment. GPs may be

able to work in a rural practice for a limited time and need to be confident they can move back to an urban area. Limiting urban Section 51s has added to the difficulty of finding a practice and has widened the gulf between urban and rural practice prices.

Allied issues. In many rural areas women are either missing out on antenatal care or having to travel for this. More seriously, GPs will not have the experience to deal with obstetric emergencies.

The changes in personnel and HFA structure have meant that progress in dealing with rural issues has been diluted. A rural director post for educational and other support is to be established, based in the South Island. This is a promising concept and a similar position needs to be developed in the North Island.

- *The full version of John Burton's paper is available on request*