Reported changes in how rural general practices operate since the introduction of the 2001 Primary Health Care Strategy

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ABSTRACT

Aim

To assess how rural general practice has changed since the 2001 introduction of the Primary Health Care Strategy (PHCS).

Method

Self-completed postal questionnaire surveys (quantitative and qualitative questions) sent to rural general practice managers and nurses.

Results

206/217 rural practices (95% response rate) and 445/682 rural nurses (65% response rate) returned surveys. Implementation of the PHCS has had both positive and negative impacts on rural general practices. Positive effects included increased funding to enable lower patient fees, expanded roles for nurses in addressing disease prevention and chronic disease management, and specific funding for GP retention. The main negative effect was increased paperwork.

Conclusion

The implementation of the PHCS has rural general practices reporting significant benefits from the targeted rural funding initiatives aimed at improving working conditions. Some practices reported an increased burden of paperwork.

(NZFP 2007; 34:18–24)

Introduction

In 2001, the New Zealand (NZ) Primary Health Care Strategy (PHCS)[1] adopted a population-based health focus geographically defined by 21 District Health Boards (DHBs), and underpinned by the NZ Health Strategy[2] and the NZ Disability Strategy.[3] The overall goal was to improve the health of every New Zealander by investing heavily in the provision of high quality primary health care. A key plank in this strategy was the establishment of Primary Healthcare Organisations (PHOs) within each DHB region. Each PHO is responsible for improving the health of their registered population of patients through improved primary health care. Patients register with a PHO by enrolling with one of its contracted general practices. These practices are paid for health care to their enrolled patients by a combination of government capitation and patient co-payment. Capitation does not include accident care, maternity care or immunisations, which are still funded separately and paid by fee-for-service. The PHCS expressly hoped to allow for the expansion of nursing roles in primary health care.[1]

The PHCS acknowledged that *'misdistribution of workforce is a par-*

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ticular issue for rural areas' and *'the difficulties of attracting and retaining basic health services in rural communities have not lessened in recent years'*.[1] Existing initiatives to encourage doctors into rural general practice were noted to have had little impact on addressing the problem. NZ's principal rural retention initiative prior to 1999 was the 'rural bonus' payment, which was paid to GPs by the government to offset the added costs of practising in rural areas.

Rural funding initiatives

In 2002 the MOH provided $32 million over three years from the primary health care funding package to specifically support the retention and recruitment of the rural primary health care workforce.[4] The Rural Workforce Retention Funding was a flexible resource for supporting and retaining the primary health care team, while the Reasonable Rosters Funding was a targeted resource aimed at supporting those GPs experiencing onerous on-call arrangements ('one-in-one' or 'one-in-two' on-call rosters). These funding streams were extended in October 2004 by $10.9 million (starting in the 2005/06 financial year) to help rural areas retain GPs, nurses and other health care professionals.

Once Primary Healthcare Organisations were established within its region, each DHB was required to pass on the Rural Workforce Retention Funding to the PHOs, to allow them to address their workforce retention and recruitment issues.[4] This funding could be used to provide for time off duty, a supportive professional working environment, access to continuing professional development and peer support, financial incentives and the ability to enter and leave rural practice with minimal restrictions.[5]

Other recent rural initiatives have included paying more isolated rural GPs a higher 'rural bonus', better support for emergency care in some areas (Primary Response In Medical Emergencies [PRIME] scheme), improved rural locum support (NZLocums®), and an increased intake of 20 rural origin students at each of the two medical schools.[6,7]

In 2005, after a gap of three years, the MOH acknowledged *'the need to continue the annual rural workforce survey...This is because the provision of accurate data is an important part of managing rural workforce issues, particularly in areas where government funding has been targeted to relieve workforce issues.'*[4]

One of the main positive themes to emerge was the ability to implement new initiatives, such as free annual diabetic checks, CarePlus and health promotion

The aim of this study was to ask rural general practices how their working patterns had changed since the introduction of the PHCS, including any impact of the specifically targeted rural funding initiatives.

Method

Data for this study were derived from a 2005 national survey of rural general practices, specifically their managers, GPs and nurses.[8] General practices were defined as 'rural' if a rural GP worked in the practice (i.e. the GP had a Rural Ranking Scale [RRS] score =35 or had been assigned a 'notional' RRS =35 by their DHB).[9] Rural primary health care nurses were nurses working at these rural general practices.

Workforce questionnaires were developed using existing knowledge on issues identified from the literature, in conjunction with input and feedback from the researchers, other consultants and professional bodies. Ethics approval was obtained from the University of Auckland Human Participants Ethics Committee. Databases from relevant professional bodies were utilised to distribute questionnaires, which were disseminated in November 2005. Practice managers, GPs and nurses were contacted (and followed up) by a combination of postal, fax, email and telephone approaches.

The survey questions requested quantitative and qualitative (free text) data, and specifically asked for ways that practices may have changed since implementation of the PHCS in 2001. Free text questions were only included on the practice manager and practice nurse surveys, although in a number of cases the GP also acted as the practice manager or gave input to the manager. The practice managers were also asked whether the way their general practice now operated with respect to these health practitioners had changed and also to give examples of innovative recruitment and retention initiatives that had been undertaken in the 12 months to 30 September 2005.

The free text data analysis used a general inductive approach with individual text responses analysed to identify themes. The data were collated into table form and analysed for emerging categories.

Results

For the overall study, a total of 217 rural practices were deemed eligible and sent questionnaires. Two hundred and six practices returned completed surveys giving a response rate of 95%. Surveys were sent to the 682 rural nurses identified by the practices and were returned by 445 (65% response rate). These nurses represented 194 of the 206 rural practices returning surveys.

Practice managers

One hundred of the responding 206 practices provided instances of how their practice had changed under the PHCS. See Table 1 for examples of their responses. Fifty-three reported improvements, 16 reported minimal or no change, and 31 practices re-

Table 1. Examples of reported changes in the operation of rural general practices since the introduction of the Primary Health Care Strategy (PHCS).

THEME	QUOTES
Improvements	
Health promotion initiatives	*'Helping us promote healthy lifestyles.'* *'Healthy lifestyle, smoking cessation and nutrition clinics.'* *'This year we have run a Health Day for over 60s, a "benefit of exercise day" and we are planning a Men's Health evening.'*
Implementation of chronic disease management	*'New initiatives in place: Careplus, Get Checked, asthma.'*
Improved access for patients	*'Cheaper fees for service – youth, children and over 65s.'* *'Free sexual health contract for under 20 yr olds and under 24 with CSC.'* *'Transport patients to clinics.'*
Improved services for patients	*'Provide meals on wheels.'* *'Pharmacy provides free blister packs to patients coordinated by practice.'* *'Skin cancer excisions under DHB payment.'*
Improved resources funding	*'Have been able to employ a phlebotomist and become fully computerised.'*
Greater utilisation of practice nurses	*'Providing nurse led clinics. Nurses are more involved with patients' assessments, care plans, referrals, recalls.'*
Improved funding for staff	*'Able to pay on-call practitioners more realistically due to Rural Premium.'*
Improved staff training	*'Increased training resources available for nurses.'* *'More coordinated CME for doctors.'*
Community liaison and networking	*'Closer links with other health providers.'*
Reduced after-hours call burden	*'Now have three weekends off in a month as we used to open/cover our own patients after hours and weekends.'*
Neutral	
No change	*'Business as usual.'* *'Virtually no change.'*
Deteriorations	
Increased paperwork and administration	*'Compliance costs rocket up to the moon.'* *'Paper and IT workloads markedly increased.'* *'Complying with bureaucracy has absorbed extra resources.'* *'We feel like we are drowning in a sea of administration and paperwork.'*
Worsening services to patients	*'Maternity care no longer provided.'*
Dissatisfaction with introduction of PHOs	*'I am sure PHO system is designed to frustrate and then eventually shut down solo practices.'* *'Funding disjointed under PHO, practices are still privately owned but another tier has been added to structure and there is less communication to practice.'*
Ongoing aging of workforce	*'Doctors have aged and replacement is still critical.'*
Increased workload	*'The need for extra GP hours has become more desperate.'* *'Cost of locums much greater'.*
Reduced income	*'Often difficult to get payment for urgent consultations.'* *'Less remuneration for after hours because of clawbacks – we are virtually doing this for nothing.'*

Table 2. Examples of reported changes in the practice of rural PHC nurses since the introduction of the PHCS.

THEME	QUOTES
Little or no change	*'At this stage I can't say anything is different.'* *'As I'm only new to this area it has made very little difference for me.'*
Increased workload / more bureaucracy	*'Busier. More paperwork and accountability – less time with patients.'* *'Less patient centred. More bureaucratic centred.'* *'We have become inundated with never ending paper/tick box requirements from various bureaucratic nursing and government departments. Thank goodness I am 64.'*
Increased autonomy / wider scope of practice	*'Greater nurse role in prevention education plus we now give a wider range of nursing services – suturing, plastering, diabetes, Care plus clinics, A&E assessment.'*
Team-building	*'My role is valued here as an important team member – not previously the case.'*
Education	*'Funding is now available to help meet most of the expenses for continuing education and training.'*
Improved support from, or involvement with, IPA, PHO or DHB	*'Improved communication with DHB and better focus on primary health generally.'*
Improved services	*'Providing more accessible and affordable health care for patients – cheap access for under 18 years, free sexual health contract for under 20s.'* *'Better able to meet the needs of our community.'*
Worsening services	*'Our GP is giving up delivering babies'* *'Have just lost our 0–5 years well child service, which I feel goes against the Primary Health Care Strategy.'*

ported that conditions had deteriorated, usually because of increased paperwork.

One of the main positive themes to emerge was the ability to implement new initiatives, such as free annual diabetic checks, CarePlus and health promotion. Other key themes were the ability to offer cheaper visits and hence improve access for poorer patients, and the increased use of nurse clinics. For a few practices there was more time off because they no longer provided 24-hour cover, with after-hours service available through the local hospital or nearby urban centre.

For the practices where practice managers reported conditions had worsened, the most prominent theme to emerge was significantly increased paperwork

For the practices where practice managers reported conditions had worsened, the most prominent theme to emerge was significantly increased paperwork: *'We feel like we are drowning in a sea of administration and paperwork'* and *'compliance costs rocket up to the moon'*. For a number of practices any additional funding was completely absorbed by *'complying with bureaucracy'*. Funding issues was another key theme. For some, the PHO funding added another tier with reduced communication to practices which were still privately owned. One practice manager said that the practice had become a lot more difficult to run and was now *'administration-focused rather than patient-focused'*. While capitation and population-based funding had led to reduced charges in some practices, in others the population-based formulae did not meet the needs of people *'in a high deprivation area'*. Another funding issue was that only 65% of practices reported receiving Rural Workforce Retention Funding in the previous 12 months. Prior to the introduction of PHOs, all rural practices received this funding.

Primary Health Care (PHC) nurses

Examples of the nurses' responses to ways their practice had changed since the implementation of the PHCS are shown in Table 2. There was a large volume of free text responses to this question, which were collated and key themes identified. The range of responses were diverse. Some reported little or no change, often because they were relatively new in the job.

Many nurses commented positively on increased autonomy with

nurse clinics and a wider scope of practice. Some reported an associated increase in a team approach. A number also reported increased opportunities for education and upskilling. A few reported improved support from, or involvement with, their IPA, PHO or DHB. Many reported that patient services had been improved or expanded and become more accessible although, for a few, some things had changed for the worse. Similar to the practices, the strongest negative theme to emerge was increased workload, especially paperwork (*'We have become inundated with never ending paper/tickbox requirements from various bureaucratic nursing and government departments'*).

Sixty-nine practices responded to the question asking whether the way their practice worked with other practitioners had changed since the implementation of the PHCS. Of these, 25 reported improvement, such as in communication, integration (*'Relations good with all providers with exception of midwife – she prefers sole exclusive care. More joint projects with Pharmacy and Iwi providers since implementation of PHCS'*) and teamwork (*'Working better together as a team'*) of primary care providers.

Thirty-seven practices were of the opinion that little or nothing had changed (*'No, not an iota'*) and often commented that they already had good integration of services (*'We have always had this relationship with other practitioners'*; *'In truth the teamwork was excellent before and really this has continued excellently after. Our aim is to make sure that implementation of the PHCS does not fragment this excellent team'*). Several practices commented that they were unable to achieve a good working relationship with midwifery, but this pre-dated the formation of PHOs (*'Unfortunately we host no useful working relationship with midwifery, however these changes pre-dated the primary care strategy'*).

Only seven practices (10%) reported deterioration in relationships with other practitioners since implementation of the PHCS. This included tensions rising between the 'low cost access' versus 'interim cost access' PHO funding arrangements (*'The competitive nature of funding [access versus interim] has exacerbated some strained relationships'*; *'Patients from outside area are able to enrol and therefore receive free treatment. More paperwork'*) and the downgrading of some services (*'Less liaison than previously with DHB district nursing and Plunket'*; *'St John has downgraded the paramedic presence'*). One nurse commented *'What is that? Sounds like something politicians talk about. We don't see what that means for us. Call hasn't changed. Services don't change'*. Another noted that it was *'Increasingly difficult to get GP locums. Very hard to find replacement nurses'*.

While rural general practices report significant benefits from the targeted rural funding initiatives aimed at supporting retention and improving recruitment, the rural workforce shortage is far from being solved yet

Reasonable Roster Funding had been received by 76 of the practices (37%) and Rural Workforce Retention Funding by 134 of the practices (65%) in the previous 12 months. Practices reported a number of innovative recruitment and retention initiatives using this funding. Initiatives included advertising to recruit GPs from overseas, assistance to new staff or to locums such as provision of housing and a car, improving staff pay or providing for holiday or sabbatical leave, employment of additional staff for specific tasks, paying for education or funding out-reach activities.

However many practices were still struggling with locum issues (*'Finding locums is a major problem'*; *'Having to pay very expensive locums. Hourly rate not proportional to practice income'*; *'After hours on call and weekend on call make it very difficult to recruit locums'*) and some expressed difficulty in replacing GPs (*'Unable to attract replacement for retiring GP aged 79 years'*).

Discussion

The key message to emerge from this study is that the implementation of the Primary Health Care Strategy, including the introduction of PHOs and capitation, has had both positive and negative reported effects on rural general practice. Positive effects included increased funding to enable lower patient fees, expanded roles for nurses in addressing disease prevention and chronic disease management, and specific funding for GP retention. The main negative effect was the increased paperwork and bureaucracy. The second key message to emerge is that while rural general practices report significant benefits from the targeted rural funding initiatives aimed at supporting retention and improving recruitment, the rural workforce shortage is far from being solved yet.

PHOs

The formation of PHOs, including capitation funding, appears to have been of considerably varied benefit to rural general practices. For some it has led to improved funding with the ability to reduce fees and to implement new initiatives for disease prevention and chronic disease management. Other practices however, reported that any additional funding was completely absorbed by the significantly increased paperwork and compliance costs. For some it has led to closer professional collaborations, while for others, the two different

funding formulae ('low cost access' for PHOs with >50% of their enrolled population designated 'high needs'; 'interim cost access' for PHOs in areas with populations of a lower health need) created conflict between neighbouring PHOs funded by different formulae. Remarkably, a number of practices reported little impact or change resulting from the implementation of the PHCS and PHOs.

On-call

Since the introduction of the PHCS, many practices reported significantly reducing their on-call workloads. Changes have included applying extra rural funding to engage more staff, sharing on-call rosters more widely with neighbouring practices, and withdrawing from on-call provision entirely by arranging for after hours patients to be seen in nearby urban towns (for example, emergency departments in nearby base hospitals). Participating in a rural on-call roster is a prerequisite for eligibility for the RRS which, with a score of 35 points or more, provides for a range of 'rural' funding for both the GP and their PHO. Because providing on-call contributes such a significant part of the RRS score, in theory, these practices will have experienced marked reductions to their RRS points. Some GPs may have had to be given discretionary RRS points by their DHBs in order to retain their rural status and their eligibility for rural incentive payments.

It is unclear whether those rural GPs who have managed to offload some or all of their on-call to urban centres have indeed had their RRS scores reduced. It is possible that some may even have ceased to qualify for the rural funding which was meant to compensate them for the on-call burden. The NZ Rural General Practice Network and the MOH are aware of these dynamic changes and a review of the RRS is currently underway.

Reasonable Roster Funding and Rural Workforce Retention Funding was reported to have been received in the previous 12 months by 37% and 65% of the practices, respectively. While only those practices with '1-in-1' or '1-in-2' on-call rosters were eligible for the Reasonable Roster Funding, all rural practices had previously been receiving Rural Workforce Retention Funding prior to the establishment of PHOs. This suggests that some PHOs may now be applying this funding to other workforce retention projects rather than simply passing the funding directly to rural general practices. The use of Rural Workforce Retention Funding by PHOs is an area needing further research.

Practices reported using these two rural funding sources for a wide range of strategies to improve working conditions, especially reducing on-call, and hence promoting retention. These included salary increases, reduced on-call hours, improved resources such as computers and Internet access, more time off for holiday and study, or even providing meals for doctors on-call. Staff recruitment strategies included promoting the practice overseas (such as web-based advertising with photographs of what the area had to offer), assisting with transfer and set-up costs, providing accommodation and transport, and welcoming them into the community.

While these rural funding opportunities were generally considered advantageous, the move to PHOs, with capitation and the many associated changes, was much less likely to be viewed favourably. Concerns about increased paperwork and compliance issues were expressed by many of the respondents. While certain advantages of the implementation of the PHOs (for example, increased use of nurse clinics, health promotional activities, chronic disease management systems) were acknowledged, for some practices these gains were over-shadowed by the associated administrative burdens.

GPs doing onerous on-call ('1 in 1', or '1 in 2') needed to apply for Reasonable Roster Funding during 2000 to 2002. The available money was then allocated, and further applications, for example from new entrants into rural practice or those whose on-call roster has worsened, were not accepted. Some of this rural support funding was allocated to national initiatives for recruitment of primary health care workers, to encourage them to work in rural areas, both on a short-term and long-term basis.

Rural GPs submit their RRS scores annually to their DHBs who make the final determination on points – reducing some scores and increasing others by allocating discretionary points. There is a dispute mechanism available to rural GPs who feel their points have been reduced unfairly. The Rural Bonus scheme is administered by the DHBs but there may be inconsistency in how it is paid – in some cases practices receive the money directly from the MOH (HealthPac) and others via their PHO. Overall, the administration of rural funding streams to general practices appears to vary across the country.

What is clear is that there is a large degree of heterogeneity in the experiences of rural general practices regarding the PHCS, PHO implementation and targeted rural funding payments. Some have benefited with improved ability to recruit staff and employ locums, enhanced working conditions (e.g. less on-call) and the capacity to provide cheaper and additional services for their patients. Other, more rural practices, are still struggling with recruitment and retention issues and onerous on-call burdens.

The introduction in 1999 of the Rural Ranking Scale (RRS) provided an agreed definition of a 'rural GP', and permitted the first census of NZ rural GPs, which identified a total of 469.[10] We have used this definition of a 'rural GP' to also define both rural general practices (those with rural GPs) and rural practice nurses (those working with rural GPs). Without this clear definition of 'rural', it

is not possible to have meaningful data on the rural workforce.

Many of the successful rural recruitment and retention strategies suggested by international research[11-15] have recently been introduced in NZ, with the exception of significant periods of undergraduate medical training in rural community-based programmes, and a specific postgraduate rural GP career pathway. Despite the range of initiatives introduced over the last few years, a 2004 analysis of the NZ GP workforce indicated that most Territorial Local Authorities (TLA) had sustained losses of GPs over the previous four to six years, and, in particular, a net loss of rural GP full-time equivalents (FTEs) with the more remote areas experiencing the greatest losses.[16] Geographical information system mapping has been used to show that NZ rural populations residing more than 30 minutes from their nearest GP continue to have the poorest access to primary health care, and within these rural populations access is even worse for Maori and those with high levels of socio-economic deprivation.[17] It is also possible that it is still too early to assess the full impact of the PHCS, including these recently introduced rural funding initiatives. Furthermore, rural practices close to urban centres may be better able to benefit from the increased funding of the PHCS (e.g. by being able to share or relinquish after-hours on-call duties), compared with more isolated rural practices. The 2005 Rural Health Workforce Survey provides important information, raises areas for further research, and confirms the need for ongoing rural workforce surveys.

Competing interests

None declared.

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Disclaimer

Any views expressed in this paper are personal to the authors and are not necessarily the views of the New Zealand Ministry of Health. The New Zealand Ministry of Health accepts no responsibility or liability in respect of the contents of this paper.

The full 2005 Rural Health Workforce Survey as a PDF file can be downloaded from the Ministry of Health website at: http://www.moh.govt.nz/moh.nsf/by+unid/A7F0BB37CF895C39CC25721200012A2C?Open

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