

Executive Summary

To determine what the challenges are to rural primary health care, and make recommendations to enhance sustainable service provision.

My objective is to qualify the future needs of Community Health Trusts. They must meet the Ministry of Health directives regarding Primary Healthcare. These are as stated in the back to back contracts between PHOs and individual medical practices. I have compiled; from a representative group of rural patients, doctors and other professionals, facts, experiences, opinions and wish lists regarding primary medical services and its impact upon them, now and into the future.

The information was collected by survey and interview and these are summarised within the report.

During the completion of the report,

- I have attempted to illustrate the nature of historical delivery of primary healthcare in rural Southland.
- The present position and the barriers that are imposed on service provision and sustainability
- I have also highlighted some of the issues regarding expectations of medical service providers and their clients, re funding and manning levels
- The Goal; “A well educated (re health matters) and healthy population serviced by effective providers”.
- As stated by the Chris Farrelly of the Manaia PHO we must ask ourselves “Am I really concerned by inequalities and injustice?”

We find that in order to achieve the PHO goals (passed down to the local level) we must have;

- Additional health practitioners
- Sustainable funding

And sound strategies for future actions through a collaborative model.

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In compiling the research for this project I would like to thank all the members of the community, health professionals and committee members who have generously given their time and shared their knowledge.

A quote from Peter Ayson.

After thanking Peter personally for his contributions he said and I repeat
"That's alright I don't mind helping another volunteer".

“Putting The Bricks In Place”; Primary Health Care Services in Rural Southland

Introduction

This report is an attempt to identify the issues surrounding effective and sustainable Primary Health Care Delivery in Rural Southland and to then state how we go about putting all the bricks in place to make this happen.

“One in four New Zealanders live in rural areas or small towns, “The Primary Health Care Strategy in Rural New Zealand” indicated the need to develop a coherent approach to rural health care provision including the issues of retaining and attracting the appropriate workforce.”

This quote from the foreword by Director-General of Health to the report

“Implementing the Primary Health Care Strategy in Rural New Zealand”, confirms that many of the issues raised within my community, were recognised three years ago and a simple answer has not yet been found.

SECTION ONE:
HISTORY

“Putting The Bricks In Place”;
Primary Health Care Services in Rural Southland

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History of Medical Services in Otautau

A Brief Timeline of the History of Doctors Services to Otautau

We have listed many of the GPs' who have worked in Otautau, and are aware that some have been missed, during the mid eighties one year saw 28 locums pass through the practice.

Bill Reekie	New Zealander	1930 – 1963
Lyn Moffatt	New Zealander	1963 – 1972
Rangit Fernando	Sri Lankan	1972 (Nightcaps) covered Otautau for 6 months

The following Doctor's covered Otautau for the next 3 years:

Baycroft	(Te Anau)
Wilson	(Winton)
Moore	(Te Anau)
Elder	(Tuatapere)

The Otautau Town Council bought Lyn Moffatt's surgery building and a doctors house after a community fund raising effort. Both were later sold and the money was invested into the town sewerage scheme and the Sports Complex.

Malcolm Fernando	Sri Lankan	1974 – 1977
Sivakumar	Sri Lankan	1977 – 1980

Len Kitson arrived from Nightcaps and set up practice in opposition to Sivakumar in the Plunket Rooms. He then built the present Medical Centre; he however eventually experienced financial problems and moved on. In 1991 the Otautau Ambulance Committee purchased the medical centre, to maintain continuity of service supply.

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Locums were employed to provide the service for 8 years – here are some of them:

Danie Gower, South African Practice in Tuatapere)	Six months (left & purchased Dr Elder’s
Stuart & Marion Johnson, British	1986 – 1987
Gavin Ballenden, South African	1987 – 1990 (leased the Practice)
Paul Weaver, English Johns for first 2 years and then purchased it in 1993)	1990 – 1995 (leased surgery from St
Deirdre Clink, Scottish	1995 – 2000 (owned practice)
Frances Edwards, Welsh	1997 - 1999 (owned practice)

In 2000 the Otautau Community Health Trust was formed and they purchased the practice and recruited GP’s mainly through the Global Locum Agency. The Trust initially rented houses for the Doctors use before purchasing a house in 2004 which the Otautau Lions Club took on the upgrade as a club project.

Locums employed:

Joseph Aukoko	South African	2 months
Jim Morse	American	8 months
Lewis Robertson	American	5 months
Sandra Price	English	2 years (leased the practice)
Ken Pavlik	American	6 months
Wendy Kloesz	American	6 months

From October 2004 until March 2005 Global could not provide a Doctor. We then had short term locums from the Rural GP Network and other local Doctors filled in.

Pat Maguire	American	12 months (March 2005 – 2006)
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Comment:

Whilst ideally the OCHT would like to attract the services of a doctor for longer periods, allowing the patients to have a more settled relationship with their GP this has not yet been achieved.

We presently have a Dutch GP, contracted for 18 months starting March 2006, hopefully he and his family will like Western Southland and the community and decide to stay longer.

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Interview with Jon Newson

Jon arrived in Otautau 40 years ago as a farm consultant and valuer, he is a past member of the Otautau Town Council’s Doctors Committee (TCDC), and an original Kellogg’s Scholar.

Describe the history of Doctors in Otautau.

Lyn Moffat had taken over from Bill Reekie – whose son Alistair became a well known Southland Dentist. Lyn came from a family of 8 children and with guts and determination; he shorn sheep, to pay his way through Medical School.

In those days it was a prestigious calling and involvement in the district was important. On call 24 hours, delivered the babies and had legendary long waiting times for patients.

Like Dr Elder the Tuatapere icon, he worked out of his house – the extra rooms for services.

Lyn Moffat built a custom designed surgery which was placed along side his house. Doctors’ were the top community earners – John Wilson (Menswear Shop) showed me “This is the suit the Dr will buy for this winter”.

Lyn Moffat gave plenty of warning that he

- a) wanted a partner or
- b) wanted out.

In late 1969 Mr. Knight said he would answer Moffatt’s prayers and started to share in the operation of the practice. After two weeks he was exposed as a fraud and jailed.

Lynn left in 1972. He wanted to sell all his assets to the community which wouldn’t ‘buy in’. From then on, there was a period of locums and then the Doctors Committee advertised widely and Malcolm Fernando arrived. The Community decided to purchase a doctors house that was provided rent free (I remember sitting on the Council and he presented an account for a dish mop!)

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These doctors, (mainly Asians) would start in places like Otautau and then move north to denser populations and warmer climates.

Period of uncertainty but along came Len Kitson, a New Zealander who set up in opposition to our then present Doctor Sivakumar and operated out of the Plunket Rooms. He came from Sydney where group practices were common and with Ngai Tahu consent and special finance built a purpose built surgery on Main Street.

[An anecdote heard from another community member during research refers to the good work done by local identities from the committee in demolishing the pre-existing building on the site. The good doctor Kitson had suggested to the TCDC that he would build a medical centre on the present site if the old hall was removed. This was completed in short order over one weekend; to the subsequent dismay of the members of the local Buffalo Lodge. Who had neither been asked for nor given permission for this activity. The anecdote bringer says “You would not get away with that today!”]

Dr. Kitson's dream didn't work and the premises were sold to the Otautau Ambulance Committee. The price paid was 20% of the replacement cost.

Danie Gower practiced as a locum for 6 months. He didn't have an opportunity to purchase the Otautau Medical business. He liked the Western Southland area and moved across to purchase Dr Elder's business in Tuatapere.

Gavin Ballenden arrived with his young family from South Africa – he leased the community assets for a moderate rent for 3 years. He was fully involved in the community and coached the local rugby team.

Then Paul Weaver, who showed capitalist traits, encouraged the community to sell their assets at cost with promise of long lasting stability and GP control! He managed to sell the surgery to the in-coming Doctor for about 4 times what he paid for it. He was also able to sell the house, which he had extensively renovated, to the same family as part of the sale condition.

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Jon believes: That most community decisions are based on emotion and no business reason.

Some doctors are more skilled in business than the community leaders (i.e. fleeced)

The community should really leave the \$ flow of normal business practice to provide the health services a community needs rather than community ownership.

Could you please give me a brief description of the Otautau Town Council’s Doctors Committee Role.

We strived to provide a reliable quality service, I quickly realised “The more you have, the more you want” mentality which is still alive today.

How well do you think the current Otautau Community Health Trust is operating and in which ways do you think we could improve our health service to the local community?

I admire those who have the input, but still believe the above holds true.

How would you describe the Otautau/Nightcaps Community?

Fragmented, from being vital and alive – the mining industry changes killed Nightcaps and public service reductions decimated Otautau.

Cheap housing has attracted more of a beneficiary mentality.

Farming also had restructuring, only the advance of dairying has been really positive, however it has been a great place to live, work and bring up a family.

Have you any other comments on the Role & Value of Community Health Trusts in rural Southland?

Be vigilant to ensure we get our share! From central government down.

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Highlights:

The length of time they practiced here

The terms of employment – ownership – salaried – lease

Their nationality (country of origin)

The changes of ownership

The report shows that doctor and community ownership of assets has been integral in maintaining a health service over the last 75 years in our area. The Otautau Town Council, Otautau Ambulance Committee and now the Otautau Community Health Trust have all at various times in our history, had to purchase with community funds the medical rooms, equipment, doctors houses and vehicles to be able to attract doctors to our town.

We have had to recruit overseas doctors, learn about immigration and Medical Council requirements, and keep up to date with the changes thrust upon us by the Ministry of Health under various changes of Government.

If you refer to the OCHT Chairman’s Report 2003 he describes “a minefield of acronym’s’ that make up the various layers of organizations that compete for the health dollar. He has missed a few MOH, HFA & SHB, PHS, IPAC, RHA etc, etc they keep changing over the years with restructuring.

You must as a community organisation look forward positively, whilst not just identifying the problems in the health system but assisting in providing solutions.

Those solutions evolve over time:

Nurse Practitioners Scholarships

Community Ownership

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Scholarships for Medical Students

After hours funding – reasonable roster funding

- rural bonus
- rural retention funding

However referring to Dr Robert Henderson’s thesis on “Why Doctors leave Rural Practice” (1999) 138/139 he states “that rural practices vary considerably and the rural ranking scale does not correlate well with the difficulties experienced by Doctors. There needs to be a classification of rurality that reflects more accurately the difficulties experienced by Doctors”.

Dr Henderson examined the problems of Rural Practice, the sample in this study consisted of ten doctors and spouses who left Otago and Southland over a period of one and a half years while the practices varied considerably, the reason’s for leaving were very similar.

He made eight recommendations for some solutions to the problems in rural practice:

- There needs to be some recognition of the work of being on call
- Individual rural doctors should not be caring for more than 2000 patients
- Rural doctors should be required to take regular holidays and time away from work – Practice cover must be provided.
- Formal avenues of communication should be established between a representative of Regional Health Authority and doctors so that the problems of rural practitioners can be heard by health care administrators.
- Continuing medical education ought to involve families to engender some community belonging and support.
- Rural practitioners need to know that if complaints are laid against them they will get fair treatment in the hands of the disciplinary process
- There is a need for effective education for rural practice which involves spouses

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- Rural practitioners need special continuing medical education which should be part of rural doctors re-accreditation and should be subsidised.

He also identified further areas for research (p138) and asked “Have some doctors learnt strategies that have helped them cope in rural practices and could some of these strategies be used by other doctors?”.

Rural Practices vary considerably, farming is not always the chief primary industry, in some areas it could be tourism, fishing or forestry.

Some areas are seen as attractive to retire in and contain many retired people, some areas are wealthy and others poor with difficulty in paying bills and more health problems.

Some areas are vast and sparsely populated, in tourist areas it is easier to attract locums and some areas a single GP’s case load can be up to 2800 patients.

Some new Government initiatives that are being trialled are 20 extra places for medical students from a rural background and the increase in scholarships for the Nurse Practitioner courses. These are positive steps; however there are also questions to be answered by the Government on why there is a cap on how many New Zealanders can be accepted into Medical School each year and the obligation by the Universities to train so many overseas students.

Rural New Zealand has a shortage of doctors.

In the past medical students have been encouraged to specialise and that being a GP is a ‘poor cousin’. This is so wrong – to be a good rural GP you have to have a wide range of skills and the confidence and backing to make life saving decisions.

Universities need to be financially encouraged by Government to work in partnership with Rural Practices as happens in America and Australia where in Simon Bidwell’s ‘International Literature Review of Successful Models of Rural Health Service Delivery and Community Involvement in Rural Health (2001)’²³ he reports on the “Academic

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Rural Practice (ARP): THE TWO BIRDS” model where the Academic Rural Practice is made possible by the growing recognition of rural medicine, rural nursing and primary rural health care as distinct generalized disciplines in their own right.

There has been consensus for some time that recruitment and retention of health professionals to work in rural areas is made more likely by exposure to rural practice at either the undergraduate or graduate level.

The involvement of universities in rural areas may help reverse some of the diseconomies of scale inherent in rural health service delivery. The resources specialty skills and financial base of the tertiary institution potentially address some of the intrinsic difficulties for rural practice such as professional isolation, lack of relief and rudimentary infrastructure.

A third 'bird' to potentially be felled by ARP involves the possibility of on-going research being carried out in rural areas, university involvement suggests a sustainable way to analyse and address some of the contingent rural health issues related to the particular demographic, cultural and occupational features of rural communities.

There have been studies done by Simon Bidwell, Sue Grimwood and Martin London for the Centre for Rural Health.

I advise any Community Health Trust member to read them, to try and understand what some of our responsibilities and challenges are. We don't have to reinvent the wheel, but by becoming more knowledgeable we will be better equipped to assist in providing a sustainable health service for our local communities.

Robert Henderson's thesis and the Rural Women NZ Health Survey 2001 also give good guidance on the issues involved with Rural Doctor retention and the needs of rural patients.

Public Support For Rural Health Services

There must be an acknowledgement of the tremendous public support in raising funds to purchase the Medical Practice; from the local people, businesses and the Community Trust of Southland.

Also the initial donation of \$48,000 from the Otautau Lions Club was integral in reaching our fundraising target. These funds were left over from the Tracey Holmes Organ Transplant Appeal 1985. Tracey was a local girl who needed a lung transplant in England and the Otautau Lions Club enthusiastically embarked on raising funds, eventually raising \$120,000. Tracey had the transplant, came back to New Zealand but experienced a rejection and had to go back to England again to be stabilized. She recovered and now lives a normal healthy life.

This highlights an advance in health provision in New Zealand where now the transplant operations are done at the Auckland Hospital. The Lions Clubs of New Zealand donated generously to help build and equip this unit; they also continue to give funds to the Air Ambulance appeals.

The Nightcaps Community has also been very generous, with local people donating and the Nightcaps Lions Club giving money for both the purchase and for the on-going computer and equipment upgrades.

The Otautau Community Health Trust initially rented houses for the Doctors use before purchasing a house in 2004 which the Otautau Lions Club took on as a renovation project.

The community support in providing Health Services in our local area has been considerable with everybody realising that a medical surgery with GP services is essential to the structure and social essence of the community.

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A Brief Timeline of the History Of Pharmaceutical Services to the Otautau Area

Pre 1928
Mr. King

1928 - 1958
Gordon Sinclair

1958 - 1979
Barry Carleton

1980
Roger Mills

1981 - 2005
Geoff & Michelle Carleton

Comment

The provision of a comprehensive health service in rural areas wouldn't be complete without the input from Pharmacists. They are experiencing similar problems recruiting chemists to work in rural areas and with the tightening of Government subsidies many rural pharmacies have either closed or been turned into 'depots'.

In Otautau's case the chemists have been the stable influence over the past 75 years and without their professional advice to both patients and doctors I'm sure the road would have been a lot 'rockier'.

A Brief Timeline of the History of Events Involving the Otautau Ambulance Service

The first meeting of the Ambulance and Nursing divisions was held in 1964 – Dr Lindsay Moffatt gave the first of his many first aid instruction classes.

Home nursing courses were offered as well as duties at sports and public functions was undertaken.

September 1965 Otautau Sub Centre of St John was formed

- 1966

Public fundraising enabled a full reconditioned Ambulance to be purchased for 1,100 pounds. Eight local people became rostered drivers with brigade members acting as Ambulance orderlies. Local groups and individuals donated equipment for training and extra equipment for the Ambulance.

- 1968

A \$2.00 per household subscription was introduced rising to \$5.00 in 1977.

- 1973

During this year a successful fundraising effort by Jaycees, Lions, WDFW, business firms and individuals saw a new ambulance purchased.

Mr. Mick Menzies was awarded Life Membership of the Sub Centre in recognition of his fund raising work. As the Ambulance was under the Jurisdiction of the Southland Hospital Board, drivers were required to attend training courses at Kew Hospital.

- 1977

Four members received their 12 year service medals and drivers were required to undertake more advanced training.

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- 1979

The tragic deaths of Sub-centre Chairman Barry Carleton and his wife Marion was a severe blow to the centre.

Concerns about changes to the ambulance operating systems led to the sub-centre joining the Southland Hospital Board’s Transport Scheme, which meant that local committees would no longer have to finance ambulance replacements.

[An anecdote: The chairman of the Southland Hospital Board; an accountant, liked to be able say “ that the hospital board was operating within budget” this on occasion led to issues with completing regular maintenance for example on ambulances. One ambulance was known to have had poorly working brakes, due to a lack of available funds to complete the required servicing. The change in 1989 to St Johns operating the ambulance service saw these shortcomings corrected.]

- 1983

Because of the increase in the ambulance workload during this time, ambulance officers found it very difficult to carry out the administration duties because of the time involved with ambulance call outs and training.

- 1986

An ambulance call out paging system and 111 Emergency telephone numbers came into operation. An Ambulance Administration Committee was elected; Vic Keen was the inaugural Chairman for two years. This is now known as the Otautau St John Ambulance Area Committee

- 1989

Following a bequest from the late James Potto Estate a new Ambulance Station was purchased in the Main Street which was dedicated on November 3rd 1989.

St John having won the Government Tender to provide Ambulance Services throughout New Zealand, took over the administration of Ambulances from The Southland Hospital Board.

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Area Committees came under jurisdiction of St John as well – the subscription scheme was introduced.

- 1991

The Area Committee purchased the Otautau Medical Practice to maintain services.

- 1993

Sold Practice to Dr Weaver

- 1995-2005

Ongoing refurbishment of centre and training and recruitment of volunteers

- 2002

The introduction of 'First Response Programme' for remote rural areas was introduced in Blackmount, Orepuki, Hedgehope, Dipton, Athol, Mokoreta, Waikaia and Omaui.

Long Serving Members and Awards

1987	Graeme Froude	awarded Serving Brother of Order of St John
1996	Pat Stearne	awarded Servicing Sister of Order of St John
2000	Muriel Brown	awarded Serving Sister of Order of St John
2002	Muriel Brown	awarded Life Membership Area Committee
2002	Pat Stearne	awarded Life Membership Area Committee

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2002 Alan Stearne awarded Life Membership Area Committee

Southland had the first Air Ambulance service in New Zealand, but they would not let it land at Kew Hospital so it had to land at Invercargill Airport.

Interview with Peter Ayson

Peter has lived in the Otautau District since 1934.

A member of Jaycees and Lions for 35 years, a Life Member of Lions, and also a Lloyd Morgan recipient.

Peter has been a member of the Otautau St Johns Ambulance Area Committee for 18 years, chairman for the last 16.

Is a Past Chairman of the Central Western Health Committee.

Peter has been a member of the Otautau Community Health Trust for the last 5 years.

The Ambulance service in a rural area is critical in supporting a Doctor; they rely on each other to save lives so I asked Peter what he thought that the Government and St Johns could do better to encourage more people into the service?

He said “that the Government and ACC are partly funding the ambulance service and that St Johns should say that they can’t continue to provide this level of service at the current funding levels in the contract

(Go slow; don’t transfer non-urgent patients to Dunedin).

The local communities shouldn’t have to continue fundraising to make ends meet. He said that the Ohai First Response Service is a good model of how an emergency service should operate.

They operate under the Fire Service umbrella:

The siren goes off, everyone turns up

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90% of the call outs are to accidents and sickness

Funded by the Fire Service through the Government and insurance levies

No responsibility to transfer patients to hospital, they turn up and stabilise patients until the ambulance turns up. (There is therefore not as much down time from their jobs).

There should be Government funding available to either recompense employers or the employees in giving volunteers time off work to attend emergencies.

There also should be paid ambulance officers in each of the rural centres to complement the volunteers. These professionals could be rotated around Southland centres to maintain the necessary experience levels”.

Finally he said “When Kew becomes a cottage hospital the main road to Dunedin is going to be bumper to bumper with ambulances”.

Summary

My conclusion is that due to the population of rural communities having declined, incentives and support is now (more than ever) needed to maintain this critical service.

Why should urban areas get a 24hour/7day cover by paid officers and rural areas don't? Do we want this dedicated bunch of volunteers to be continually taken advantage of to the extent that there is nobody left willing to run the service in rural areas?

The government needs to urgently address a coordinated and fully funded Emergency Service in rural areas

SECTION TWO:
ROLE OF CHTs

“Putting The Bricks In Place”;
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The Role of and Value to of Community Health Trusts (CHTs) in Rural Southland

Included in this section is data intended too highlight what the role and value of CHTs is to rural Southland and what we should be focusing on for the delivery of sustainable and effective health services to our local communities into the future.

Purpose Of The Otautau Community Health Trust

Provide primary health care services based at Otautau, and also regular clinics at the Nightcaps Medical Centre.

Purchase the Medical Centre at Otautau

Promote and attract health professionals to ensure service and facility provision

"We as a committee were determined that Otautau, Nightcaps and the surrounding community has access to a doctor and a sustainable health service."

What is a PHO?

A Primary Health Organisation is funded by the District Health Board and is made up of representatives from the local community, Health Professionals and Iwi. Its responsibility is to provide a coordinated Primary Health Care Service directed towards improving and maintaining the health of their enrolled population.

They must be able to identify and respond to the communities needs. Look at ways of educating people to take some responsibility for their own health and to improve access to health services.

To achieve this outcome, PHO's are expected to consult regularly with their local communities and work collaboratively with both the Medical Practices and the DHB's i.e. 'One could say we have been the meat in the sandwich'.

During the establishment phase the Takitimu PHO has found it difficult to access quality information regarding who the current health providers in Southland are. The DHB has admitted that they can't easily identify all the funding streams and MOH who should know, refer us back to the DHB.

It is difficult when charged with the responsibility of carrying out a health needs analysis within our community and to identify any gaps, not to have this information available!

A collaborative partnership is certainly still a goal!

For further information go to:

<http://www.moh.govt.nz/primaryhealthcare>

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The following illustrates the MoH Health Care Working Party’s view on the separation between DHB, PHO and Practices to each entities responsibility for providing after hours primary health care.

Listed below from;

Towards Accessible, Effective and Resilient After Hours Primary Health Care Services

Report of the After Hours Primary Health Care Working Party

Published in July 2005 by the
 Ministry of Health
 PO Box 5013, Wellington, New Zealand

Proposed actions to clarify roles and responsibilities for effective service planning and delivery

Clarifying responsibilities of key agencies

Agency	Responsibility for after hours primary health care	As reflected in
DHB	<ul style="list-style-type: none"> • <i>Service coverage</i> – Ensure availability of primary medical services and/or nursing services with medical back-up after hours within 60 minutes of travel for 95 percent of DHB’s population. 	2005/06 Service Coverage Schedule
DHB	<ul style="list-style-type: none"> • Identify how it will work with PHOs to ensure all people have appropriate 24 hour access to essential primary services (<i>after hours, First Level Services</i>). 	2005/06 Operational Policy Framework
DHB	<ul style="list-style-type: none"> • In collaboration with PHOs, after hours service providers and EDs, develop and implement a planning and funding strategy for after hours primary health care for its district, including rural communities, that enables accessible, effective and resilient primary health care services for all service users within current resources. 	Advice in After Hours Primary Health Care Working Party report on how DHBs should work with PHOs to ensure all people have appropriate access to after hours services; Ministry of Health to arrange for inclusion as a District Annual Planning requirement for 2006/07

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Agency	Responsibility for after hours primary health care	As reflected in
PHO	<ul style="list-style-type: none"> • Demonstrate to the DHB that it has 24/7 arrangements in place for all service users by establishing sub contractual arrangements with member practices that make their obligations clear or by contracting with another provider to provide after hours services. 	Advice in After Hours Primary Health Care Working Party report on how PHOs should deliver on PHO Service Agreement obligations.
PHO	<ul style="list-style-type: none"> • Detail the principle of funding following the patient so that, as the increased first contact primary health care strategy funding becomes available, this can be used to improve access to after hours services for its enrolled population. • Ensure that eligible people get access to low cost pharmaceuticals. 	Advice in After Hours Primary Health Care Working Party report on how PHOs should deliver on PHO Service Agreement obligations.
GP/practice	<ul style="list-style-type: none"> • Provide after hours services or agree with the PHO an alternative arrangement. 	Back to back agreement with PHO
Independent after hours service provider (e.g., Accident and Medical Clinic)	Either: <ul style="list-style-type: none"> • provide after hours services for PHO's enrolled population and/or • provide after hours services to casual users. 	Contract with PHO and/or Operate under section 88 agreement
ED	<ul style="list-style-type: none"> • Provide secondary level emergency services. 	DHB responsibility – service specification for EDs
ED	Provide after hours primary health care services either: <ul style="list-style-type: none"> • as part of co-location arrangement with primary care services; or • overnight by arrangement as sole after hours provider. 	Agreement between DHB and PHOs/GPs Agreement between DHB and PHOs

From the OCHT viewpoint this table indicates that after negotiation with the Takitimu PHO we should be able to attract SIA (services improved access) funding to assist in meeting after hours responsibilities.

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PHOs can improve the line of communication to the CHTs, i.e. a summary of PHO meetings including new and relevant information that CHT members would benefit from. This could be forwarded to the CHT secretaries for further distribution.

To supply a sustainable after hours service OCHT would need to attract additional staff, this would become an ongoing additional expense.

A Planning Framework for DHBs and PHOs—The Working Party has developed a Planning Framework for After Hours Primary Health Care based on the key guiding principles of access, effectiveness and resilience (refer Appendix 3). As well, the Working Party has outlined the strengths and weaknesses (in terms of the three guiding principles) of a number of after hours service models that operate in different settings (refer Appendix 4). Appendices 3 and 4 are designed to assist DHBs and PHOs in their planning of after hours services.

DHBs take lead in planning at district level— DHBs are required to identify how they will work with PHOs to ensure all people have appropriate 24 hour access to essential primary services.¹ The Working Party considers this requirement would best be met by DHBs, in collaboration with PHOs, taking the lead in developing a planning and funding strategy for after hours primary health care services for all service users within their district.

The District After Hours Services Plan should follow as a guide the Principles Based Planning Framework for After Hours Primary Health Care (Appendix 3). The plan should include the following elements:

- encouraging the rationalisation of after hours services in urban areas to provide adequate geographical access, including to services overnight
- exploring co-location models as an option

¹ Ministry of Health, 2005/06 Operational Policy Framework.

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- building professional development into service planning, especially where health professionals are expected to take on different roles
- in relation to the current utilisation of EDs by primary care patients, considering the opportunity costs to DHBs of current utilisation of EDs by primary care patients, equity of access and the possible impact on health outcomes in terms of unacceptable delays in accessing services
- collaborating to ensure seamless after hours primary health services across DHB boundaries
- ensuring coverage for casual patients, including visitors to the district.

Notes From PRIMARY HEALTHCARE FOCUS Conference

MOVING IN THE RIGHT DIRECTION CONFERENCE, February 2005

There were lots of new initiatives; with PHO's and DHB's forming partnerships with the community in creating an understanding that people have to take responsibility for their own health, to enroll with PHO's and present for checkups.

Annette Kings Opening Speech

Patients need to easily identify what practices are charging

180 new Scholarships for nurse practitioners

Rafael Bengoa – Director, World Health Organisation

Globalisation is increasing poor health and that health systems are still reactive.

Patients are disappearing from the radar screen.

Patients need to self manage their own health

Needs to be quality indicators to map patients' progress with chronic diseases

Use health dollars more effectively

Market approach – Should 10% Salaries be based on patient satisfactory surveys?

Local people providing local solutions

PHO Chair's Meeting With Annette King And Karen Poutasi

It's amazing how some DHB's have embraced the PHO concept working in a collaborative partnership and exploring new initiatives

Karen Poutasi and MOH visiting Southland DHB and PHO's 1st April

Agree with Cam McCulloch that Southland PHO's invite Chris Farrelly from the Mania PHO, Whangarei to address us, his understanding of the role of PHO's would evolve our thinking.

The viability of small PHO's questioned, announced at conclusion of Conference a 3 million dollar increase in funding for PHO's with less than 20,000 enrolled patients

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Ageing Health Workforce 24/7 causing burnout with patient expectations that they can see GP's at any hour of the day

Overall – no real progress with most questions being met with “The working party is looking into this”

Some Points I Picked Up From The Conference:

'Time Banks' – earning credits for community work e.g. Church group members in the States accompanying people to the supermarket, helping them to read, the ingredients and advising them of the products, nutrition and value for money.

Healthy Kai!, getting local food outlets to provide healthy menus

PHO's in the North Island providing free chickens to promote patients for health checks and providing heaters for the elderly to prevent colds in winter

Need to encourage people to present earlier to GP's e.g. the survival rates of cancer are increased

Change the way Medical Services operate. Some people in health provision haven't got good customer service skills, change appointments so working people can have access. Some DHB's are still micro managing their outcomes

The booklet 'A Difference in Communities' what is happening in PHO's has some great examples and also if you want to access information from any of the presenters at the Conference you can visit the MOH website.

I suppose at the end of the day some of the most important 'Take Home' messages I got were that PHO's have to have a collaborative partnership with our DHB's. We need to communicate with other PHO's, carry out a health needs analysis of our community and look at inter-sectorial partnerships for example, Counties Manukau PHO work together with WINZ, the Police., Community Groups, District Councils and Health Providers sharing resources and working to improve all agencies KPIs.

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An interesting quote, “I know my children should drink milk but coke is cheaper”

PHO’s are going to be monitored by KPIs and we need to measure outcomes not just processes.

For PHO’s to achieve its objectives it will take “TIME” so we will have to be in it for the long haul, build a good trusting relationship with the community and understand our own behaviours and motivations towards a healthier population and inequalities.

Karen Poutasi in her speech to windup the conference used a quote from Sir Peter Blake

“ To win you have to believe you can do it, we are underway, we have a passion, we want to make a difference”.

What do you consider the Role & Value of Community Health Trusts in Rural Areas to be?

Tracey Wright – Service Manager Oraka Aparima Health & Social Services

Reduce barriers to service access by supporting clients transport to urban areas
Provide a rural mobile nursing service (strong focus on primary health and early detection)

Andrew Tucker – CEO Tucker Consulting Ltd, Business Advisor to Health Trusts

Protect and promote the community interest in the provision of health care

Ensure that the community retains ownership of the physical assets

Irrefutable evidence that without Community Trusts in some areas there would be no health services available

Dr Martin Minogue –

On call arrangements – no more than one in four roster

Lobby hard for money to find Nurse Practitioners to aid GP's

Provide professional support to GP's and nurses

Family support

Dr Jerry Imms

After hours roster one in four week

Improve GP remuneration

Improve levels of funding to employ additional GP's

Community support of GP's

Trish Burborough – Regional Manager, MAF Policy

To help deliver an appropriate and affordable level of primary health care to its community of interest

To increase democracy in local health care (identify health needs)

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To provide financial stability, stewardship of trust assets and a vehicle e.g. bank accounts, annual accounts and reports for financial reporting.

Advise DHB etc of looming issues and problems

Southland District Health Board

Ownership of assets

Continued interest and contribution to the health of our community

Be sensitive to the changes to health needs of the community

Ian McAra - PHO Client Manager - Southland

Role – understanding and prioritizing health service needs of local communities

Resource and support of GP, Practices, recruitment and retention of health staff

Linkage to PHO and SDHB on local health issues

Value – grass roots input to local health needs

Credibility with local communities

Autonomy, responsive and stakeholder with local issues

Dulcie Sellars – Practice Manager Otautau

the hardest thing is trying to obtain a locum to give the resident GP some time off, the

Rural GP Network has been helpful but can't always deliver

their needs to be improved communication with the public

Amanda McCracken – Practice Nurse Otautau

The Trust is good to work for because they have the best interests of the community at heart, being a charitable organization their aim isn't to make a profit and funds can be channeled into extra medical equipment, staff training and programmes for improving access and health education for our patients.

It was also suggested that the well male population needs to be targeted

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Summary

It is generally agreed that;

- the community held Medical assets should remain in community ownership
- the Trusts role is to help with support, education and recruitment of the health practitioners.
- to ensure that there are enough qualified people to take part in the after hours roster and that one in four is the minimum level required to prevent 'burn out'.
- to identify needs in our local community and to lobby hard for the resources to fulfill those needs for example to fund nurse practitioners and extra GP's hours.
- to advise DHB's and PHO's of any looming issues and problems.
- Trusts must continue to work hard at securing locums to give GP's time off.
- Communicate initiatives and health concerns effectively to the public, whilst "hearing" all of the public's needs and wants.
- Identify means of improving patient access to services and health education.
- Develop improvement programmes for our patients and continued education for our staff.

Retention and Recruitment of Doctors in Takitimu PHO

A discussion paper by Dr. Stephen Graham

Aims of this document

This document is intended as a guideline for retention and recruitment of doctors inside the PHO.

It is not intended to be prescriptive, but is rather intended to provide a record of the conclusions made by the local doctors and employers (trusts) of some of these doctors. A lot of this information has existed only inside the heads of local people, working hard on behalf of their local trusts to keep medical services together, or in the heads of local doctors.

The ultimate goal is to create a stable, experienced medical workforce within the Takitimu PHO, taking into account the various workforce and employer issues involved. The ideal is to have keep doctors locally for significant periods of time, so that they have local knowledge of how medicine works in our locality, and can provide continuity in medical care for local people.

Current Doctor Workforce

As we understand it, the current situation is;

Riverton	2 doctors. adequate workforce
Tuatapere	1 fulltime doctor plus 2 part time doctors. adequate workforce
Otautau	1 fulltime doctor(moderate term locum) with additional help from other doctors, adequate in short-medium term
Te Anau	2 fulltime doctors(one of these FTE made up of Drs Stephen and Katie, i.e. 2 Drs), 1 medium term locum(with view). adequate currently in addition Dr Liz Scott is returning in June, and will provide additional cover in Te Anau, and probably elsewhere also.
Winton	Have 3 doctors currently, could use further 1/2 time doctor.

There seems to exist at the moment an opportunity to stabilise the GP workforce long-term, if it is managed well (and if we are lucky !)

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Retention Issues

- Medical Council requirements to practice.

Most of the doctors in the Takitimu PHO area are not vocationally registered in New Zealand.

Most doctors coming here will require oversight from a vocationally registered doctor (vocationally registered in general practice that is). The only exceptions would be New Zealand vocationally registered GPs.

The pool of doctors, within the PHO, willing to provide oversight consists of Dr Hamilton and the Drs Graham in Te Anau and Dr Stewart in Winton.

Invercargill doctors, i.e. Steve Brown and others, continue to also provide oversight.

- Community support.

This is hard to quantify, but consists of appropriate friendliness, and acceptance that doctors have life outside the profession.

Spouse happiness in the area is a major reason that doctors move away from rural areas from our experience.

The initial contact between community and arriving doctor/family always seems absolutely vital.

- Professional Support and Development.

Collegiality with surrounding doctors. We believe this is in fairly good heart.

Peer group membership and attendance. A requirement from the medical council, it is very important anyway (that is we would suggest it even if it wasn't compulsory !).

We wonder about encouragement towards post-graduate courses. The aim being to strengthen the confidence and ability to do the job well, and keep well up to date (ideally ahead of the game).

Examples of these courses are Rural hospital course or General Practice through Otago, or Community Emergency course through Auckland.

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- Some control over working environment.

In particular the ability to control on call time , and to have holidays, and other leave when it is needed or wanted.

- With regard to phone triaging service

As far as it affects local services phone triaging is only an add on.

It does not necessarily remove the covering on-call doctor or nurse from the responsibility of actually being available on the ground.

Phone triaging potentially improves the patient's ability to obtain advice, it does not in our opinion make much difference to local services (which need to be around to action some of that advice) at all !

- Financial adequacy

I think that the aim for full time rural practice, including as it does on call, is at least \$150,000 annually I'm afraid. In fact \$150,000 is probably too low.

As a comparison Westland DHB is currently advertising a salary of approximately \$170,000 with 5 weeks holiday, study leave, and same attachments offered to hospital consultants.

It may be (and is) appropriate to offer a package initially to new doctors. Such a package could include housing, car and financial payment.

Recruitment Issues; Potentially a great expense.

Money spent on recruitment is better spent providing better services locally (if you have the choice).

Nationwide, government funded short and long term locum scheme is run by NZ locums. They are a free service and have considerable expertise in the practicalities, such as medical council / immigration. Utilising NZ locums for the minefield of medical council, immigration and other issues can save an unbelievable amount of time and effort and money.

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Other locum agencies take a large amount of the income generated by doctors, which we believe can be used to make the job truly financial.

Sometimes there is no alternative to using other locum agencies, and some of them are good at bringing doctors in, particularly Doctors Global.

Financial Viability of Practices

Practices need timely access to the government subsidies which make such an enormous difference to them.

These government subsidies are retention/recruitment, rural bonus, reasonable roster (in case of Te Anau). We believe these subsidies are most efficiently and effectively used at the local level. Local level being practice or trust.

It is reasonable to expect better patient support with stable, long term doctors. Better patient support leads to better income.

There are significant amounts of funding available through ACC for emergency attendance.

PRIME is potentially a vital part of funding after-hours. To be paid for PRIME, the doctors and nurses must be PRIME eligible, and must be attending emergencies in the community.

Increasing patient fees is used as a last resort in the current PHO environment.

However, it would be unwise, and in fact a disservice to the community, to avoid fee increases if that is what is required to maintain services' financial viability.

Locums and nurse-practitioners must charge appropriately for services they provide, even if they are DHB provided. To do otherwise is to undermine the practice viability. When they are being employed by the practice, they must do as the practice does.

Ambulance Services

These are vitally important to be able to provide a true emergency and after-hours service.

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We believe we should support our local ambulance services as we are able to. We believe our local volunteers should be paid for callouts and for training.

It is much easier to work in isolated rural areas if excellent local ambulance services are present. Our communities deserve excellent local ambulance services.

Other Issues

It is unusual to have single doctors in rural practice. This is for a variety of reasons.

These reasons include

- difficulty meeting prospective partners in a rural area where everyone is potentially your patient
- difficulty of single lifestyle in an environment of being on call a lot.

A lot of general practitioners do not feel comfortable being on call for medical emergencies or accidents, such as motor vehicle accidents. Emergencies are not part of normal city general practice, so city doctors rarely have recent experience in such emergencies.

Many doctors choose to work part-time nowadays.

In a rural area this would equate to days off during the week.

Being on call for emergencies is not a day off.

Schooling for children is not too much of a problem for primary age children, but is likely to become so at college level.

Do you have any other comments or suggestions regarding the Rural Health Trusts provision of services to their local community?

Tracey Wright

Form strong sustainable relationships with existing providers

Andrew Tucker

Professional Management and sound business advice

Dr. Martin Minogue

Promote Rural General Practice in partnership with the Otago Medical School, liaise closely

Dr. Jeremy Imms

Look at employing Nurse Practitioners to relieve the workload on the GP's

Trish Burborough

Acknowledge the huge volunteer input that goes into running a Health Trust.
Lobby local and national politicians of your success's so that new policies and initiatives help rather than hinder health services in rural communities

Ian McAra

Trusts are supplying excellent support mechanisms for isolated health professionals.
The value and importance of trusts work is largely unrecognized by DHB and Government

SDHB

Trusts need to work with PHO and SDHB to understand how health issues can be overcome or minimized for the benefit of all

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Trusts must actively communicate the message of wellness to its local community

Trusts can do better to consolidate administrative and transaction resources under one umbrella to enable them to respond to future health planning funding and service delivery

Ambulance Services

When I refer to Peter Aysons interview and the history of the Ambulance service in Otautau he has identified:

The huge commitment & volunteer input into providing this service over the years the underfunding of the National Ambulance Service contract by the Government and the necessary top up required in funding by the local community

With the depopulation of rural areas it is time to encourage and recompense volunteers for their time in providing such an essential service and support them with paid paramedics

Southland has been pro-active in providing emergency services over the years, fundraising by local communities to purchase their own ambulance & stations, first to have their own air ambulance and lately the commencement of a co-response set up in outlying areas to stabilise patients until the ambulance turns up.

What is needed now to halt the decline in volunteer numbers and potentially the effectiveness of the service is a genuine commitment by the Government to address this shortfall in funding. The Ambulance Service is full of unsung heroes and need everybody's support.

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Summary

In summary of the four answers given by these and other professionals regarding Primary Health Care delivery by Rural Community/Health Trusts they have reinforced the importance of recruitment and retention, the befriending of GP's by the community, nurse practitioners sharing the oncall roster and forming strong relationships with existing providers. We also need to do a health needs analysis to find out exactly where we should focus.

The Trust's are going to be very busy going into the future, what with forming better relationships with PHO's, DHB's and delivering on new health imitative, forming collaborative recruitment and retention plans with other regional Trusts, supporting their GP with more time off and lobbying Government to recognize and tangibly assist us, not to forget maintaining a close liaisons with the Medical School and promoting General Rural Practice.

The issue is not so much about business management of Health Trusts but rather about putting systems in place so that everybody involved with health delivery including the patients have some 'fun'. If the medical providers are enjoying their work with plenty of time off, then they are more likely to be retained in rural areas and the patients are more likely to listen to them and take some responsibility for their own health.

Questionnaire for Community Trusts

In compiling this report, comment, opinion and fact was gathered from many different individuals.

They include GPs' practicing within rural areas, community health trust chairpersons, other health sector professionals, rural sector professionals and the enrolled patients.

We asked nine Southland community health trusts for some general data including numbers of enrolled patients, how the trust came into existence, what services and what type of service it provides and approximate asset backing.

With the exception of Fiordland (and perhaps less so Riverton) these CHTs are providing medical care to rural service towns.

3 CHTs were initially created to operate maternity annexes and subsequently took control of the local GP services.

Trusts have enrolled numbers ranging from 0 (GP services are provided from outside the trust) to approximately 5000.

Specifically within the Takitimu PHO there are a total of about 14000 enrolled patients.

Fiordland has a large number of more transient (therefore not enrolled) patients.

There are presently 12 GPs' filling 13.2 full time equivalent (FTE) positions. This number makes no allowance for rosters, on-call time or holidays. Takitimu utilising MOH guidelines requires a minimum of 10 FTE GPs.

Nb At the date of writing there are 3 less GPs' available on a daily basis, this due to accident, resignation and maternity leave. This stands as a reminder of how much flexibility can be demanded, at times, of our GPs'.

The distribution of enrolled patients within this sample ranges from 1250 / GP to 2800 /GP.

In the report of the Rural Expert Advisory Group to the Ministry of Health published in 2002, “Implementing the Primary Health Care Strategy in Rural New Zealand” pg22, under the section title Addressing Heavy Workloads, “Doctor to patient ratios as high as

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1:2000 should signal the need for DHBs and PHOs to take action to avoid safety issues arising for the provider.” On this basis the sample data collected indicates that before the issues raised by on call time and leave are attended to there needs to be additional personnel available (and the funding to achieve this) to meet this most basic measure.

	CHT	Enrolled	Year Created	Nature	Assets owned by CHT	Asset \$ /EP	FTE	Other
1	Bluff	1360	1991	Medical Centre	\$71000	\$52.00	1.0	Physiotherapist
2	Central Southland	5000	2002	Maternity then GP	\$100000	\$20.00	4.0	Maternity
3	Fiordland	2800	1998	Landlord	\$1100000	\$393.00	3.0	Physiotherapist District Nurse Public Health Nurse
4	Nightcaps	0	1991	Medical Centre	\$170000		0.0	Practice Nurse
5	Northern Southland	2800	1996	Maternity then GP	\$810000	\$289.00	1.0	Maternity Physiotherapist Nurse
6	Otautau	2450	2000	Medical Centre	\$220000	\$89.80	1.2	Physiotherapist
7	Riverton	2500	1998	Medical Centre	\$242000	\$96.80	2.0	
8	Waiau	1640	1991	Maternity then GP	\$360000	\$219.50	1.0	Maternity
9	Wyndham	0	1999	Medical Centre	\$50000		0.0	Practice Nurse

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How do you think PHO’s could assist you?

These are the answers:

- Fiordland * promoting health awareness, health days
- Riverton * more education and funding from PHO to set up programmes
- Wyndham * health days and encouraging extra services

- Northern Southland * a comprehensive after hours system involving primary caregiver and nurse practitioners in local area
- Bluff * health education programmes and more regular and affordable medical check ups
- Winton * help groups with similar disabilities to manage their problems
- Nightcaps * health days, education sessions and surveys, also clinics for special health issues
- Tuatapere * encourage programmes for early detection of health problems. Promote healthy lifestyles, target high risk groups and improve access.
- Otautau * health education, healthy living and eating, health days, follow up appointments and improve access – target high risk groups

Summary

The health trusts all replied that what they need most from the PHO are resources that allow them to be proactive, and they are suggesting that this is best achieved through effective education and extra services and clinics, better and more localised after hours service, improved access for patients.

The health trusts separately and collectively are doing a tremendous job taking the responsibility of providing local health services and I believe that the PHOs and DHBs should be working more collaboratively with them.

The lines of consent within the health sector seem far too long.

There need to be more effective lines of communication between the three parties.

Doctors seem to be unwilling to commit to planning for time off. I am not sure if this is because they do not want another GP seeing their patients or if it is due to financial considerations, but it would be a lot easier if an extra GP was employed in a region and rostered between the practices to relieve GPs' for planned study leave, holidays and for short notice unavailability. The cost of this additional GP would be allocated between practices and the PHO, on an enrolled patient basis (to ensure utilisation).

Could you please give me your opinion on the role your trust plays in your community and how you see that role developing?

Fiordland * to provide a facility which has the capacity to stabilize seriously injured patients and treat minor accident victims. To promote and attract to Te Anau, medical practitioners and other health professional to ensure the provision of health services

Riverton * ownership of medical building and equipment to encourage GP retention and ensure available medical services to our area

Wyndham * provide continuity of staff and resourcing to make this happen

Northern Southland * drive community health initiatives, expand knowledge, also support Doctor services and maternity facility

Bluff * continue to provide a GP service to our community and also 'recruitment and retention'

Winton * a leadership role in providing health services in the region and react to health related needs as they arrive

Nightcaps * to provide a local service, so the elderly don't have to travel and patients receive local nursing advice

Tuatapere * to maintain both the maternity and Doctors services and ownership of assets, also to attract health professionals to a rural area

Otautau * to own and maintain the assets, to recruit and retain GP's and nurses, also to employ our staff and help them with further

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education. Finally to have a succession plan to attract new and able trust members.

Summary

The Health Trusts all agreed that their main role was to provide a health service to their local communities and to do this by way of:

Ownership of the medical facilities

Recruitment and retention of the Health Professionals

Leadership role

Expanding health knowledge

Keeping services local

Continued education of staff

Of the 9 CHTs in rural Southland, six own the assets and employ the medical professionals; the remaining three own the assets and the doctors own the business. When planning for the long term requirements of GP cover, whether it be for normal working hours or for after hours cover, we have to consider the different business requirements; the self employed doctors tend to say we can work longer whilst the trusts do not have the same financial objectives and should be planning to ease workload across the board.

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WANTS

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What Does The Community Want From Its Health Services

Otautau Community Health Trust Patient Survey

A patient survey was distributed to 1200 households in an attempt to determine what they the patients think of, and want from their medical centre. The response was not as large as expected or as demanding.

When asked;

“Is a Medical Practice an essential service?” the response was 97% Yes, 3% No

When asked;

“What is the minimum medical service level you believe is required in the greater Otautau district?” the responses were;

Service Level	%age
An on call doctor	26.
24 hour ambulance with a professional paramedic, a practice nurse, and an on call doctor	24.
24 hour ambulance	17.
24 hour ambulance with a professional paramedic	15.
24 hour ambulance with a professional paramedic, and a practice nurse	8.
24 hour nurse staffed national helpline	8.

Presently Otautau has an on call doctor, an ambulance service that operates when there are enough volunteers available and access to the 24 hour nurse staffed national helpline.

Free 24-hour health advice - call Healthline on 0800 611 116

When we asked what the requested level of cover is for after hours services the responses were similar;

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37% requesting a 24 hour 7 day doctor rostered with other districts,
27% requested an ambulance and professional paramedic on 24 hour 7 day call,
and a further 24% requested an ambulance and service to Invercargill.

We also attempted to determine whether the location of the medical centre was seen as a major factor, when asked are you prepared to travel to visit a medical professional 78% said they would be while 22% either did not answer or would be unwilling to travel. Similarly 86% are able to travel, so it can be assumed that those who can travel are willing to travel.

What Can We Do Better?

Patients

- Share the responsibilities with the Trusts in welcoming, befriending and supporting the local GP and their family into our community
- Respect that the GP has a life outside of the surgery
- Listen to your GP’s advice when presenting after hours i.e. when they say “next time this happens, make an appointment during business hours”
- Pay your bills
- Lobby for support for local Ambulance services
- Take responsibility for our own health and that of our families by having a healthy lifestyle – smoking
 - obesity
 - alcohol & drugs
 - dental hygiene
 - taking your medicine & following professional advice
 - prevention – be proactive rather than reactive with health

PHO’s

- Need to form a better working relationship with our DHB
- Communicate better feed back to the public and the practices (a lot of people still don’t know what a PHO is)
- On-going training of Directors
- Health needs analysis of the community

DHB

- While the DHB has had a very busy year and received the big tick from the Minister, she did highlight the difficulty in recruiting staff was maybe due to a perceived ‘culture’ and learning environment.

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- Better working relationships with PHO's, Trusts & Doctors
- Employ an extra person in planning & funding team to liaise full time on Primary Health Care issues in rural Southland

MOH

- Let the PHO's know the basic structure and funding streams of health service providers in our local regions, so there is no doubling up or gaps in service delivery
- Fully fund the Ambulance Service Delivery Contract with the view to also fund for more professional paramedics in rural areas

Health Trusts

- Form strong stable relationships with existing providers
- Look at ways at reducing barriers to service access for patients
- Lobby MOH, DHB, PHO, District Councils, Community Trusts, Universities for extra Nurse Practitioners and GP's to ease the workload in some areas, i.e. MOH recommendation is for a doctor/patient ratio one GP : 1400 patients
- Improved lines of communication and transfer of information with patients/PHO/DHB
- Lobby Government for extra funding for local Ambulance services
- Education of Trust members – business & strategic plans (how can we keep our health service sustainable) & succession plan for new Trust members
- Support of GP both socially and with more regular time off from work. In a rural area there is greater level of responsibility and workload so to prevent unhappy, stressed GP's & possible 'burnout' they need regular time off! i.e. can't find a locum, 'close the shop for the week'
- Plan for the changing needs of our population
- Co-ordinate a recruitment plan with other practices and the DHB
- Reward ourselves and our health professionals, 'have a party', 'wine tasting trip' or a 'BBQ' – have some fun!
- Scholarships for Medical Students

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Questionnaire of Health Professionals and Others

What challenges do you see in the future that Rural Trusts will have to adapt and plan for?

Tracey Wright

An ageing population

Rural isolation, lack of transport and poverty

Similar to today

Andrew Tucker

Business support and training

Similar challenges as there are today

Dr Martin Minogue

Rural Trusts will have to lobby hard to employ extra GP's and employ Nurse

Practitioners to decrease 'burnout'

Dr Jerry Imms

On-going recruitment of health professionals

Perhaps funding could be freed by transferring work from the secondary sector to the primary sector e.g. * post operative assessments *follow up of chronic medical conditions * pre operative checks

Provide locum cover so GP's can have time off to enjoy the potential of an enviable quality of life that is on offer

Trish Burborough

Ageing and decreasing population – i.e. Southland District will have less babies and more oldies which means less vaccinations for children and more need for geriatric care, disability and mobility issues

Keep fighting for the retention of services

Trust provides a stronger voice than individuals

SECTION THREE: What Does The Community Want

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A Trust gives a focus and continuity over time

It represents the changing needs of the community – Financial challenges, succession of Trust members and improving technology

Dr Pat Maguire

To provide a longer familiarisation period when doctors arrive in the practice. Make sure there is plenty of time working with the out going doctor.

Ian McAra

Maintain continuity of interest from local residents

Roll out and involvement in PHO programmes – primary health i.e. health education, care plus etc

Maintain local autonomy and the viability of practices

Staff recruitment (tightening market nationally and internationally for GP's)

SDHB

Health Trusts should review health priorities and contracts renewed

Improve access's to services within available funding

Don't just carry on 'business as usual'

Establish good working relationships with PHO & SDHB and respond to changes in demographics, technology and epidemiology

Questions to GPs' on Resources Required and Lifestyle Mix

1 What services do you as a GP need as resources so you can do your job properly for the next 5 years?

2 What else is required for you to have a good lifestyle / work mix?

Stephen Graham (Permanent GP Te Anau)

1

Adequate drs.

We are aiming for 4 in summer 3 in winter.

If we can make up to this, or close to this with locums it will tide us over.

Adequate income to afford this.

Ongoing good relationship with St. Johns - in particular ongoing appropriate access to helicopters for emergencies using local helicopters and support of ambos.

Improved working relationship with local hospital, particularly with medical and general surgical departments, other departments are excellent in this regard.

Some support from trust (or from someone else) for buying medical equipment-best we don't own it- I might take it with me if I leave!

2

enough drs. , enough income to afford holidays.

Pat Macguire (Global Locum 12 month contract), Otautau

1

After hours service – minimum one in four

Need good cell phone coverage

Educate patients to make appointments in normal working hours, i.e. next time this happens – make an appointment

Peer group meetings have been beneficial

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High turnover of GP locums can lessen the quality of care i.e. (if you don't ask your patients, you won't find out)

2

Community support is important and I get this from my patients, we need good open lines of communication with patients, staff and Trust need more overlap with outgoing GP, familiarization with NZ Health System Practice and after hours

Need locums available for time off

An annual budget for medical equipment

Money isn't an issue; next job is (3 days a week)

Caroline Stewart (Permanent GP Winton)

1

Up to date accurate information on management of various diseases – also easy to access

On going CME meetings, further education and easy access to specialists and colleagues

2

Lifestyle/work mix – supportive family and community with regular time off

The ability to say 'no' when overloaded and someone to talk to and help you 'de-stress'

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Funding issues

From the provider perspective the issue of funding and funding streams is too complex. See below for an extract from the Healthcare Working Party Report on After-hours.

There is a sector view that the PHO capitation formula does not adequately recognise the cost of after hours care. This is perceived by some providers as a significant problem affecting sustainable service delivery.

Funding of after hours services is complex with multiple funding streams that are not specific to the time of day or night. These are:

- first contact PHO capitation for PHO enrolees
- GMS for casual patients
- a rural primary health care premium paid to PHOs with rural practices, which comprises workforce retention funding and reasonable roster funding. Reasonable roster funding is specific to after hours services but is narrowly targeted at practices experiencing onerous after hours rosters (1:1–1:3) for geographical reasons
- DHB-funded EDs which in some cases are the main after hours primary health care service provider either by arrangement or by default
- funding from some DHBs towards some after hours arrangements to support access and resilience
- ACC fee for service based on the Injury Prevention Rehabilitation and Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003 and Rural General Practice contract or Accident and Medical Clinics contracts. ED services are funded via the Public Health Acute Services agreement
- PRIME services funded by both Ministry of Health and ACC
- Patient co-payments.

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Summary

Community Health Trusts

Plan for a decreasing and ageing population

Look at ways for GP's to take on some of the secondary care consultative work

Identify the changing needs of our population

Continue to improve our technology – both computers and medical equipment

Establish good working relationship with PHO and DHB's

Maintain local autonomy and viability of practices

Keep lobbying for our fair share of funding

Simplified funding

The ability of for example the OCHT to easily obtain (to the maximum allowable funding that it is entitled to.)

Additional staffing, to achieve cover on-call, leave etc, and to meet health education and promotion aspect of PHO charter.

Paid Paramedic in each local ambulance station

Improved communication from DHB regarding services available in Southland

Support from family and community.

Resources (cash) to purchase new equipment.

Collegiality with surrounding doctors.

Professional development and support

Primary Health Organisation

Plan for succession of Trust Members

DHB funding for trust member training

Respond to changes in epidemiology

Simplified funding.

Communication, communication, communication.

SECTION FOUR:
SOLUTION

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SECTION FOUR:

How We Achieve Our Goals	2
What Are Our Goals; Utopia	2

“Putting The Bricks In Place”; Primary Health Care Services in Rural Southland

How We Achieve Our Goals.

What Are Our Goals; Utopia

- a healthy population
- a doctor patient ratio of less than 1:1400 with after hours cover that is sustainable
- local ambulance services that provide 24/7 cover
- OCHT must aim to employ 2 GPs', completing 8 sessions (3.5 hour blocks) weekly each. Both available for after hours, on call.

How do we achieve Utopia?

- A healthy population, by educating & encouraging people to have a healthy lifestyle and removing the barriers to access of health services
- a doctor patient ratio of 1:1400 with after hours cover that is sustainable, promoting General Practice in our universities and providing the funding and support for extra professionals to share the workload
- Local Ambulance Services that provide 24/7 cover, by fully funding the National Ambulance Service Contract and recognizing the true value of the Volunteer Ambulance Officers

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Otautau Community Health Trust

CHAIRMANS REPORTS FROM 2001 to 2005

CHAIRMAN’S REPORT TO 31 MARCH 2001

Since our inaugural meeting on 16th October 2000 we have set ourselves up as a Charitable Trust with the objective of providing a sustainable health service to our community.

We have entered into an agreement to purchase the Otautau Medical Centre and medical equipment for \$95,000 with the final payment to be made by 30 June 2001.

Since the 8th January we have been running the Medical Centre as a business, employing the Doctors, Nurses, Practice Manager and Receptionist and during the first ten weeks of operation have averaged 150 patients per week. A big thanks to our staff who have worked very hard during this start up period.

Our fundraising target has been set at \$180,000 and on the 12th January 2001 we have succeeded in raising \$113,000 of this. With further pledges and fundraising of \$52,000 to come brings our total to \$165,000 with a further \$15,000 to be raised. Our local community has been very supportive, which gives us encouragement to apply for funding from Trusts with similar charitable objectives in mind.

It has been an incredibly steep learning course for all of us involved – learning how the medical industry operates and the challenge, cost and effort required in recruiting Doctors to come to Otautau.

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The Otautau Medical Practice offers to Doctors a financially rewarding return and a wonderful lifestyle here in Western Southland and it is our intention to recruit Doctors who are keen on that lifestyle change for a minimum of one to two years.

So far it reads like a who’s who from the United Nations with the six locums that we have employed in the four months to date. Coming from Scotland, Ireland, South Africa, England, United States and New Zealand. We have only had to bring two of these Doctors into the country but I’m sure I speak on behalf of the rest of the Trust members when I say that we’d love to sign somebody up for two years. Not only to give us a breather but to give our patients in the community some continuity with the same Doctor.

I would like to thank very much, all the members of the Otautau Community Health Trust who have worked very hard to bring us to where we are today. These volunteers are a credit to the community that they represent and an honour to work alongside.

Mark Crawford
CHAIRMAN

CHAIRMANS REPORT TO 31ST MARCH 2002

The Trust has done very well over the last year, what with reaching our fundraising target of \$180,000, organising and redecorating the surgery, employing the staff, getting a computer system up and running and connected with the Nightcaps surgery, supporting the doctors and their families (i.e. housing, cars & socially) and last but not least securing Dr Sandra Price from England to lease our practice for 2 years starting 1 February 2002.

Also a special mention of Dr Jim & Jill Morse and family, they fitted very well into the community and made a lot of friends – a big thank you to Jim for his 8 month tour of duty and all the hard work and extra hours of on-call duties he put in, helping to establish the Otautau Medical Practice as a reliable identity.

Dr Lewis Robinson and Kathy arrived in September from the States. They were in Otautau for 5 months, employed like Jim through the Global Locum Agency. There were real challenges for both Lewis in adapting to the New Zealand Health Service and the issues of being a rural G.P. in Western Southland and also for the Trust in learning how to accommodate and deal with some of these issues. They were resolved successfully and both Lewis and Kathy left Otautau with fond memories.

Dr Sandra Price from England took over from Lewis and has now leased our medical practice for the next 2 years, while it is extremely good news, we as a Trust should not relax. We must continue to make Sandra, Stuart and their family most welcome in our community and look at ways of making their stay here worthwhile and enjoyable to the extent of hopefully rolling the lease over for another year or two.

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As you know it is becoming increasingly difficult in recruiting G.P's to work and live in Rural NZ, even larger towns like Balclutha, Gore & Winton are having problems in maintaining full cover for their patients. One idea I think we should look at is to raise funds to provide scholarships to Medical Graduates bonding them to work alongside our resident Doctors once they are qualified. This would have two main benefits: Firstly helping to relieve the workload of our G.P's and secondly introducing more Doctors to rural general practice. We should be working alongside neighbouring Health Trusts and sharing in these costs much like we are now with the Western Southland Health Trusts working together, investigating ways of setting up our own Primary Health Organisation which would be funded through the Southland District Health Board.

The main benefits of a P.H.O. would be to better utilize existing services through cost saving and directing the increased funds provided by Government to exactly where they are needed most in our community, rather than those decisions being made from afar. We also need to keep lobbying for more financial support for our Rural Ambulance Service in Southland – they are an essential link in our local Health Service and our G.P's couldn't operate without them.

In conclusion I would like to thank the staff of the Otautau Medical Practice for their hard work over the past year and wish them all the best under Sandra's guidance. Also thank you, the community for your support and in return I trust you appreciate what the Otautau Community Health Trust is endeavouring to do, on your behalf.

Mark Crawford
CHAIRMAN

CHAIRMAN’S REPORT TO 31st MARCH 2003

For the period covered by this report the Otautau community has been fortunate to have arranged to lease the medical practice to Dr Sandra Price: doubly so that her husband Stuart is an able administrator with a background in accountancy. Not only has she provided a competent and caring professional service; but past medical records, which had been poorly maintained, have largely been brought up to date. This will be of great importance since changes towards funding of primary health care by the government will be capitation based. My first thanks are to Sandra and Stewart and the other staff involved in running the practice and providing our community with a competent and caring service.

The politics surrounding the issues of primary health care funding have taken up quite a lot of space in the press and have occupied a significant amount of OCHT committee member’s time. Even a “Noddy” version of these events traverses a minefield of acronyms. The government is moving to fund primary health care through a network of Public Health Organisations (PHOs). Distribution of money to the PHOs was to be via local District Health Boards (DHBs). The problem is that many doctors (dare I say GPs?) are distrustful of DHBs and the majority prefer to negotiate through their own Independent Practitioners Associations (IPAs). The IPA representing most doctors in the South Island is Southlink Health (SLH). The problem for trusts such as ours is that without permanent doctors with a long-term political will, there is a danger that we will be ignored by SLH in its negotiations to pry funds from the reluctant hands of the Southland DHB. A lot of OCHT time has been spent making submissions and attending meetings to ensure that the medical trusts are not left out of the loop. This has brought the three Western Southland Trusts (Tuatapere/Ohai, Riverton and ourselves) closer together and we have recently determined to form a combined Western Southland PHO. (At the time of going to press, this has been broadened to include Winton as a Central Western PHO.)

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There has also been greater liaison between our three trusts to establish a reasonable roster so that our doctors are not on after-hours duty too frequently. There has been government funding to the doctors enabling employment of locums and the roster is now at a more satisfactory and sustainable one-in-five level.

The end of our financial year sees these funding issues, vital to our long-term viability, in a constant state of flux. It is hard to keep up with the progress, so I would like to thank my colleagues for the many hours of work they have put in behind the scenes on behalf of the trust.

It is extremely disappointing to report that despite this massive voluntary input and in contrast to the support the trust has had from the wider community, bad debts seem to be a continuing problem for the medical service. Steps have been taken to address the issue, but it is always in the nature of some people to profit from the goodwill of others.

Since our initial round of fundraising it is satisfying to report that the lease arrangement with Sandra has worked well and the trust has managed to work more or less within budget yet at the same time purchase new medical equipment. It is not in our interest to be continually preying on the local community for funding especially after that initial success, but we cannot rule it out for the future, especially if we end up in a situation where we have to rely on a succession of locum doctors.

The prospect of finding a replacement doctor (preferably long-term) by November 2003, will be our next major hurdle.

We had one resignation from the committee during the year, Ruth Stewart. Her work for the trust in its formative stages has been much appreciated.

John Hicks 31.03.03

CHAIRMANS REPORT TO 31st MARCH 2004

Doctors and housing

It has been a demanding twelve months for the trust.

The two-year leasing arrangement we had with Dr Sandra Price finished in November and we have had to fall back on our least favoured option of employing locums through an agency. We would much prefer to see a more stable solution, but with the present serious shortage of doctors willing to work in rural areas, it looks as though this will be the pattern for some time to come. Employing locums is also expensive. We are responsible for travel costs to and from the country the doctor is working in, and also we are obliged to provide accommodation “suitable for a consultant”.

This last point was uppermost in our minds when we were able to secure suitable accommodation for Sandra’s successor, Dr Ken Pavlik, only at the very last minute.

Accordingly, much effort has gone into finding, funding, purchasing and refurbishing a doctor’s residence at 32 Chester Street. It will be ready for the next locum, Dr Mary Kloesz, who replaces Ken at the end of April.

At this point it is worth acknowledging the superb support we have had from the Otautau Lions on this project. They have made this into a classic community project and enlisted support from locals, local businesses and trades people.

Clinic Staff

We are extremely fortunate that we presently have a dedicated, efficient and happy crew at the medical centre. Dulcie Sellars, originally recruited by the Prices, was elevated to Practice Manager when they left. She has had a welter of work, coping with enrolments required by the PHO scheme, computer problems and staffing issues. Amanda McCracken, as practice nurse, has given her able support over this whole difficult transition period. Without the continuity provided by these two, in particular, this report may have had a different ending.

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There was one staff change during the year. Leone Beatson resigned her position as part-time receptionist and was replaced by Jan Winders.

Public Health Organisation (PHO)

This was raised in last year’s annual report. Negotiating with the interested parties has taken up a lot of time, but the Takitimu PHO has finally been formed (1st April 2004). Signing the final documents awaits legal advice and we may have cause to restructure this Trust before we can do so.

The Takitimu PHO comprises the Tuatapere, Riverton, Otautau/Nightcaps, Winton and Te Anau medical practices.

Like so many government initiatives, this is a bit like the curate’s egg, but we feel that after a plethora of discussions we have managed to sift out most of the bad parts.

Ultimately we hope that the increased funding and better access to management expertise will enable us to implement some of the benefits on which the government is promoting the scheme.

Trustees

We were sorry to lose the financial expertise of Lorraine Swain who has very ably acted as Treasurer since the Trust was formed. Natalie Carran has stepped into her position. It is a tribute to Lorraine’s dedication that, despite moving to Christchurch, she has been willing to provide Natalie with continuing support with this demanding job.

It seems to be an axiom of modern management that the smaller a committee is, the better. Obviously, as a committee of nine, we don’t quite fulfil this ideal. There has been a significant effort put in by all the trustees, all of them part-time volunteers doing a job that should, properly, be the government’s responsibility. It would be hard to imagine how this workload could have been effectively managed had it been placed on the shoulders of just a few. We are lucky to have a wide cross-section of people from the community with a range of different

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skills. We have worked well together, and I feel that we have overcome some major challenges this year.

More lie ahead.

John Hicks

CHAIRMANS REPORT TO 31st MARCH 2005

Public Health Organisation (PHO), Otautau Community Health Trust and Otautau Health Ltd.

There was a lot of paper work and meeting time involved in launching the Takitimu PHO. One of the major concerns was to limit exposure of the assets of the Otautau Community Health Trust (OCHT) to litigation. To protect these we needed to separate the assets (viz. the clinic building and doctor's house and car) from the business.

The clinic business is now Otautau Health Ltd. (OHL). After protracted legal negotiations OHL was finally set up with the same committee members as OCHT. OHL was ratified by the trustees at a meeting on 15th November 2004.

At this meeting OCHT provided a seeding fund to set up OHL. From this point OHL received income from the medical practice itself and other funds from the PHO. OHL leases the premises and other assets from OCHT, thus providing income for OCHT. Other income for OCHT comes from the District Health Board (DHB). The object is to keep the assets, as much as possible, under OCHT control. Funds can then be released for OHL as required.

It is OHL which has signed the contract to provide a medical service to Otautau/Nightcaps via the PHO - along with other rural trusts, medical practices and the DHB. It is OHL that employs the staff. New employment contracts were just one of a multitude of changes that we were required to make. Liability insurance was also arranged for the trustees – a regrettable overhead, but sadly necessary in the litigious world in which we now live.

Each time your trust (OCHT) meets we now have a concomitant meeting of OHL. Because the finances are separate the treasurer files two reports and there are two sets of minutes! It may appear to be administratively clumsy, but it seems to be the simplest way round a complex situation.

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Trustees

During the year Robert Bruin joined the committee, which now comprises:

Peter Ayson

Gordon Bennett (Nightcaps representative)

Jeff Broomfield

Robert Bruin

Geoff Carleton

Natalie Carran (Treasurer)

Mark Crawford (Deputy Chair, PHO representative)

Jim Flett

John Hicks (Chairman)

Joanna Simpson

Ngaire Watson (Secretary)

I would like to thank all my fellow trustees unreservedly. It has been a taxing year but there are a good range of skills on board, and a willing attitude which has enabled us to work well together.

Community input

I would also like to thank other organisations and individuals who have donated time and financial support. Particular thanks must go to the Otautau Lions who have put in a magnificent and continuing effort on the doctor's house (and the local trades people who have been involved in this or given their time and help freely), the Nightcaps Lions for a generous donation towards the same, Ian Watson Ltd. for regular mowing of the clinic and house grounds. We are also grateful to David Merton who has kindly helped with his computer expertise. When the trust was first set up we received donations from individuals and many local businesses. This year we were delighted to receive a generous donation

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from another local business. This backing certainly helped our decision making to invest in further improvements to the trust’s assets.

Doctors

We started this (financial) year with Dr Ken Pavlik. When he left he was replaced for a six-month period by another locum from USA, Dr Mary Kloesz.

Unfortunately Global Locums, hitherto a reliable agency, was unable to secure a successor when Mary left in October 2004. This put us, and the clinic staff in particular, under severe pressure until our present doctor, Pat Maguire, started in March 2005. During this hiatus several doctors were employed on a short-term basis and, once our plight was publicised we were even assisted by two doctors who came out of retirement. In the end, and thanks to some desperate juggling by Dulcie, our practice manager, there were only a few sessions where there was no doctor present. Nevertheless, from a patient’s point of view, it was an entirely unsatisfactory few months.

The Takitimu PHO has formed a sub-committee to liaise on doctor recruitment. Long-term GP recruitment must remain a priority for this trust and the Takitimu PHO in an environment where even the local DHB is short of doctors.

Clinic Staff

We are fortunate to have had stable support staff while the doctor situation is so unstable. Dulcie Sellars has had a challenging year as practice manager – and she has coped diligently and efficiently with the support of Amanda McCracken (nurse) and Jan Winders (reception).

The trustees have given support to Amanda’s wish to gain further qualifications. She is currently studying towards a degree with the aim of becoming a Rural Nurse Practitioner. If she achieves this it will contribute greatly towards the standard of service that the medical centre can provide. Her study will involve some periods of study away from work. In addition the nurse’s work load has increased with the implementation of CarePlus and the new National

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Immunisation Register. Accordingly, in March this year, Otautau Health Ltd employed an additional nurse, Karen Tidey. Also, Sue Broekhuysen's hours (Sue is the rural nurse specialist at Nightcaps) have been extended to provide extra cover in Otautau.

Physiotherapy and building extension plans

Physiotherapy is an integral part of the service we provide. For a while it has been apparent that the room that we lease to Prohealth is too small and limits patient throughput for the physiotherapists. This, plus the cramped administration area, prompted the trustees to investigate extending the building. A lot of planning has gone into finding a practical and cost-effective plan to address both these deficiencies. A tender has been accepted for this extension, and we expect building to start later this year.

Prohealth is keen to increase its business and a new long-term lease arrangement has been agreed with them.

Summary

It is my pleasure to end this report on an optimistic note. Despite the extra expenses incurred with the locum arrangements we are forced into to obtain doctors, the practice is currently financially viable. The doctor's house has become an indispensable asset and has been much appreciated by the doctors themselves. Apart from our physical assets, however, we are extremely fortunate to have good support staff. They provide a continuity which becomes even more important when the GP is employed on a short-term basis.

Funding from the DHB and other sources is fickle, so we can never afford to be complacent; however it does seem that by belonging to a PHO we will have a stronger platform from which to exert political pressure (e.g. on recruitment or funding) if required. The PHO also promises to support preventive health initiatives which can only be in the long-term interests of the whole community.

John Hicks

26.04.2005

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Otautau Community Health Trust SURVEY.

This survey is to determine your thoughts on the community and the Otautau Community Health Trust.

We would appreciate one individual from each household taking the time to complete the survey.

To tempt you into a prompt response we enclose a self addressed envelope and each response will be entered into a draw for a \$100 meal voucher at Gerks.

If you wish to enter the draw complete the Name and Address section which will be removed from the response sheets, on arrival at the PO Box, so confidentiality is maintained.

The Otautau Community Health Trust owns the medical centre, equipment, the doctors home and a car. It employs the doctor and all staff. The trustees are ten elected members, including one representing the Nightcaps Medical Trust. The greater community fund raising has allowed the trust to develop and provide a service that the community has demanded. We wish to determine the role and values that the community expects of the trust into the future.

Please list what you believe to be the eight most important services within a community?

For example, a primary school

So that we can better analyse the survey results please complete the following.

Your sex? Male Female
Ethnicity European Maori Other

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Your age range?

	Less than 20 years
	31 to 40 years
	51 to 60 years

	21 to 30 years
	41 to 50 years
	61 to 70 years
	Greater than 70 years

Do you have children living in your home? Yes No

What do you understand the purpose of the Otautau Community Health Trust, to be?

What services do you believe the Otautau Community Health Trust should be providing to the public?

Please list in the space below, those services provided today.

Please list in the space below, extra services that are needed.

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What is the minimum medical service level you believe is required in the greater Otautau district?

Please tick your choice.

24 hour ambulance with a professional paramedic

24 hour nurse staffed national helpline

24 hour ambulance with a professional paramedic, and a practice nurse

24 hour ambulance with a professional paramedic, a practice nurse and an on call doctor

24 hour ambulance

An on call doctor

Please add any comments, stating your reasoning below.

Please consider the current available medical services, are there in your opinion any services which require upgrading?

Please tick your choice. Yes No

If you ticked Yes, what upgrades do you believe are necessary and why?

What in your opinion is required in the district as after-hours medical cover?

A doctor on 24 hour, 7 day call

A doctor rostered with other districts (eg Riverton or Winton) on 24 hour, 7 day call.

Ambulance and professional paramedic, on 24 hour, 7 day.

Ambulance and service to Invercargill.

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Are you prepared to travel to visit a medical professional ?
 Yes No

Are you able to travel to visit a medical professional?
 Yes No

Should Otautau continue to have a medical practice?
 Yes No

Is a medical practice an essential service?
 Yes No

If you answered Yes. Why is a practice essential?
If you answered No. Where should the service be provided from?

Questionnaire to Rural Health Professionals and Others

- What do you see as the Role & Value of Community Health Trusts in rural areas?
- What challenges do you see in the future that Rural Health Trusts will have to adapt and plan for?
- How do you think Health Trusts can improve in attracting and retaining Health Practitioners to rural areas?
- Do you have any other comments or suggestions regarding the Rural Health Trusts provision of services to their local community?

Questionnaire for Community Rural Health Trusts in Southland

‘The Role & Value of Community Health Trusts in Rural Southland’.

Could you describe your Location & Community.

What date was your Trust formed, why and how?

What is the value of your fixed assets including buildings, medical equipment & cars?

What is your enrolled population?

(I am trying to work out the average asset backing required per GP and per enrolled patient)

Could you please list the services that you provide and the numbers of health professionals that work from your building?

Do you have any services which require investment or disinvestments and what would the impact be on your asset list to make this happen?

How do you think the PHO’s could assist you in encouraging your community to take more responsibility for their own health?

Could you please give me your opinion on the role your trust plays in your community and how you see that role developing?

The important role that the Community Health Trusts provide in Rural Southland, to the best of my knowledge has not yet been documented and with the updated enrolled patient figures now available, this will give us a very accurate picture of the current health requirements for Rural Southland.

Yours sincerely

Mark Crawford

"Putting The Bricks In Place";
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REFERENCES

		Community Health Trust Representatives
Colin	Ballantyne	Winton
Rosalie	Blanchard	Riverton
Ian	Collie	Te Anau
Kim	Dale	Lumsden
Trish	Greer	Nightcaps
Nicol	Horrell	Waiau, Member of Southland Rural Health Advisory Committee
Neroli	McRae	Wyndham
Rex	Powley	Bluff
		Otautau History
Peter	Ayson	Otautau St Johns Ambulance Area Committee
Zola	Ayson	Practice Nurse, and Public Health Nurse, 1972 - 1996
Geoff	Carleton	Pharmacist
Amanda	McCracken	Practice Nurse OCHT
Sue	Newson	District Nurse, 1986 - 2005
Dulcie	Sellars	Practice Manager OCHT
		Professionals
Simon	Bidwell	'International Literature Review of Successful Models of Rural Health Service Delivery and Community Involvement in Rural Health (2001)'
Trish	Burborough	Regional Team Leader, MAF Policy, South Island
Robert	Henderson	"Why Doctors leave Rural Practice" (1999)
Jeremy	Imms	GP, Tuatapere for 3.5 years FRNZCGP
Ian	McAra	PHO Client Manager - Southland
Martin	Minogue	MA MB BChir (Cantab) FRCGP DRCOG, The black hole of general practice manpower Published in the NZ Journal of Family Practice Oct 2005 Why be a GP? Carrots and sticks - a qualitative study Submitted to the British Journal of General Practice in July 2005
Jon	Newson	Doctors Committee Otautau Town Council
Gershu	Paul	Chief Executive SDHB
Andrew	Tucker	Chief Executive Officer, Tucker Consulting Ltd
Tracey	Wright	Service Manager, Oraka Aparima Health and Social Services
		Doctors
Pat	Macguire	GP, Otautau
Stephen	Graham	GP, Te Anau Member of Southland Rural Health Advisory Committee
Caroline	Stewart	GP, Winton Member of Southland Rural Health Advisory Committee

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Documents and Papers

1

Implementing the Primary Health Care Strategy in Rural New Zealand

A report from the Rural Expert Advisory Group to the Ministry of Health 2002

2

Towards Accessible, Effective and Resilient After Hours Primary Health Care Services

Report of the After Hours Primary Health Care Working Party 2005