Te Whare Whakakotahitanga Mo Te Hauora Taiwhenua

New Zealand Annual Rural Workforce Survey 2000

Martin London
Centre for Rural Health
2001

PUBLISHER

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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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New Zealand Annual Rural Workforce Survey 2000

SUMMARY

Rural Shared Roster Areas	**116**
Rural practices	**212**
Rural GP workforce	**528 (= approx. 400 FTE)**
Rural GPs arrived in 2000	**53**
Rural GPs departed in 2000	**48**
Net gain of rural GPs	**5 (>10% of requirement)**
SRAs with heavy workloads	**40**
SRAs with demanding on-call	**34**
Rural GP shortfall	**80 (approx.)**

Martin London (2001)

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INTRODUCTION

Monitoring the comings and goings of the rural general practitioner workforce in New Zealand is of vital importance for workforce planning as we try to achieve equitable access to health services for rural people. Not only does our knowledge of the rural workforce at any time, give an indication of how actively we need to work to retain our existing general practitioners and seek others to support them, but also annual monitoring gives us an idea of what interventions on behalf of rural practice have been successful.

The ability to monitor the rural workforce has been held up for a long time while efforts were made to define rural practitioners, recognising a continuous spectrum of rurality from very remote, isolated solo practitioners to those working in small towns close to large cities. This was finally resolved in November 1999 with the establishment of the Rural Ranking Scale, based on an agreement between the Ministry of Health and the NZ Rural GP Network. Practitioners scoring 35 or more points on the Rural Ranking Scale have been deemed to be "rural general practitioners" and their practices, "rural practices".

The historical perspective on rural GP retention and recruitment was carried out on 217 rural practices identified on this basis and covered the period 1995 to 1999. This was reported to the Ministry of Health in February 2001. Following this baseline measurement, an annual survey of rural practitioners has been commenced, the first involving the year 2000. As well as following the fluctuations of rural GP numbers, this survey has extended to identifying boundaries relating to the delivery of general practice services to identifiable populations, the practices sharing rosters to serve these populations and the practitioners working within those practices. It has also enabled us to make an initial crude calculation of the population count within these "shared roster areas". Future mapping will lead to more accurate measurements of population and deprivation based on the national census. These latter measurements will enable better workforce planning to ensue, more accurately identifying practitioner numbers required to serve the needs of these populations.

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METHOD

There were three aspects to the year 2000 annual rural survey. The first was to consolidate the database regarding the shared roster boundaries and the practices serving those areas. The second was to monitor how many rural GPs had left rural practice and how many had entered during the year 2000 and the localities where these changes have occurred. Thirdly, the current GP workforce in full time equivalents (FTEs) was assessed to relate service to population ratios.

Shared Roster Areas

The definition of Shared Roster Areas (SRAs) and their boundaries was derived initially from the 1995-99 rural survey in which practices were asked to name their locality and identify the other practices sharing their on call roster [Appendix 2]. This was followed by a study of maps to deduce the roster's area of responsibility from political and physical geographic features. The boundaries derived were modified opportunistically when talking to rural practitioners on other Centre for Rural Health business and by presenting the map to them at meetings and conferences.

This allowed them to modify the borders to fit the realities of their on call responsibilities and inform on any changes in practice arrangements in their area.

The final draft of the rural shared roster areas and their boundaries were hand drawn on a map of New Zealand. This map has now been used as the database for transfer to a Geographic Information System (GIS) map with the assistance of the Ministry of Health.

Workforce Monitoring

The questions regarding workforce status and fluctuations were based on a single questionnaire. The questionnaire was made as simple as possible, recognising that rural practices are constantly under stress from paperwork and receive a multitude of surveys for different reasons. It was also preceded by a cover note giving brief reports on the previous survey and acknowledging practitioners' contributions to its success. The letter also specifically indicated the use to which the information was being put with the expectation that recognising its value would increase survey participation [see Appendix 1]. The survey asked three simple questions about the practice:

Q1. The comings: *Please list all doctors and PRIME trained nurses who have arrived in your practice during 2000 to work for at least 6 months (i.e., not short term locums).*

Q2. The goings: *Please list all doctors and PRIME trained nurses who left the practice during 2000 after at least 6 months practice. Please show their total time in rural practice and their destination (e.g., retired; went to urban practice; other rural practice, etc.)*

Q3. *Please indicate the current workforce in your practice (names not required). This required response on how many full time GPs (taken as 8/10 or more), how many part time GPs, how many PRIME nurses and the on call roster for the practice.*

There was a subsidiary question asking whether any new practices have commenced or previous ones closed down in the locality. There was also opportunity for respondents to write any extra comments on the form.

Populations of the Shared Roster Areas were derived from the 1996 census by identifying on the GIS map those census mesh blocks whose centres lay within the boundaries of each SRA.

RESULTS

The workforce results were based on the situation on December 2000. A certain amount of *ad hoc* adjustment has been made to the information since then, relating to the total workforce figures but not to the information about arrivals and departures.

Mapped Shared Roster Areas

The Shared Roster Areas (SAR) and their boundaries were hand drawn on a map of New Zealand and transferred to a Geographic Information System (GIS) map. 116 SRAs have been identified and numbered, 62 in the North Island and 52 in the South Island plus Stewart Island and the Chatham Islands. Of these Shared Roster Areas, 33 require GP on call rosters of 1:1 or 1:2; 32 have rosters of 1:3 or 1:4; 41 have rosters of 1:5 or more [Table 1].

Table 1: Shared Roster Area on call duties

Rural SRAs on **1:1 or 1:2** on call rosters	**33**
Rural SRAs on **1:3 or 1:4** on call rosters	**32**
Rural SRAs on **1:5 or lighter** on call rosters	**41**

Workforce Questionnaire

After three trawls of the questionnaire, 195 returns (92%) were obtained from the 212 practices ultimately confirmed. The relevance and accuracy of answers to questions was generally good although some cross checking with other databases was required to correct obvious anomalies.

Failure by some to include the number of full time equivalent tenths of part timers in their current workforce required estimation based on averaging all other part timers' contributions. This involved 17 out of those 90 returns that included part timers.

17 (out of 212) practices failed to provide a return and information about these was gleaned from other databases.

Rural GP Numbers

The questionnaire returns identified:

310 full time rural GPs (working 8 tenths or more)
188 part timers (doing an average of 4 tenths sessional work)
Total workforce of 498 practitioners providing 378 full time equivalents (FTE)

In addition, the 17 non-returning practices are estimated to represent 30 other GPs

Estimated total workforce – 528 GPs providing somewhat under 400 FTE

These practitioners are not distributed evenly over the population. Using the populations of the SRAs as the denominator the full time equivalent GPs serving each area included:

14 localities (38 doctors) with doctor/patient ratios of > 1:2000
12 localities (56 doctors) with doctor/patient ratios of > 1:1750
14 localities (34 doctors) with doctor/patient ratios of > 1:1500
15 localities (70 doctors) with doctor/patient ratios of > 1:1250

Workforce Fluctuations

The 195 returns indicated a net gain of 5 rural GPs with 53 practitioners (= 44 FTE) arriving and 48 (no FTE data available) departing during the year 2000. However, the majority of these gains (4) were in the less remote practices (RRS 35-45) with only one in the more rural practices (RRS 50-100) [Table 2].

Table 2: Workforce Fluctuations

	Gains	Losses	Net
High RRS practices (50+ pts)	33 (28 FTE)	32	+1
Low RRS practices (35-45 pts)	20 (16 FTE)	16	+4
Total	**52**	**48**	**+5**

The turnover of the workforce is approximately 10%. The gain in practitioner numbers is, at best, only 10% of the requirement and in high RRS practices, may be barely 2% of requirement.

Departing Doctors

The destination of departing doctors was sought as an indication of what contexts drew doctors away from rural practice. Table 3 shows that 6 of the 48 departing doctors found other rural positions. Of the 9 with unknown destinations, 6 had left practices which, according to informants from the same locality, had closed down and so were removed from the database.

Table 3: Destinations of doctors leaving rural practice

Destinations	Numbers
Rural	5
Academic Rural	1
Urban	14
Overseas	9
Retired / Died	6
Maternity / Sick leave	4
Unknown	9

Rural Nurses

There are several localities where the front line primary health and emergency services are provided by rural nurses. They receive emergency back up from doctors at a distance who may also visit regularly to provide medical clinics. These exist in the locations listed in Table 4. Only those at Stewart Island receive back up from non-rural GPs.

Table 4: Localities with rural nurse led frontline services

Great Barrier Island	French Pass
Moana / Otira	Fox Glacier
Haast	Tokonui
Stewart Island	

There are an increasing number of places where on call duties are shared between doctors and rural nurses. These are shown in Table 5.

Table 5: Rural nurse supported on call services

Te Araroa	Karamea
Murchison	Hanmer Springs
Whataroa / Harihari	Diamond Harbour
Roxburgh	Ranfurly

There are also increasing numbers of rural nurses trained in PRIME. All nurses who have completed the Certificate of Primary Rural Health Care will have completed PRIME as part of the course. Not all of these will be using these skills alone on call. However, they represent a resource in the rural workforce able to back up the GPs and to participate more directly in the management of emergencies.

DISCUSSION

While the methodology of evaluating populations and workforce is reasonably sound, there are a number of factors which invite inaccuracies and anomalies. Drawing SRA boundaries is an imprecise art and the behaviour of populations within them unpredictable, particularly in rural areas close to urban areas. In some more remote areas and those with high Maori populations, incomplete census returns are believed to exist. Some population counts from the GIS data seem absurdly high or low for the localities and require further examination.

No account has so far been made for large influxes of tourists to many of the rural areas. This would increase the numbers of SRAs where workloads are demanding. A methodology for estimating the visitor impact needs to be the subject of further research during 2002.

There were some obvious inaccuracies in the way the rural workforce survey was completed by practice staff as was revealed and corrected by direct contact with the practices. Resources would not allow this to be done universally and other inaccuracies may well have been overlooked.

There is also the problem of the 17 practices (8%) that failed to return their questionnaires.

A final point is that the situation is in a constant state of flux and nearly a year has passed since the reference date for the data.

While these drawbacks introduce a margin of error, the overall workforce situation for rural health services remains understaffed and fragile and the margins of uncertainty do not significantly alter the imperatives of government policy development for which this data is required.

Mapping

Shares Roster Areas

From the point of view of both workforce planning and future rural research, it is extremely valuable to have defined the localities covered by rural practices sharing rosters, the practices providing the services and the workforce within those practices. The SRAs are particularly useful units as the workforce within them tends to be inter-dependent and the stability and sustainability of health service provision can be related to these areas. Setting the full time equivalent medical workforce against the populations of the Shared Roster Areas, it is possible to identify the under-doctored areas and take special steps to create working conditions able to retain the current workforce and attract new practitioners. Isolated localities with very small populations also stand out from the survey and represent places where extra practitioners (doctors or nurses) may be required to create sustainable on call rosters.

The creation of workforce and practice profiles for the Shared Roster Areas will make future workforce monitoring easier and a form is being prepared [Appendix 3] to send out in early 2002 to monitor the changes over the past year and to confirm the validity of current data.

Workforce Monitoring

Heavy Workloads

There are 40 localities (involving 118 GPs) where there seem to be notably insufficient practitioners to serve population numbers. This is based on an assumption that for the provision of comprehensive primary health care, a practitioner/patient ratio of 1:1200 is desirable. This takes into account the increasing levels of accountability expected of practices over the past decade and the wider range of services provided by a rural, as opposed to an urban, general practice. In many of these overburdened practices, it is the high levels of deprivation that prevent the population being able to financially support more than their current numbers of practitioners. Persuading more practitioners to work in these areas will not be successful without providing extra resources to sustain the service.

Demanding Rosters

The survey indicates that there are still 34 areas where practitioners are on 1:1 or 1:2 rosters. This level of call is considered not to be consistent with sustained good health and can seriously threaten the continuity of health services to an area if a practitioner decompensates. These communities with very small populations will need extra resources if sufficient numbers of practitioners are to be available to share rosters. The Rural Practice Support Scheme (RPSS), trialled in 2000-2001, was one attempt to address this problem and met with some success.

1:3 and 1:4 rosters are considered to be the maximum sustainable on call requirement although a busy 1:3, serving a larger population is undesirable. In the next annual survey it might be useful to hear from those practices on 1:3 rosters whether they are comfortable with their on call workload. The sustainability of extensive on call responsibility depends on opportunities for meaningful and affordable periods of time off for annual and educational leave. The Rural Locum Support Scheme about to be launched, if it proves successful, could have a major impact on this aspect of rural services and reduce some of the pressure on the 1:1 to 1:3 roster SRAs.

Workforce Fluctuations

The overall numbers of rural practitioners seems to have been stable during 2000, a slight increase noted in the less remote practices and the still under-resourced status quo maintained in the more vulnerable areas. Some of this stability may have been due to the RPSS mentioned above.

However, simply replacing losses, generally in the more attractive locations, obscures the issue of practices and localities where practitioners continue to carry on in strained circumstances of high workload and/or demanding rosters. The disincentives for simply leaving these places include a commitment to continuity of the service, a commitment to colleagues not to leave them with increased burdens and a desire to remain where their home and social networks exist. The stressed practitioners simply carry on.

Having identified those 40 practices with heavy workloads and considering only those with more than 1:1500 doctor/patient ratios, if these were to gain sufficient doctors to achieve a 1:1200 ratio, a further 60 GPs would be needed. If we add the 34 practices with 1:1 or 1:2 rosters but subtract those 14 practices where both situations exist, there is still a deficit of 80 doctors, comparable to the 100 estimated deficit in 1999 as reported in 2000 to the Ministry of Health (London, M. 2000).

There were a very few places where the gain of rural GPs was truly problem solving. Gains in Great Barrier Island, Roxburgh, Oxford (lost after 6 months) and Twizel (gained1, lost 1) were directly related to the Rural Practice Support Scheme initiative. It is of particular concern that this scheme has no funding past 31 December 2001 with any further funding appearing at present only to be available, if at all, in July 2002. **The intervening 6 months may be expected to see the loss of this valuable workforce with all the advantages of retention over recruitment being squandered. This issue requires urgent attention.**

Gains in other fragile areas included 2 practitioners arriving in Hokitika from South Africa, the result of extensive efforts from the Westland Medical Centre although 1 doctor also departed and the area remains under-serviced with a 1:1630 doctor/patient ratio. Te Araroa, Tairawhiti, Chatham Islands and Westport were other gratifying gains in localities traditionally hard to fill but resolved by creative arrangements. Whether the recruitments prove retainable remains to be seen.

Turangi (gained 1), Waimate (gained 1, lost 2), Amuri (gained 1, lost 1), Waihi (gained 1, lost 1). High RRS practices which lost GPs without replacement during 2000 were Te Anau, Whangamata, Wairoa (gained 1, lost 2), Otautau, Opotiki (lost 2), Tuatapere, Kaitaia, Whitianga, Taihape, Taumarunui and Te Aroha.

The small change in the overall workforce suggests that there is still a substantial deficit of general practitioners in rural New Zealand as estimated in the report relating to 1999. However, a number of localities may have solved some of their problems by increasing the contribution made by rural nurses to routine and on call services. This is another level of analysis still required of the data.

A group of rural doctors and nurses that have not been included in this survey and report are those working full time in rural hospitals. Now that a degree of stability has been reached with rural hospitals it would be valuable to create a database of this workforce to hold alongside the current general practice database.

Another rural workforce requiring survey is the Maori Providers. This might be more effectively done by the North Island based Institute of Rural Health who might usefully integrate their formats and approach with the ongoing workforce monitoring at the Centre for Rural Health.

SUMMARY

Workforce monitoring is extremely difficult to carry out with complete certainty but a substantially accurate baseline has been generated for the NZ Rural GP workforce. This is based on rural localities defined by their rural ranking scores and the areas covered by practices sharing on call rosters. We are now able to identify the 116 localities, the 209 practices serving these localities and the medical workforce numbers of 517 practitioners supplying approximately 400 full time equivalents working in those practices. The next round of workforce monitoring will involve the creation of SRA specific profiles to include the names of the practitioners. Other work to extend workforce monitoring to rural nurses within the practices, the staffing of rural hospitals and rural Maori Providers, will add further accuracy.

While the workforce appears stable it remains grossly under-staffed by over 13%. There remain problems of mal-distribution and the need to create working conditions in the higher RRS practices to attract more practitioners and reduce the turnover of the workforce.

Rural Shared Roster Areas

1.	Kaitaia	40.	Reporoa	79.	Hokitika
2.	Mangonui	41.	Murupara	80.	Waipara
3.	Whangaroa	42.	Waikohu	81.	Whataroa
4.	Kerikeri	43.	Tolaga Bay	82.	Malvern
5.	Hokianga	44.	Taumarunui	83.	Oxford
6.	Kaikohe	45.	Turangi	84.	Fox Glacier
7.	Bay of Islands	46.	Wairoa	85.	Methven
8.	Tutukaka	47.	Opunake	86.	Ellesmere
9.	Hikurangi	48.	Okato	87.	Diamond Harbour
10.	Dargaville	49.	Inglewood	88.	Akaroa
11.	Ruakaka	50.	Stratford	89.	Haast
12.	Lower Northland	51.	Eltham	90.	Mackenzie Country
13.	Great Barrier Island	52.	South Taranaki	91.	Fairlie
14.	South Kaipara	53.	Waverley	92.	Geraldine
15.	Warkworth	54.	Waimarino	93.	Pleasant Point
16.	North Coromandel	55.	Waiouru	94.	Temuka
17.	Waiheke Island	56.	Taihape	95.	Wanaka
18.	Beachlands	57.	Waipawa	96.	Kurow
19.	Tairua	58.	Central Hawkes Bay	97.	Waimate
20.	Whangamata	59.	Rangatiki	98.	Te Anau
21.	Waihi	60.	Southern Hawkes Bay	99.	Wakatipu Basin
22.	Waiuku	61.	Foxton	100.	Cromwell
23.	North Waikato	62.	Southern Tararua	101.	Alexander/Clyde
24.	Hauraki	63.	South Wairarapa	102.	Maniototo
25.	Te Aroha	64.	Golden Bay	103.	Oamaru
26.	Katikati	65.	Motueka	104.	East Otago
27.	Morrinsville	66.	Mapua	105.	Lumsden
28.	Raglan	67.	French Pass	106.	Roxburgh
29.	Matamata	68.	Havelock	107.	Greater Taieri
30.	Kawhia	69.	Picton	108.	West Otago
31.	Rangitaiki	70.	Karamea	109.	Milton
32.	Kawerau	71.	Wakefield/Tapawera	110.	Tuapeka
33.	Opotiki	72.	Westport	111.	Western Southland
34.	Te Wharau/Apanui	73.	Murchison	112.	Central Southland
35.	Te Araroa	74.	Reefton	113.	Eastern Southland
36.	Te Puia Springs	75.	Kaikoura	114.	Balclutha
37.	North King Country	76.	Moana/Otira	115.	Tokonui
38.	South Waikato	77.	Amuri/Hanmer Springs	116.	Stewart Island
39.	Te Kuiti	78.	Cheviot		

APPENDIX I

Annual Rural Workforce Survey 2000

Introduction & Questionnaire

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Te Whare Whakakotahitanga Mo Te Hauora Taiwhenua

ANNUAL RURAL WORKFORCE SURVEY – 2000

THANKS!!! Last year virtually all the 220 circulated practices sent in records of the comings and goings of GPs over the past 5 years. This has been very valuable and showed that after an optimistic period of a net gain of practitioners in 1995 to 1997, the situation has turned around and there is now a progressive net loss of practitioners. It looks like this:

Year	GPs Recruited	GPs Departed	Gain/Loss
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 **net loss of 17** but these figures are incomplete. Our impression is that the attrition of rural practitioners is accelerating. We are now asking you to let us know the situation in your practice.

The questionnaire (next page) is quick and incredibly simple

3 questions, 1 minute, no training required

(Plus add your own comments anywhere you like!!!)

Your help in completing the questions, combined with other work we are doing with you identifying gaps in the rural workforce, is specifically supporting our collaboration with the Ministry of Health in addressing the urgent rural problems. We hope to be able to show a turn around in recruitment over the coming years.

Next year we hope to be able to send you a completed profile of your practice according to our records, requiring you only to check or modify the details.

Martin London
Co-Director
Centre for Rural Health

ANNUAL RURAL PRACTICE WORKFORCE SURVEY – 2000

Practice Name……..

1. **THE COMINGS:**
Please list all DOCTORS and PRIME TRAINED NURSES who have arrived in your practice <u>during 2000</u> to work for at least 6 months (i.e. not short term locums).

Name (Dr or Ns)	Full time (8/10s or more) or part time (10ths)
……	……
……	……
……	……

2. **THE GOINGS:**
Please list all DOCTORS and PRIME TRAINED NURSES who left the practice <u>during 2000</u> after at least 6 months practice. Please show their total time in rural practice and their destination (egg. retired, went to urban practice, other rural practice, etc.)

Name (Dr or Ns)	Total time as rural GP	Destination
……	……	……..
……	……	……..
……	……	……...

3. **Please indicate the current workforce in your practice (names not required)**

Name (Dr or Ns)	On-call Roster
How many full time GPs? (8/10s or more)……	Weekdays……
Part time GPs (how many 10ths for each?)……...	Weekends……
How many PRIME nurses?……	

PS: If, in your locality, any new practices have commenced or previous ones have closed down please would you identify them so we may correspond with them appropriately.

……

ADD EXTRA COMMENTS ANYWHERE YOU LIKE

PLEASE FAX TO 03 364 0451
(or post to letterhead address)

APPENDIX II

Shared Roster Area Survey 1999

Martin London (2001)

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…….

Population of the whole locality you cover……...

Practices with whom you share on call roster:

a) ***Weekdays***

……..

……..

……..

……..

……..

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

……..

……..

……..

Martin London
Co-Director
Centre for Rural Health

APPENDIX III

Rural Practices Profile 2001

(draft document)

Martin London (2001)

Rural Practice Profile

Shared Roster Locality

Name……

Reg. No…… **Population** *(based on 1996 census)*……

Practices: 1)……

2)……

3)……

4)……

This Practice……..

Address……...

Contact Nos……

On Call Roster: ***Weekdays***……. ***Weekends***……...

Doctors	1/10s working	Year Arrived	Year Left	Destination

(Please cross out any doctor who has left the practice and state year of departure)

Doctors who have joined the practice during 2001 to stay for at least 6 months including the tenths they work:

Doctors	Tenths	Where From

Have any practices in your locality opened, closed or merged?

……

……

……

Nurses:

Practice Nurses	PRIME Trained?		Share in 1st on call roster?	Year Left
	Yes	No		

(Please cross out any nurse who has left the practice and state year of departure)

Special Local Arrangements: *(please modify as appropriate)*

……

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