

22 August 2006

Dr Colin Feek  
Deputy Director General  
Clinical Services Director  
Ministry of Health  
PO Box 5013  
WELLINGTON

Dear Dr Feek

### **Review of the Rural Ranking Scale**

Thank you for the opportunity to comment on the review of the Rural Ranking Scale, (the “RRS”). I commend the Ministry of Health for undertaking the review.

The Health and Disability Commissioner is charged with the role of promoting and protecting the rights of health and disability services consumers, as set out in the Code of Health and Disability Services Consumers’ Rights (the Code). Under section 14(1)(d) of the Health and Disability Commissioner Act 1994, one of my functions is to make public statements in relation to any matter affecting the rights of health or disability services consumers. I hope the following comments will assist in the review of the RRS.

Generally I do not involve myself in funding policy and decisions; however, the funding of rural General Practitioners (“rural GPs”) has the potential to impact considerably on many health consumers. I therefore consider it is a matter which merits my consideration. As well as responding to some of the issues raised in your letter I include some comments about the needs of rural health consumers and rural GPs.

I start with the fundamental premise that rural health consumers are entitled ongoing, stable, quality health care. I therefore strongly support the ongoing funding of rural GP services. The current RRS is based predominantly on geographical factors and while these factors are significant it does occasionally create inconsistencies and a review is timely.

#### ***What makes a “rural” community different***

From the perspective of the provision of health services, there are number of factors that make rural communities different from their urban counterparts. Any assessment of what makes a community “rural” should consider factors such as:

- The distance and remoteness from other centres and health facilities;
- The lack of public transport and the subsequent reliance on one's own or others' vehicles;
- The lack of or limited choices with regards to health provision within a community;
- The requirement to travel to other centres for specialist services;
- The requirement at times for whole families to relocate for prolonged periods to other centres when specialist services, (such as radiation oncology) is required.

Rural GPs and health practitioners also face a number of specific issues that differentiate their practice from urban practitioners and which need to be taken into consideration. Some rural GPs carry institutional case loads such as rest homes and other residential facilities in the area, while others have responsibilities at local prisons located in remote areas. Rural GPs are often required to deal with a wider range of health issues and have to gain expertise in a wider range of areas and this deserves recognition.

The ability for rural GPs to provide quality services can be compromised if they get no relief or have to constantly work extended hours due to lack of support. Research<sup>1</sup> suggests that rural GPs tend to order fewer tests, and investigations than their urban counterparts and that rural health consumers have a lower rate of follow-up care. It is essential that the RRS recognises these issues and that the funding of rural GPs is sufficient to address recruitment issues, as well as ensure that GPs have adequate on-call relief and training opportunities.

The recruitment and retention of health care professionals in rural areas remains an area of concern. Research<sup>2</sup> suggests that one third (32%) of rural shared roster areas have a doctor patient ratio above the "alert level" of 1:2000 proposed in the *Implementation of Primary Health Strategy in Rural New Zealand* (Ministry of Health 2002). Such heavy workloads when combined with large amounts of on-call time and travel raise issues of patient safety and of quality of care.

Any review of the RRS should take these factors into account and ensure that health consumers in rural communities are not disadvantaged and receive a standard of care and services similar to their urban counterparts.

In response to the specific issues raised in your letter I make the following comments:

### ***New Zealand Index of Deprivation***

In my opinion, deprivation and poverty is a separate issue from rurality and the New Zealand Index of Deprivation should not be included as part of the RRS. As set out above, rural health consumers face unique and specific difficulties in accessing health services that are not attributable to their financial or social economic status. It is their

---

<sup>1</sup> Ministry of Health. 2004. *A comparison of Primary Healthcare provided by Rural and non Rural general practices: The National Primary Medical Care Survey (NatMedCa): 2001/02 Report 4* Wellington: Ministry of Health.

<sup>2</sup> New Zealand Annual Rural Workforce Survey 2002, Martin London, Rural health Consultancy, 2002,

isolation and distance from health services and the limited choice of services offered in a small community, that is relevant.

Quality health services in rural areas and the long term stability of these services is essential and should be guaranteed whatever the socio-economic status of the community. Deprivation or poverty should be funded on top of and in addition to rurality.

### ***Statistics New Zealand***

I do not support the use of Statistics New Zealand's definition of a rural community based on population alone. The size of the community should not be decisive when considering rurality in the health context. This definition does not adequately take into account the difficulties of health service provision to isolated communities that do not meet that definition. For example, Great Barrier Island with a population of 1,200 may not meet this definition and yet patients are required to travel considerable distance to access specialists.

A community with a population of 6,000 such as Westport would not meet the Statistic's definition yet emergency services are 90 minutes by road. Geographical isolation is a significant factor in terms of provision of and access to health services and a solely population-based assessment would not be satisfactory.

The primary issue, in my view, is the time it takes to access, in the first instance primary care, (a GP or rural nurse) and secondly, the time it takes to get to a base hospital for secondary or tertiary level care. Population size is relevant when considering issues such as adequate on-call back up, consumer choice and the type of services offered.

I support the ongoing funding of rural GPs. My concern is to ensure that rural consumers continue to have access to quality health care. I encourage the Ministry to consult with consumer and community based organisations with a particular interest in promoting rural perspectives.

It is essential that whatever RRS is in place, it ensures that all consumers have continuity of, and access to, quality health services. The RRS should ensure funding that allows for all GPs to be supported with on-call backup, peer support, ongoing education and training, as well as generous remuneration that acknowledges the isolation and extra responsibility involved in the total care of remote communities. This will ensure that rural health consumers receive the quality of care that is required.

Thank you for giving me the opportunity to comment on this review and trust that these comments assist in the development of the system of funding for rural doctors.

Yours sincerely

**Ron Paterson**  
**Health and Disability Commissioner**