PRIMARY HEALTH "CRISIS"
In South Taranaki

The Problem

The Taranaki District Health Board (and the Hawera Hospital Steering Committee) have been concerned about medical staffing issues for the Hawera Hospital, but the future primary health care of the community also needs urgent attention as GP retention becomes a critical problem.

- In 2001 the NZ Medical Council Workforce Survey noted that the "ratio of doctors to local population was highest in Nelson, Kapiti, Clutha districts, Queenstown Lakes, South Wairarapa and Thames/Coromandel, and **the lowest in South Taranaki**, Western Bay of Plenty, Tasman and Southland, where the number of GPs drops below 50 per 100,000 people [1:2,000]" [1]. Despite this finding, Rural Retention funding was given to Balclutha (RRS=60), South Wairarapa (RRS=50), North Coromandel (RRS=70) but not Hawera (RRS imposed by TDHB = 20).

- In May 2004 the New Zealand Medical Association released a report on the NZ General Practitioner Workforce [2] which identified **South Taranaki** (along with Tasman and Southland as **having New Zealand's third worse FTE GP to population ratios (46**:100,000 **or 1:2174**), beaten only by Grey at **45** and Gore at **43**. By comparison Stratford has **103**:100,000 or 1:970 (and a RRS of 45), New Plymouth has **79**:100,000, Auckland City has **104**:100,000, the average in NZ is **81.3**:100,000 and the Australian average is **110.6**:100,000 and they think that is too low.

- The NZMA Report "demonstrates a substantial and growing shortage of GPs. If early action is not taken the problem will get progressively worse". For areas such as South Taranaki, this issue is already at crisis level. The Report raises concerns about relying on overseas-trained doctors and is critical about replacing GP functions with nurses. Attracting New Zealand graduates into General Practice is the most sensible approach but this will not occur "**until conditions for GPs improve**".

- Initiatives to attract GPs to Hawera (such as forming a Trust) may improve recruitment but will not improve retention (GPs can leave more easily) [3], [4], [5].

- Recently efforts were made to improve conditions for Hawera GPs by asking the TDHB management to modify its attitude to the Rural Ranking Score for Hawera in order to recognise their high patient loads, enable them to access improved patient subsidies and to improve their practice viability. **This was rejected outright**. More than any other factor, it is this Rural Ranking difference that results in Stratford's ability to retain GPs at more than twice the GP to population ratio to Hawera. [See "3. Rural Funding", next page.]

- Discriminatory Public funding of Access PHOs and organisations with Maori names without matching funding for other practices (which have just as many or more low socio-economic patients [6]) has reduced the viability of those practices and reduced GP morale. Patient expectation of lower fees, which cannot be provided without appropriate public subsidy, creates further stress and job dissatisfaction or a tendency to reduce consultation times.

The Local Response

While a rural background has been overwhelmingly the most important independent recruitment predictor of rural practice in US, Australian and NZ studies, retention appeared to be more related to practice issues such as income and workload. [7]

1. Reducing GP on-call time

Most studies identify onerous on-call as a major factor in poor retention [3], and so the GPs of Hawera and most of South Taranaki agreed on a combined GP-after-hours/Emergency Department arrangement where

the rostered GP is second-on-call for the combined service. Excessive call-out for home visits has been curtailed by the simple policy of charging a realistic call-out fee which has been copied by other after-hours GP services around the country. Rural GPs outside Hawera now join in this system reducing their stress and enhancing their retention.

2. GP Trust

While those GPs involved are enthusiastic and a Trust management system can be useful for all GPs if there is a spirit of co-operation, there remain issues of GP retention and public vs private funding. As noted above, if public money is made available to some practices (such as PHOs and Trusts) but not others, there is the potential for further GP loss to the area.

It is quite possible to have different types of practices existing side by side if funding is based on need and not who employs the GP. Alternatively some practices may target the "top end" patients and aim for quality, not quantity. This can be unfair for low socio-economic patients who value time and service with a trusted GP but cannot afford to pay for it.

3. Multi-skilled Medical Officers

Dr Dennis Pisk had a vision of a Hawera Hospital eventually staffed by 7.8 FTE Multi-skilled Medical Officers working in the Emergency Department (ED) and the Inpatient ward [8]. In essence, this has happened with three Medical Officers (TDHB employees), three Casualty Officers (White Cross Employees) and some GPs working part-time (for White Cross) as Casualty Officers. The Hawera Hospital Steering Committee would like to be able to see the TDHB offer current and prospective Medical Officers the chance to work part-time in ED and/or in General Practice to:

(a) provide a greater variety and interest to attract and retain these doctors,
(b) increase the numbers available to share their on-call roster (eg employ 4 at 7.5/10 = 3 FTE) and
(c) provide vocational pathway options in Emergency Medicine or General Practice as none exist for non-specialist Medical Officers (Hospitalists) in New Zealand yet.

As well as the help South Taranaki General Practices would obtain by hosting a Medical Officer in sessional work, this process could lead to some Medical Officers opting to continue in General Practice and/or be available for Locum work. A number of rural practices are really 1½ FTE (Patea, Manaia/Kaponga) and any GP Trust practice is likely to be flexible enough to provide GP sessions.

4. Rural Funding

On 30th May 2002, the government announced $32 million would be available for Workforce Retention and Reasonable Rosters, and that these funds were separate and "flexible". The Retention Funding indicators included "GP to patient ratios have reached or exceeded 1:2000" [MOH Information to DHBs]. After considerable debate, the previous Funding and Planning General Manager offered the Hawera GPs a "notional" Rural Ranking Score of 35 **"for the purposes of accessing the Rural Workforce Recruitment and Retention Funding**", but this was not to all GPs!

After discovering a change in the wording of the last two Rural Score Work Sheets (used to calculate a GP's Rural Ranking Score), my legal secretary contacted the relevant Health Department managers to obtain an up-to-date sheet and a "test" RRS application (for me) was made to them. Following a lot of follow-up phone calls, this eventually was sent to the local Portfolio Manager, Jenny Piquette.

The main differences from previous RRS sheets were:

1. The exclusion of Obstetric on-call for **Q2 "On Call Duty"** had been removed. Furthermore, we had previously included all doctors doing after-hours call, but the fine print allows us to exclude doctors not resident in the town and those we agreed need not contribute through poor health.

2. In **Q3 "On call for Major Trauma"** there is no requirement for a "formal" arrangement, such as PRIME. I had confirmed that a number of GPs have been called as part of their "2nd on call" arrangement with White Cross.

3. In **Q7 "Discretionary Points"**, the indication to the DHB was that it was free to "**award additional points to General Practitioners in areas where the recruitment and retention of General Practitioners is difficult**." If Hawera GPs didn't qualify for this, who in the country other than Gore and Grey GPs would??

On Monday 31st of May, Janice Donaldson, the current General Manager, Funding and Planning for the TDHB confirmed that Hawera GPs would not receive any discretionary points. This, combined with an out of date interpretation of the other criteria means that Hawera GPs continue NOT to be classed as Rural (unlike all other health providers). When informed, the GPs were understandably disappointed but not surprised as they already knew they were not valued by the TDHB.

The options left to Hawera GPs include:

- Bringing the inflexible, out of date and counter-productive decisions of management to the attention of their bosses (CEO and Board members) and the public (including the Hawera Hospital Steering Committee).
- Appealing the decision through a committee made up from the NZMA, the RGPN and the DHB.
- Increasing fees to patients and blaming the TDHB management if there are complaints.
- Selling their practices to the GP Trust, then leaving the area as soon as a better offer comes up to work somewhere they are appreciated.

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3 June 2004
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References:

[1] Medical Council News "*Workforce Survey*" 34, May 2003 also at www.mcnz.org.nz

[2] NZMA: "*An Analysis of the New Zealand General Practitioner Workforce – A Report from the New Zealand Medical Association*" May 2004 www.nzma.org.nz/news/GP%20Workforce%20May%2004.pdf

[3] Humphreys, S et al, "*Workforce retention in rural and remote Australia: determining the factors that influence length of practice*"; Medical Journal of Australia 20 May 2002 176(10): 472-476 www.mja.com.au/public/issues/176_10_200502/www.mja.com.au

[4] MacIsaac, P et al "*General Practitioners leaving rural practice in West Victoria*"
Aust J Rural Health 8: 68-72, 2000 [**mean length of stay over double if self-employed**]

[5] London, M "*Retention before recruitment –creating the contexts of sustainable rural health services*"
New Zealand Family Physician Volume 29, Number 2, April 2002 p83-5

[6] Public Health Consultancy (Wellington School of Medicine and Health Sciences) "An assessment of health needs in the Taranaki District Health Board Region" Oct 2001 (Internet ISBN: 0-478-26253-1 on www.tdhb.org.nz **["most people [in Taranaki] of low socioeconomic status are not Maori"]**

[7] Rabinowitz, H et al, "*Demographic, Educational and Economic Factors Relating to Recruitment and Retention of Physicians in rural Pennsylvania*" Journal of Rural Health Vol. 15, No 2, pp212-218, Spring 1999

[8] Pisk, D "*Independent Reviewer's Report Concerning the Provision of Medical Services at Hawera Hospital*" TDHB Oct-Dec 2001 [See Board resolution on report at www.tdhb.org.nz/board/resolution.htm]