Hauora Taiwhenua
Rural Health Network

Rural General Practice Stocktake Survey

October 2024

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EXECUTIVE SUMMARY

OVERVIEW

This is the second year Hauora Taiwhenua has conducted a survey of Rural General Practices to quantify and better understand their current operational status, issues and morale. Our goal is to develop a repository of sector-informed data that monitors key indicators vital to rural general practice and track changes to them over time.

Building on insights from our first survey last year, we refined our methodology for collecting and analysing response data this year. This refinement enhances our ability to produce multi-year data and enable comparisons between rural general practice indicators and urban or national data produced by other organisations.

Consequently, in this second year, we have included only a few indicators showing results from both surveys. We are optimistic that with high response rates, support from Health NZ in providing system-level data, and the University of Otago's Geographic Classification for Health (GCH), the range of indicators that we can report on a multi-year basis will expand.

SURVEY RESPONSES

This year's survey achieved a 54% response rate, with 103 out of 190 rural general practices classified as 'rural' under the Primary Health Organisation Service Agreement (PHOSA) participating. Survey respondents proportionally represent the GCH R1-R3 areas, mirroring the population distribution in each category. Collectively, their registered patients account for 46% of the rural population.

Where applicable, survey results have been extrapolated to provide an indication of the national perspective.

RURAL GENERAL PRACTICE VITAL SIGNS: TEMPERATURE IS CRITICALLY LOW!

At -38.16, the overall 'temperature' of rural general practice is critically low.

Figure 5 The 'temperature of rural general practice'

130 Nationally, there is a **SHORTAGE OF 130 FTE OF RURAL GPs**
(537 FTE GPs employed, 667 FTE GPs budgeted)

REFLECTIONS

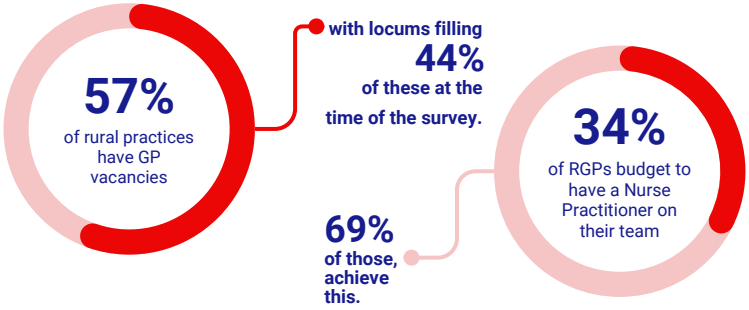
This report provides insights to the rural general practice environment in June 2024. It asserts that:

- Rural general practice is premised upon the dedication of those who combine their expertise, energy and unwavering commitment to the health and wellbeing of rural communities.
- The temperature of rural general practice is critically low. Its symptoms have a corrosive effect on the capacity of the rural health team to meet the health needs of rural communities, and the seasonal influx of tourists, holidaymakers, and outdoor adventurers.
- Under-investment in rural general practice and its multi-disciplinary specialists hinders recruitment of new staff and threatens the retention of the existing workforce. The retraction of off-site and out-of-hours services, and limited ability to take on new patients, or initiatives has a direct impact on equitable health outcomes for rural whānau.
- The evolution of the multi-disciplinary rural health team, and development of comprehensive primary and community care teams enhances clinical capacity and enables innovative models of care. This is countered by the additional burden on GPs to provide clinical supervision, strain on facilities and the required infrastructure, and limits the ability of the rural general practice to host visiting specialists and train the future rural health workforce.

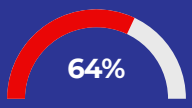
WORKFORCE

The **rural GP: Patient ratio is on average 1:1598** compared to the **RNZCGP maximum accepted ratio of 1:1300**

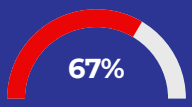
The **'missing' 130 FTE** of GPs **would achieve the maximum GP:Patient ratio**



THE BUSINESS OF RURAL GENERAL PRACTICE



of respondents operate as a private business with 15% of the 64%, run by a single GP.



report their facilities are fit for purpose. Those with inadequate facilities find it challenging to bring more services closer to home and to participate in training the future workforce.

of respondents have been in emergency situations where patient care has been impacted by poor mobile coverage or internet connectivity.

RURAL CONNECTIVITY

32% of respondents consider rural connectivity impacts on their patients having reliable access to health services.

38% of respondents have been in emergency situations where patient care has been impacted by poor mobile coverage or internet connectivity.

21% of respondents said their community had initiated solutions to improve connectivity to health services.

EDUCATION AND TRAINING

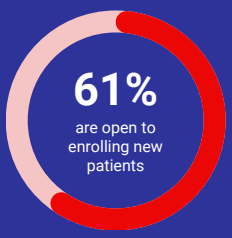
78% of respondents have hosted and/or trained health students over the last 3 years.

17% of respondents would like to host/train students but have barriers in the way of doing so.

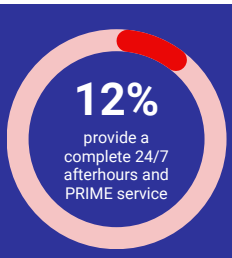
70% of respondents intend to host and/or train health students over the next year.

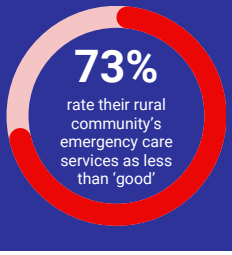
39% of respondents either provide, or have their community provide, accommodation for students.

SERVICE PROVISION



While 66% of respondents maintained their service provision, 34% had to reduce or stop some services. The most affected were out-of-hours services and those requiring an off-site, in-person clinician, such as PRIME, aged residential care, and school-based services.





Out-of-hours roster expectations negatively impact the recruitment of medical staff, and ability to source locum placements.

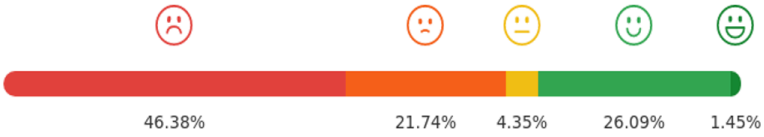
24% of respondents do not provide out-of-hours services but 76% of rural practices combine in-person, telehealth, and local after-hours networks for access to out-of-hours care.

EMERGENCY SERVICE RESPONSE

Common issues that impact on the ability of emergency services to respond to the needs of their communities, include poor funding, under-resourced HHStJ, ambulance travel times to hospitals, and the relentless demands on the clinical workforce.

Respondents were asked for a subjective assessment of how well their communities emergency care needs are met:

HOW WELL ARE OUR RURAL COMMUNITY'S EMERGENCY CARE NEEDS MET?



1. RURAL GENERAL PRACTICE SURVEY RESPONDENTS AND THEIR REGISTERED PATIENTS

- Survey responses include some practices that when applying the GCH methodology, are now considered rural but do not receive PHOSA funding. 9 practices that receive rural funding, have a GCH category U1 or U2.
- There are 746,424 patients registered with PHOSA funded rural general practices.
- University of Otago GCH R1-R3 total population based on 2018 census is 888,654
- Survey respondents care for 385,528, or 43% of these.
- 9 respondents included in the PHOSA rural funding agreement, are in the GCH U1 & U2 categories.

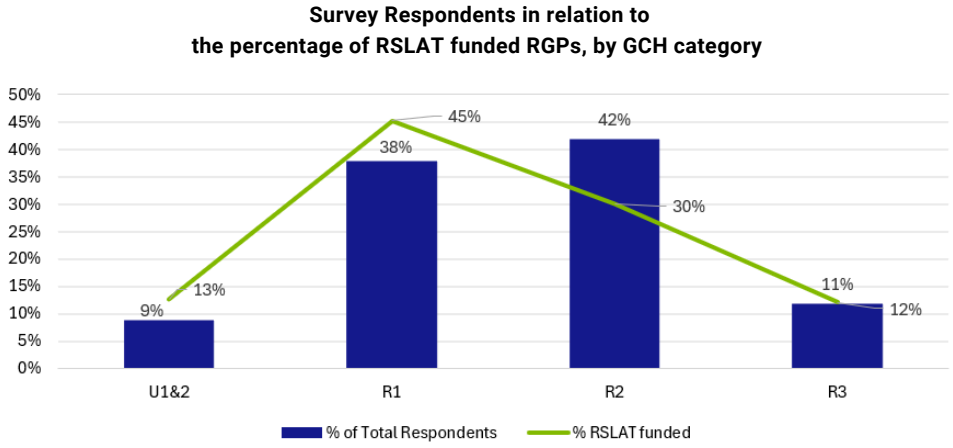


Figure 1 Percentage of Respondents, in relation to RSLAT rural general practices, by GCH category.

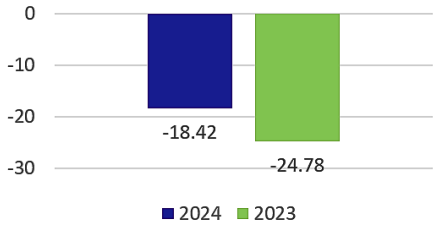
Survey Respondents					Registered Patients	
GCH Category	No of Responses		Total RSLAT Practices		No of Respondent Patients	No of RSLAT Total Patients
U1&2	9	9%	24	13%	36049	105921
R1	39	38%	86	45%	194660	376081
R2	43	42%	57	30%	139030	236604
R3	12	11%	23	12%	15789	27818
Total	**103**		**190**		**385528**	**746424**

Figure 2 Representation of rurally funded registered patients, by GCH category

ASSESSING THE 'TEMPERATURE' OF RURAL GENERAL PRACTICE

The Survey asked respondents for their subjective assessment of two statements shown in Figures 3 and 4. The 'temperature' is calculated as an average of the 'temperature' of the two statements detailed in Figure 5.

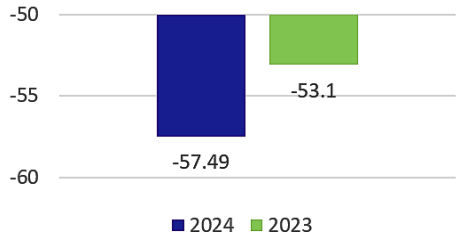
"Staff in our practice are energised and motivated"



The goodwill and commitment rural general practices have to providing excellent care for their rural communities is evidenced in an improvement of 7.5 points between 2023 and 2024.

Figure 3: Staff energy and motivation.

"Our practice is sustainable in terms of its overall 'health'"



Responses to the second statement have dropped 4.2 points since 2023, indicating an increasing view that rural general practice is 'unsustainable'.

Figure 4: Practice sustainability.

Figure 5 The 'temperature of rural general practice'

The average of these two statements (Fig 3 and 4) is combined to show the overall 'temperature' of respondent practices. The 2024 survey temperature, a critically low -38.16, is consistent with the 2023 survey temperature of -39.47 (Fig 5). This consistency underscores the ongoing crisis in rural general practice. The survey aims to quantify and explain the many factors contributing to this crisis.

2. BUSINESS OWNERSHIP AND INFRASTRUCTURE

64% of rural general practices operate as a private business. (Fig 6) There has been no significant increase in the number of corporate owned businesses since last year's survey.

67% of respondents said their facilities are fit for purpose but 33% report that their facilities are inadequate for meeting current service needs (Fig 7). This hinders the ability to offer specialist outpatient services and participate in training health students. Many said they have plans to expand but are financially constrained in doing so. This was particularly so for respondents whose facilities are owned by a community trust.

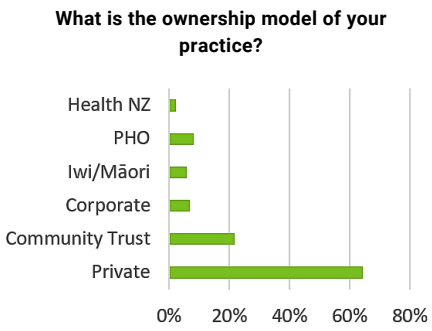


Figure 6: Ownership models of rural general practices.

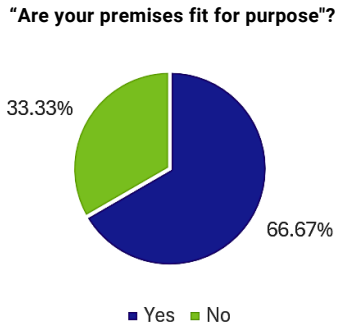


Figure 7: Premises fit for purpose.

RURAL CONNECTIVITY

32% of respondents consider rural connectivity impacts on their patients having reliable access to health services. The practice cannot rely on being able to communicate with patients by using Manage My Health, text messages or video consultations. (Fig 8)

38% of respondents have been in emergency situations where patient care has been impacted by poor mobile coverage or internet connectivity. Staff on PRIME or medical callouts can be isolated from base support, unable to call for additional assistance, and in some examples given, been unable to locate the patient. (Fig 9)

21% of respondents said their community had initiated solutions to improve connectivity to health services. Examples of these include drop-in clinics at community halls, libraries or marae. (Fig 10)

Rural general practices have taken actions to improve infrastructure resilience by purchasing emergency internet and power generators and installing Starlink services.

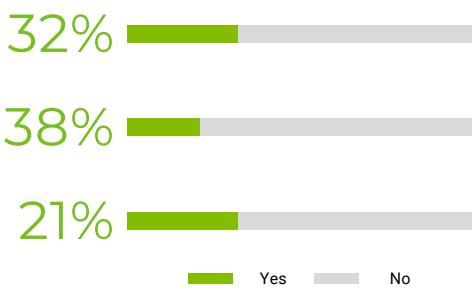


Figure 8 Does connectivity impact on access to health services

Figure 9 Has your staff experienced connectivity issues in emergency situations

Figure 10 Has your community initiated solutions to improve connectivity

SEASONAL POPULATION SURGES

47% of respondents experience significant surges in demand for their services due to seasonal activities and public events. Approximately half of these surges are managed by their regular staff working extended hours to handle the increased workload. (Fig 11).

Responses to this question are consistent with those in the 2023 Survey.

Clinical consultations that result from this are not reported in our GP-to-patient ratio but undoubtedly place significant additional pressure on all staff in the rural general practice.

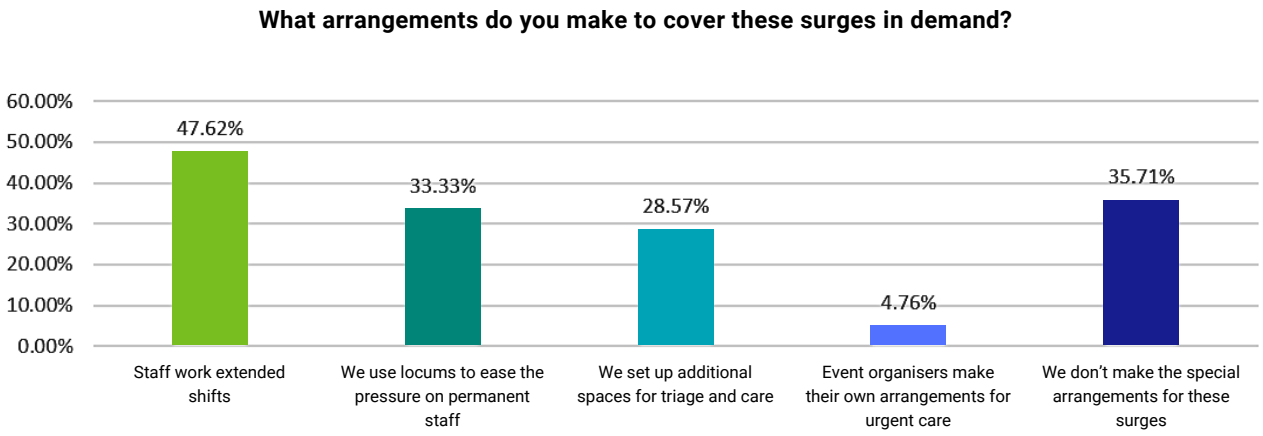


Figure 11: Arrangements rural general practices make during surges in demand.

3. THE RURAL GENERAL PRACTICE WORKFORCE

The survey investigated the rural general practice team, including medical, clinical, nursing, allied health and administration.

CLINICAL WORKLOAD

- RNZCGPs recommend a GP:patient ratio of 1:1300 across all general practices. Survey respondents budget at this rate.
- The RNZCGP rate does not consider the additional demands afterhours rosters, urgent care and PRIME places on rural general practices that would justify future work to establish a 'rural ratio'.
- Approximately 90% of Rural General Practices operate over the RNZCGP guidelines at an average of 1:1598 (only GPs). Satellite and outreach clinics hinder our ability to be exact in this calculation.
- For the 10 rural practices that operate with one GP and responded to the survey, the average ratio is 1:1790.
- Applying the 1:1300 ratio to the total rural population defined by University of Otago GCH, of 888,654, estimates that the rural health workforce requires an additional 130 GPs.
- 26% of respondent clinical teams include nurse practitioners, physician assistants, and increasingly, paramedics.

The establishment of nurse prescribing roles makes a significant contribution to the practice's ability to manage demand for its services and improves the workload of all clinicians.

The impact on the workload of rural general practices (and rural hospitals) providing care for unregistered patients, or casual patients (either national or international) has not been considered in our analysis.

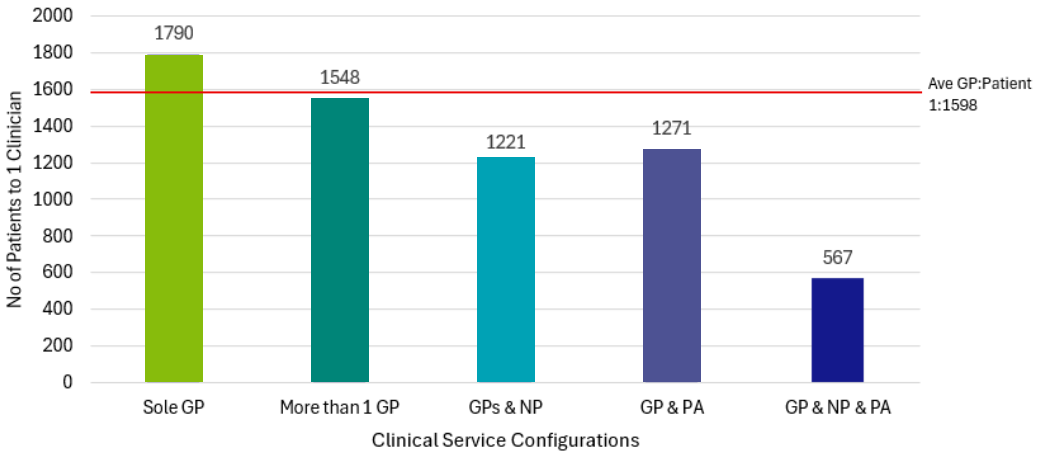


Figure 12: Average Ratio of Clinicians to Patients Across Clinical Team Configurations

COMPOSITION OF CLINICAL TEAMS

- 98% of respondent's teams are GP led, 2% are N.P led.
- 57% of RGPs have a GP vacancy; 44% of these vacancies were covered by a locum, at the time of the survey.
- 34% of RGPs budget to have a Nurse Practitioner on the team, 69% of these have achieved this.
- 7 practices employ paramedics (mostly part-time) and 5 employ physician assistants. One practice employs 2 doctors unable to be registered in NZ to work in clinical support and inbox management. Health Coaches are a part of many teams but are not always employed by the practice.
- There are a small number of practices that employ part-time allied health professionals (physiotherapists, social workers, dieticians, and pharmacists).
- Several practices noted that their nurses extend into care co-ordination, phlebotomy, dietetics, diabetes management, and mental health support.
- Data about Registered Nurse FTEs was inconsistent, so we were unable to incorporate detailed analysis of it in this report.

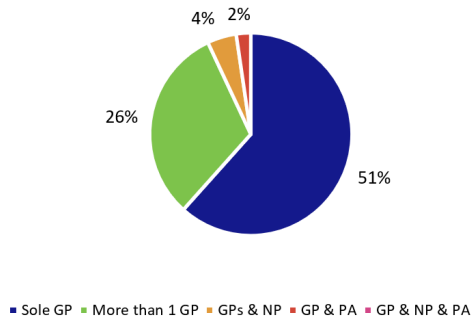


Figure 13: Rural general practice clinical team configurations.

TRAINING AND EDUCATING THE FUTURE RURAL HEALTH WORKFORCE

Rural General Practices make a significant contribution to educating and training the future health workforce, across all professions (Fig 14).

- 78% of respondents have hosted and/or trained health students over the past 3 years.
- 70% of respondents intend to host and/or train health students in the coming year.
- 17% of respondents would like to host/train students but face barriers such as demands on trainer's time, lack of space to accommodate students, lost income, and cost of meeting supervision requirements.
- 39% of respondents provide, or have their community provide, accommodation for students. Some offer accommodation free of charge or at a minimal rate, especially for nursing students. The weekly cost of providing accommodation ranges from $140 to $300, depending on the type and location. One respondent noted that local studio-style accommodation for 5th-year medical students costs $1250 per placement.

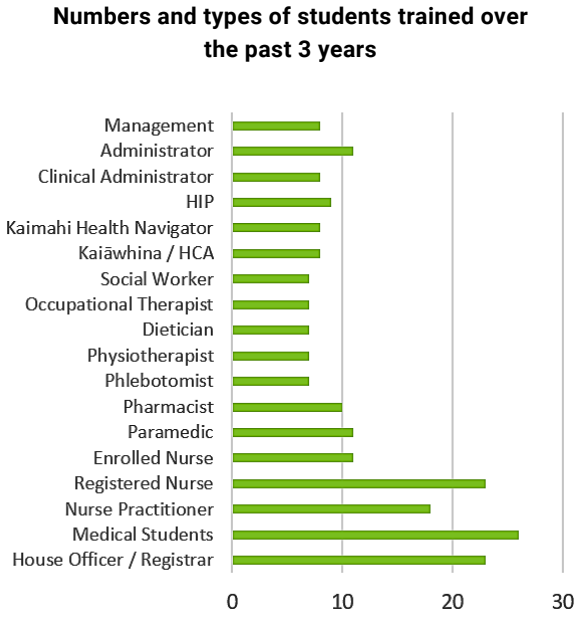


Figure 14: Students trained in rural general practices over the past 3 years.

4. SERVICE PROVISION

RETRACTION OF SERVICES

66% of respondents reported maintaining their level of services throughout the year. However, this is increasingly challenged by the higher acuity of patients presenting late, an aging population, and the rising prevalence of poverty and challenging living conditions.

34% of respondents reduced or stopped some services, including after-hours care, nurse-led clinics, and those requiring in-person off-site clinicians such as PRIME, aged residential care, and school-based clinics. Workforce shortages and inadequate funding were cited as reasons for these reductions.

Workforce shortages and poor, or no funding for the input required, were the reasons given for service reductions.

Several respondents expressed discomfort in having to charge patients for services that would be free to urban patients.

PATIENT ENROLMENT STATUS

61% of practices are open to enrolling new patients (Fig 15). However, not accepting casual or unregistered patients for GP appointments is another approach respondents took to manage clinical workload. Many practices offer outreach clinics to connect with unregistered patients. However, once a person has been seen in a clinic, they are no longer considered 'unregistered,' making it difficult to assess the impact on reducing the number of unenrolled people they see.

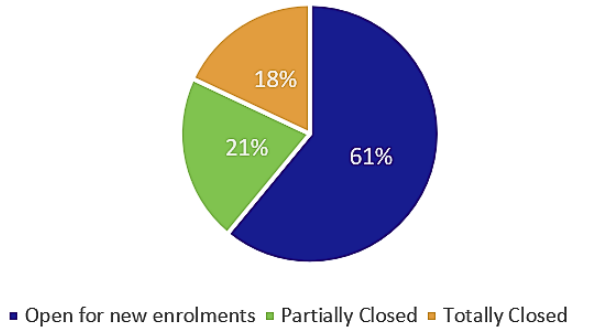


Figure 15: Patient enrolment status in rural general practices

OUT-OF-HOURS SERVICES

Respondents were asked to give details about the out-of-hours arrangements in place for their registered patients. (Fig 16-17)

- 24% of respondents (covering 18% of respondent-registered patients) do not have an afterhours roster and connect all afterhours calls to a telehealth provider.
- 76% of respondents (covering 82% of respondent-registered patients) have an on-call clinician available. This varies from supporting an external telehealth provider to in-person, planned weekend clinics, and availability for call outs.
- Three providers, all in the GCH R3 areas, offer a full in-person PRIME and afterhours service, including their own telephone triage for incoming calls.

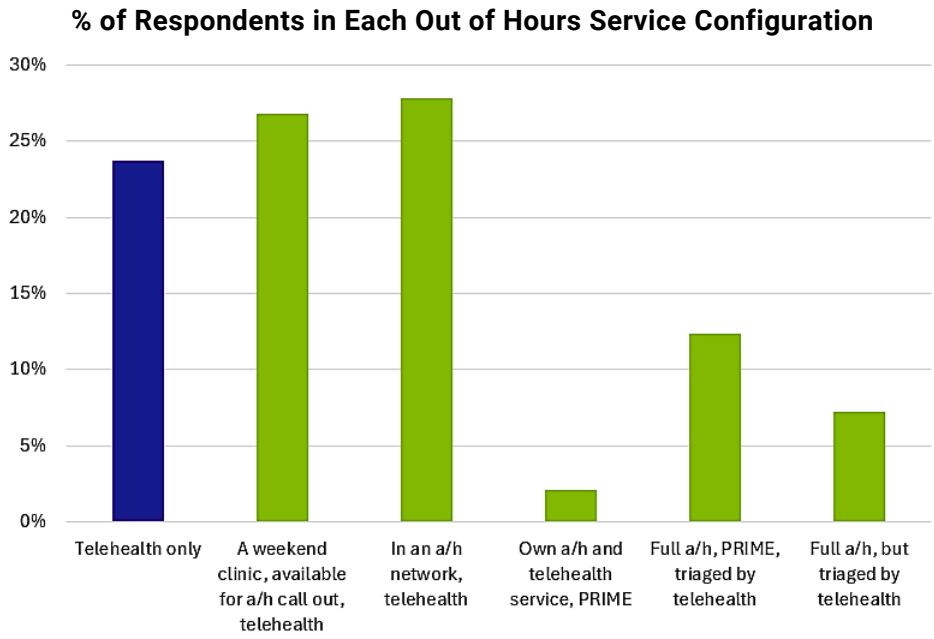


Figure 16: Respondents service configurations

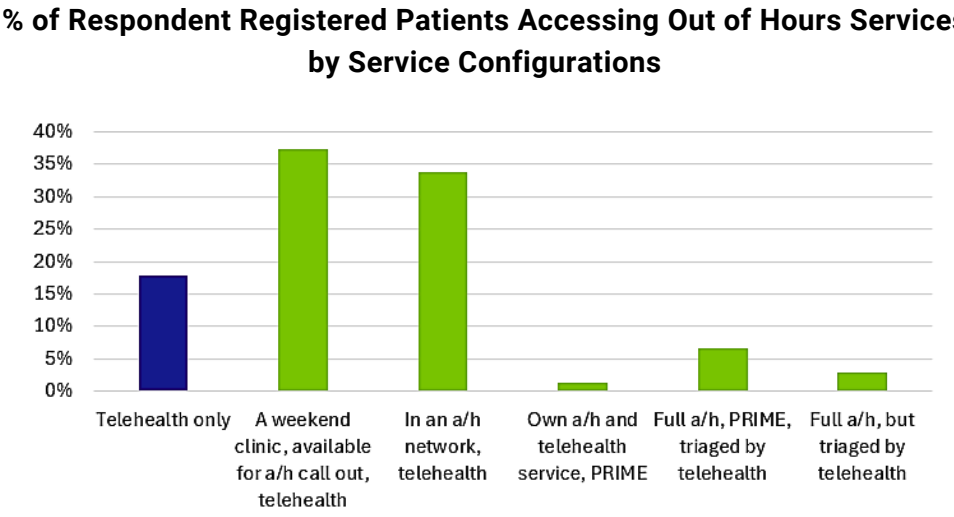


Figure 17: Registered patients access to services.

RATE THE EMERGENCY RESPONSE IN YOUR RURAL COMMUNITY

Respondents were asked to assess how well their rural communities' emergency care needs are met. 72% rated these services as less than 'good' (Fig 18).

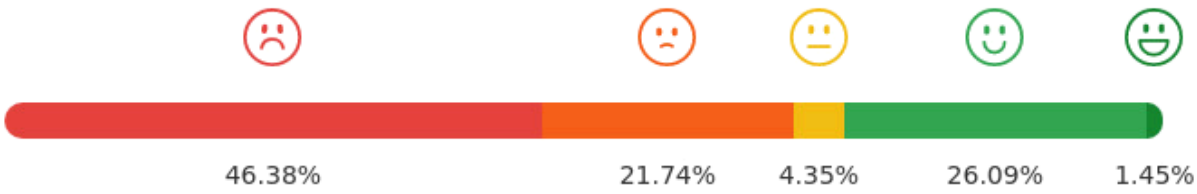


Figure 18 How well are our rural community's emergency care needs met?

Respondents identified numerous barriers to their community's access to reliable emergency care services. The most common issues impacting emergency services' ability to meet community needs include poor funding, under-resourced HHStJ, long ambulance travel times to hospitals, and relentless demands on the clinical workforce (Fig 19).

THANK YOU

We appreciate the time that so many rural general practices took to complete this survey. We thank you for taking the time to do so, for sharing your insights and information with us so that together, we strengthen the united voice of our Hauora Taiwhenua Rural Health Network.

WHAT ARE THE BARRIERS TO YOUR COMMUNITY'S ACCESS TO EXCELLENT EMERGENCY CARE SERVICES?

Figure 19 Barriers to rural communities' access to emergency care services

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