5 Rural health workforce issues

One in four New Zealanders live in rural areas or small towns, and rural areas have a higher proportion of children and older people living there. Thirty-two percent of Māori live in rural areas, compared with 23 percent of non-Māori. Of particular concern is the significantly poor health states of rural Māori compared with rural non-Māori and urban Māori. If we are to reduce inequalities it is vital that enough health practitioners with appropriate competencies are accessible to rural communities.

Recruitment and retention of health and disability professionals is problematic across provincial and rural New Zealand (Janes 2001; London 2001; Council of Medical Colleges 2001). There is an increasing role for enhanced innovation in rural areas; for example, partnerships between local authorities and communities to address issues around the provision of housing and surgeries in remote locations, and increased use of nurses and technology to support staff and services.

For rural GPs the most important issues are:

- lack of locum relief for holidays
- lack of continuing professional education
- too much on-call work
- a shortage of rural doctors.

These workload issues highlight the need for upskilling in training/emergency work and lack of quality rural and continuing professional education (Janes 2001). Also of note in the study were the disproportionately few Māori and women GPs working in rural New Zealand. Fifty-seven percent of rural GPs were vocationally registered with the Medical Council. The remaining 43 percent will require supervision or oversight after July 2001.

Suggestions for activities to maintain the workforce in provincial and rural settings include:

- training
- succession planning
- continuing education and professional development.

Importing overseas-trained doctors into New Zealand may not be an immediate solution to rural shortages. Overseas-trained doctors cannot immigrate to New Zealand and move straight into rural practice because they often need to undertake supervision or further training. Finding rural positions where this supervision/training is available is difficult, so overseas-trained doctors will usually spend at least the first year in a New Zealand urban centre.

The most significant recent initiative introduced by central government has been the locum support scheme, which is yet to start delivering services but hopefully will be useful when it gets going. This will allow doctors to take an extra 10 days leave each year. The Northern Rural GP Consortium already provides locum services to Northland rural GPs.
Other initiatives include the following:

- **Rural incentives**: these were first introduced in 1969. Under the HFA they were re-spread according to a rural ranking scale, which redistributed the bonus in favour of those who scored the highest points.

- **Upskilling nurses**: relevant to the current problem of recruitment and retention of GPs are nurses who provide advanced skills to rural communities in the form of sharing on-call duties for emergency services. In some very remote areas, such as Stewart Island or the West Coast, nurses have been providing these services full time with back up by distant GPs and hospital doctors.

- **The rural health diploma** is a multidisciplinary postgraduate Certificate and Diploma in Health Sciences – Primary Rural Health Care, being taught through Otago University. It is now generating a growing number of advanced nurses, who will have a vital part to play in resolving rural health workforce issues.

- **Project on implementing Primary Health Care Strategy in Rural Areas**: the Ministry of Health has recently undertaken a project to implement the Primary Health Care Strategy in Rural Areas. The aim is to facilitate the development of a coherent approach to rural health services provision, including the difficult issue of attracting and retaining an appropriate workforce.

- **Telemedicine and other technology** are tools for clinicians in rural settings to overcome obstacles of distance and isolation, but realising their potential requires careful service planning, training and technological support. It is current policy to use technology where possible to reduce the impact of isolation; for example, telemedicine was approved to reduce professional isolation of Westport GPs in 1999. But telemedicine and technology have been introduced erratically – funding has not followed any prioritisation according to isolation or need.

- **Raising the profile of rural general practice**: to improve the uptake of rural general practice the profile of rural general practice is being raised in two ways:
  - medical students now take part in a placement in a rural setting over a minimum of three and a maximum of six months in their second postgraduate year of training
  - the Otago University Medical School is increasing the exposure of students to rural practice, with some fifth-year students training in rural localities for up to seven weeks.

Health professionals working in rural practices need to have appropriate training in emergency treatment at all levels of clinical education. This training needs to be consistent with:

- best practice and the development of guidelines
- use of advanced technology
- the challenge posed by remote and rural practice
- a changing emphasis on capability rather than a specific health professional’s title
- current trends in labour market reform; for example, nurse prescribing (Ministry of Health 1996b).
5.1.1 Question

21 Is there an opportunity for skill mix/substitution initiatives to improve health service delivery particularly in rural areas?

5.1.2 Issues

- An ageing rural population with increasing demand for health services.
- Evaluation of recent health workforce initiatives to determine whether they are having the effect of increasing the retention of rural health practitioners.
- The key is to create systems that foster the development of collaborative local teams, to improve the provision of care and improve the working conditions of the local workforce.