Te Whare Whakakotahitanga Mo Te Hauora Taiwhenua

RURAL GENERAL PRACTITIONER RECRUITMENT AND RETENTION IN NEW ZEALAND

A report to the Ministry of Health
on the first phase of analysis
of surveys to assess the state and fluctuations
of the rural General Practitioner
workforce 1995 – 1999

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ABOUT THE CENTRE

The Centre for Rural Health was established late 1994. It was funded (initially by the Southern Regional Health Authority, then the Health Funding Authority and finally by the Ministry of Health) for a series of projects to support rural health services and community involvement. The Centre was under the directorship of Martin London and Jean Ross from, respectively, rural general practitioner and rural nurse backgrounds. It was also known as the National Centre for Rural Health. The Centre closed in late 2002, with final publications being completed in 2003. The resources and reports created under the auspices of the Centre were uploaded mid 2003 to be available indefinitely.

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February 2001

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INTRODUCTION

The aim of this project was to take a retrospective view of the fluctuations in the rural GP workforce. There has always been a deficiency of rural doctors overall, albeit more marked in some localities and non-existent in others. This deficiency has latterly been exacerbated by a change in the work and lifestyle expectations of young medical practitioners and their families and by the approach of retirement for a substantial number of the 'old style' rural doctors. In addition, the incentives, established in 1970 aimed to attract doctors to rural areas, have, in the past 25-30 years, been eroded to be almost meaningless and have lost their impact on recruitment and retention. New initiatives to this end are now being proposed to re-establish a vibrant and sustainable rural workforce.

This project was to serve as a basis for assessing the existing deficiencies and the impact of current and future interventions. It has had an additional effect of providing another opportunity for defining the current workforce. This itself, is a major task that has, up to now, been bedevilled by the lack of a clear delineation of what qualifies as a rural locality, by the obscurity of some rural practices and by the continuing fluctuations of the rural workforce, not to mention the reluctance of many practices to respond to survey questionnaires. While this task is now nearing completion, at the time of the main Recruitment and Retention Survey, there were still modest inaccuracies and deficiencies which have only partly been correctable in post-survey adjustments.

However, the aim of creating better than a general impression of the ebb and flow of the rural workforce has been served and further refinement may be achieved with what will become annual updates, starting with the year 2000. Furthermore, the scale of deficiency in the rural workforce revealed by the surveys has proved to be so large that some lack of detail need not interfere with its overall purpose.

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SURVEY METHODS

Two surveys have been carried out. The first, "**Recruitment and Retention Survey**" (R/R survey) was to identify all the GPs who have provided service in rural areas for at least 6 months over the past 5 years noting their arrivals and departures, their length of service and their destinations when leaving. The second, "**Gaps in the Rural Workforce Survey**" (Gaps survey) was to measure the current rural workforce against that required, bearing in mind each locality's population and remoteness.

The surveys were conducted in the form of questionnaires to all rural practices. This was only made possible by the recent establishment of the New Zealand Rural Ranking Scale (RRS) which defined rurality and the rural census carried out by Ron Janes under the dual auspices of the Centre for Rural Health and the Royal New Zealand College of General Practitioners which identified the rural GPs and their practices.

A third exercise, refined by the Gaps survey, was to define **rural localities** from a health provision perspective as **those areas covered by rural practitioners sharing an on-call roster**. While this may not always necessarily correspond to the local government boundaries or the communities' own perspectives of their locality boundaries, it will serve well in providing a basis for measurement and future comparisons of health services.

Copies of the surveys are attached in Appendices 1 and 2.

The "Recruitment and Retention" Survey

The R/R survey asked the practices to record the names of doctors who were currently working or had worked in the practice during the five years 1995-1999, including the following information:

- Name of the doctor
- Dates (month or year) of arrival and departure
- Total length of time in rural practice
- Destination at the time of departure

In addition the rural ranking score of the practice was requested.

The aim was to measure the stable workforce of *doctors substantially contributing to the rural service.* For this reason, locums staying for less than 6 months were excluded while doctors absent for maternity or sabbatical leave with the intention of returning to practice were not recorded as 'departures' from the practice.

The survey was sent out initially in April 2000 with a second pass to non-responders in May and a third in July, bringing the response rate up to 95%. For the purposes of monitoring recruitment and retention in general terms, this has been regarded as sufficient data on which to report. There is still an opportunity to directly contact the remaining practices to refine the data.

The "Gaps in the Rural Workforce" Survey

The Gaps survey sought a quantitative assessment of the **full time equivalent (FTE) workforce** and included nurses contributing, or able to contribute, to on-call services. The latter we defined as PRIME (Primary Response in Medical Emergencies) trained nurses, Practices were asked questions in connection with the following:

- The names of the other practices sharing their on-call roster to define their locality
- The name they used to describe their locality
- The population of their locality
- The number of full time and part time doctors in their practice
- The tenths worked by the part timers
- The number of full time and part time PRIME nurses in their practice
- Their on call roster

On this basis there followed two crucial questions:

1. **"If a suitably qualified (and socially acceptable!) practitioner arrived in your practice/locality today, available to work alongside you, would there be a job for him/her? For how many such practitioners (doctors or rural nurses, PRIME trained, would there be work?"**

2. **How many practitioners intend to leave in the coming year?**

This survey was sent out in November 2000 and the results have been based on the 58% response to this single pass.

RESULTS

Recruitment and Retention

The results had the following limitations although none were overwhelming. The response rate was 201 out of 211 practices (95%). (The process of defining rural practices still undergoes minor fluctuations. There are now a further 6 practices identified, bringing the current census up to 217.) The main error in answering questions was to omit mention of current practitioners which should not affect the losses of doctors but might slightly underestimate the gains. Several practices omitted to enter their rural ranking scores. Of the 173 departing doctors the destinations of 13 were omitted and 5 were unknown.

The raw numbers of arrivals and departures were:

YEAR	GAINS	LOSSES	BALANCE
1995	46	18	+28
1996	44	34	+10
1997	46	25	+21
1998	51	51	NIL
1999	42	46	-4

Provisional figures for 2000 suggest a loss of 17 practitioners but these figures are incomplete and will be fully reported after the return of the year 2000 annual rural survey.

Discussion with rural GPs suggests that a stay of less than 2 years does not offer the level of stability sought by a community for continuity of care. Nor does it particularly help the other practitioners in a locality who need assurance of support without the recurrent stress and cost of seeking others to join them. Below, the above figures are adjusted to include only those staying for 2 years or more:

YEAR	GAINS	LOSSES	BALANCE
1995	37	11	+26
1996	36	22	+14
1997	36	15	+21
1998	23	34	-11
1999		*unknown at this stage*	

There has been a net gain of 55 GPs. However the indication is that a period of optimism 5 years ago has been turned around and more doctors are leaving without replacements.

It is also useful to identify the localities which have gained or lost practitioners.

GAINS: NORTH ISLAND

Keri Keri	3	Beachlands	1
Wellsford	3	Great Barrier Is.	1
Waiheke Island	3	Pauanui	1
Raglan	3	Paihiatua	1
		Tuakau	1
Sth Kaipara	2	Te Aroha	1
Kawerau	2	Te Kaha	1
Putaruru	2	Turangi	1
Te Kuiti	2	Waiuku	1
Taihape	2	Mercury Bay	1
		Dannevirke	1
		Woodville	1
		Marton	1
		Shannon	1
		Stratford	1

Total = 37

SOUTH ISLAND

Oamaru	6	Golden Bay	1
		Motueka	1
Queenstown	5	Karamea	1
		Hokitika	1
Mapua	2	Waikari	1
Amuri	2	Lincoln	1
Fairlie	2	Waimate	1
Alexandra	2	Milton	1
		Fiordland	1

Total = 27

LOSSES: NORTH ISLAND

Whangamata	3	Whangaroa	1
Ngati Porou	3	Waihi Beach	1
		Pio Pio	1
Wairoa	2	Otorohanga	1
		Sth Wairarapa	1

Total = 13

SOUTH ISLAND

Sth Westland	1
Twizel	1
Roxburgh	1
Bluff	1

Total = 4

BALANCE

North Island	**+28**	**(out of total GP population of c.300)**
South Island	**+18**	**(out of total GP population of c.180)**

These figures do not exactly correspond to the apparent raw gain of 55 additions to the rural workforce due to inaccuracies in returns of questionnaires, particularly the omissions of incumbent GPs and of recording GPs who may have left after 1994 and before the incumbents arrived.

Further work by direct contract with the practices concerned is required to clarify these anomalies.

STABILITY

The question of the stability of the rural workforce in different locations has been raised in connection with identifying those who stay for 2 or more years. The locality based gains and losses exercise has not yet been applied to this sub-group but may be done at a later stage.

Another way to assess stability is to look at the average stay of GPs in a particular locality. This has been done for a few localities by way of example and would also require more exhaustive analysis of the data to provide a complete picture. To explore the concept's use it has been applied to some sample areas. The length of stay of doctors was measured only for the study period. Thus a doctor who had served the locality for over 20 years would be recorded as 5 years as would one who arrived in 1995 and was still present. The closer the average stay is to 5 the more stable the practice. Less than 3 indicates a moderately high degree of instability.

Examples:

Location	GPs In	GPs Out	Currently Present	Average Stay
Akaroa	0	0	2	5
Alexandra	3	1	8	4.8
Wanaka	3	0	6	4.6
Fiordland	5	4	4	3.67
Wairoa	3	5	4	3.65
Hokitika	2	1	4	3.6
Queenstown	5	0	12	3.0
Lumsden	1	1	1	3.0
Bluff	5	6	1	2.64
Ngati Porou	6	9	1	2.1

The example of Hokitika above reveals some of the difficulty in interpreting the data. The survey fails to identify a practice which has closed down, whose doctor's departure is omitted and his less than 5 year contribution to the average stay, not taken into account.

The figures also show that the average stay needs to be interpreted in the context of recruitment retention and current workforce numbers. Queenstown appears unstable but in fact the low average stay is an indication of a recent influx of new GPs. Conversely, Wairoa which has recently lost GPs, appears more stable than it is due to the long service of the unreplaced departees.

We were interested in the destination of those who left rural practice. Of the 176 departees the destinations were as follows:

Urban practice	48
Other rural practice	20
Non-GP medical	25
Overseas	36
Non-medical work	3
Retired	21
Died	4
Misc./"unknown"	5
(Unspecified)	(13)

"Gaps in the Rural Workforce"

125 answers have been obtained from the 214 practices surveyed (58%). In deference to the survey weariness of the rural practices, we did not pursue further passes but are slowly filling any extra data as it comes to hand. The survey itself was fairly simple so we are inclined to assume that those in greatest need bothered to respond to it. thus the need for extra help among the non-responders, while not being zero, is likely to be less dramatic.

We particularly wanted to measure the shortfall in rural workforce from firstly, the general perception of the practitioners and secondly, on the basis of practitioner/population ratios. Both these measurements have inherent inaccuracies.

The first is a subjective estimate and at times was also confused by those who, in spite of heavy workloads or demanding rosters, desired no extra help because they felt that the local economics would not sustain it.

The second measurement, while offering accuracy of FTE staff, was more subjective when estimating the population served. An attempt to compensate for this was by asking each of the practices serving a particular locality the same question about their population in the hope of a consensus emerging. This could possibly be improved by drawing on the national population census but it would again be an approximation due to census boundaries not necessarily correlating with rural health locality boundaries. Population estimation is also complicated by wide fluctuations in population due to tourist influxes in many localities.

Despite these limitations the shortfall in rural workforce is of such a scale that the inaccuracies have little impact on the gravity of the overall situation.

Of the 125 practices responding, **between 90 and 94 vacancies for GPs and 30 for PRIME nurses were identified**.

In addition the **intention of 40 GPs to leave** in the next year was recorded. It is not clear whether these need to be added to the immediate recruitment targets or whether there is some overlap with the vacancies above. Overlap is suspected in 16 of these responses based on additional comments on the returned questionnaires.

The estimated population for the localities responding was **527,000**. There were **256 FTE doctors and 38 FTE PRIME nurses** serving this population giving a **practitioner/patient ratio of 1:1800**. (The inaccurate responses of some practices required their workforce numbers and population estimates to be excluded from this calculation for the time being.)

As with the R/R survey, there are areas relatively well served and others in dire straits. Queenstown has 11 FTEs attending a stable population of 15,000 but also a very large visitor population. In the high seasons, extra locum staff are brought in to service the mountain sports but apparently there is no difficulty finding locums in this context. Motueka reported 6.2 FTEs attending 12,000. In contrast, there are 1.5 FTEs in Hokitika attending 5,300 and 2 FTEs in Waimate for 7,500.

The Ministry of Health has placed the estimated desirable doctor/patient ratio for urban doctors at 1:1400, in line with international figures for developed countries. It could be argued that rural practitioners provide a wider range of services including emergency care, in-patient care and a variety of primary care functions provided in cities by clinics and statutory services – sexual health, mental health, sports medicine, to name a few. Thus, doctor/patient ratios of 1:1200 have been proposed by advocates for rural areas. In addition, there are those remote areas with small populations but requiring higher ratios in order to avoid unsustainable on-call demands.

For an average doctor/patient ratio of 1:1400, 376 FTEs are required, indicating a current shortfall of 82 practitioners. For 1:1200 we are 145 short.

These figures relate to the situation in spring of 2000. things are constantly changing and anecdotally deteriorating. Updated figures should be available by the end of June 2001.

SUMMARY

- There are 119 rural localities
- There are 217 practices serving these localities
- There are approximately 480 GPs and 50 PRIME nurses working in these practices
- A positive trend in recruitment of +59 doctors in 1995-1997 seems to be reversing (-4 in 1998-99), supporting anecdotal evidence of rural workforce attrition
- 58% of the practices identify 256 FTE GPs and 38 FTE PRIME nurses serving a population of 527,000 – a practitioner/patient ratio of 1:1800
- According to practitioner/patient ratios there is a deficiency of 80 to 145 practitioners, bearing in mind that remote low population areas will require even more favourable ratios
- According to those working in the rural practices, they are over 90 practitioners short, remembering that 40% have not responded
- There are 35-40 practitioners contemplating leaving

It is reasonable to say that 100-120 more practitioners are necessary to create a sustainable, high quality rural health service for New Zealand.

In spite of the deficiencies of the surveys, the numbers are big regardless of detail and the situation will worsen, heading for total collapse in the harder hit localities if the incentives for rural practice and the context in which it is carried out are not rapidly remedied.

More work is required to refine the data, further layers of analysis are possible and cross correlation with other surveys and databases may also allow more accurate conclusions to be drawn. The annual workforce survey for 2000 will go out in March 2001.

APPENDIX 1

Recruitment and Retention Survey

Spring 2000

Te Whare Whakakotahitanga Mo Te Hauora Taiwhenua

Important Information Required

RECRUITMENT & RETENTION OF RURAL DOCTORS
Who comes, who goes, how long do they stay?

Dear Rural Doctor / Practice Manager

This is information we need to collate as part of the National Centre for Rural Health contract with the HFA. It is crucial for evaluating programmes to support rural practice.

There is no automated data to reliably provide this information so we are resorting to pen and paper. We ask for your help by filling out the attached table as best you can. (It should only take about 10 minutes (plus time for reminiscences!) Use the help of other staff but please do so within 1 week if at all possible.

We need to know about the doctors who are working and have worked in your practice since 1995:

- This **does not include locum** working for less than 6 months
- It **does include doctors** who come intending to stay but leave in less than 6 months.
- You may **ignore breaks in service for maternity leave or sabbaticals** if the doctor has returned or intends to return to work in your practice.

1. Please enter on the attached sheet/s the doctors' names, their starting and finishing dates (**month, if possible, but year alone will do**) and their approximate total months/years in the practice. (They do *not* need to be in sequence.) If you need more sheets please photocopy them.
2. Would you also mark their period of practice with a **bold line on the bar graph**. If the doctor worked pre-1995, extend your bar line a bit to the left of the grid (see example on the sheet.)
3. If the doctor has left the practice please show their destination if it is known.
4. Within 1 week (please?) fax (preferably) to **03 364 0451** or **post** the sheet/s to the address at the bottom of the page.

Martin London
Co-Director, Centre for Rural Health

Monitoring of Recruitment & Retention to Rural Areas

Practice:... **Rural Ranking Scale** [ ]

(Please draw a bar line to show rural term)

	Start Date Month	Start Date Year	Finish Date Month	Finish Date Year	1995	1996	1997	1998	1999
Example: **Doctor's Name:** *"Dr A Bloggs"* **Destination, if left practice:** *"retired"* **(e.g. retired, other rural/urban practice., hospital, etc.)**	?	1983	Mar.	1997					
Approx total	13 yrs *or* ____ mths								
Doctor's Name.. Destination, if left practice..................................... (e.g. retired, other rural/urban practice., hospital, etc.)									
Approx total	____ yrs *or* ____ mths								
Doctor's Name.. Destination, if left practice..................................... (e.g. retired, other rural/urban practice., hospital, etc.)									
Approx total	____ yrs *or* ____ mths								
Doctor's Name.. Destination, if left practice..................................... (e.g. retired, other rural/urban practice., hospital, etc.)									
Approx total	____ yrs *or* ____ mths								
Doctor's Name.. Destination, if left practice..................................... (e.g. retired, other rural/urban practice., hospital, etc.)									
Approx total	____ yrs *or* ____ mths								

Please photocopy this sheet if you need more space

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APPENDIX 2

Gaps in the Rural Workforce Survey

December 2000

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Te Whare Whakakotahitanga Mo Te Hauora Taiwhenua

Gaps in the Rural Workforce – December 2000

IMPORTANT SURVEY

There continues to be severe erosion of the rural workforce. Studies are going on but the urgency of the situation means that we have to bring the scale of it before the government now, when we meet them on 7 December so that our concrete proposals for solutions may be taken seriously. Please help us with a prompt reply.

Practice name…… Rural Ranking Scale…….

Rural area……. Average on-call roster…….
*(i.e. name of the rural area you cover **on-call**)*

1. Number of practitioners in your Practice:

   Doctors (**full time** = 8-10/10)…… ……..(**p/t** – state x/10)

   Rural Nurse Practitioners (**PRIME** trained)…… (f/t) ……. (p/t)

2. Please estimate the population of your ***rural area***……..

3. If a suitably qualified (and socially acceptable!) practitioner arrived in your practice/locality today, available to work alongside you, would there be a job for him/her?

   Yes ☐ No ☐

4. For how many such practitioners would there be work?

   Doctors…….. Rural Nurses (PRIME trained)……

5. Are there any practitioners intending to leave your practice during the coming year?

   Yes (how many, doctors or nurses, f/t, p/t) ☐ No ☐

6. Comments……..

   ……

Please fax back to: 03 364 0451 *today*

THANKS!!

RURAL PRACTICE SUPPLEMENTARY QUESTION

Rosters, Localities, Rural Areas

In defining rural localities we have found the best way to achieve consistent boundaries is to identify a rural area which is covered by a single on-call roster. We know some boundaries vary between weekdays and weekends.

Please would you tell us which are the practices with whom you share an on-call roster during weekdays and weekends. Do you have a geographic name for the rural area you cover (or would you like to invent one?)

PLEASE FAX TO 03 364 0451
Thanks

Your practice name *(practice stamp will do)*…….

Geographic name of your locality……..

Practices with whom you share on-call roster:

a) *Weekdays*

…….

…….

…….

…….

…….

b) *Weekends (just put "same" if this is the case)*

…….

…….

…….

Martin London
National Centre for Rural Health