Rural Health Policy

Meeting the needs of rural communities

Hon Wyatt Creech

May 1999

MINISTER'S FOREWARD

Rural New Zealanders want the security of knowing that health services will be there when they need them. I have been listening to the concerns of rural people. I believe this draft rural health policy provides assurance of the Government's interest in the health of rural New Zealanders.

Distance, geography, small populations and limited availability of providers can make access to health services difficult in rural areas. The Government recognises that there are issues in rural health service provision that must be addressed.

The *Hospital Services Plan* released in September 1998 is an important part of this. It states clearly the Government's commitment to maintaining the current distribution of services over the next three years. This does not mean no change. It does mean considered change, and change for the better. It provides a window of opportunity for communities to work together to find 'best-fit' solutions.

This. rural health policy aims to present to rural people the range of activities and policies which are together intended to ensure the right care is provided at the right time in the right place. Setting rural health in the context of Government's wider health strategies, it signals ideas and opportunities for rural communities to help them find the solution that best suits their community.

The Government is committed to providing a fair deal to rural New Zealanders.

Wyatt Creech
Minister of Health

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INTRODUCTION

The rural sector is an essential part of the economic and social fabric of New Zealand's society.

Rural people have similar health needs to their urban counterparts. However, it can be more difficult for them to reach health services. This is because some characteristics of rural areas – distance, geography, population size and availability of providers - can combine to make access to health services difficult and choice of services constrained. The Government does recognise that there are particular issues for rural health. This document shows how they are being addressed.

The Government's policy for rural health services aims at:

- enabling rural people to receive effective front-line care in their own community
- organising services around people and their needs, not around bricks and mortar
- recognising there is diversity among rural communities and their needs
- providing timely access to acute emergency services of an agreed standard of care
- using technology where possible to reduce isolation
- establishing effective alliances and networks between providers (for example, integrated care organisations, regional referral patterns)
- developing and maintaining skills in rural services
- offering greater certainty about access to service of a consistent agreed standard, irrespective of where people live.
- creating opportunities for rural communities to develop local arrangements in partnership with the Government.

The Government's priorities for the health and disability sector of improving Maori health status, reducing the prevalence and impact of mental illness, improving children's health and the others included in the Crown's Statement of Objectives (summarised on page x) apply as much to rural communities as the rest of New Zealand. The focus of the Government's Rural Health Policy is on the challenges of and commitment by Government and rural communities to maintaining and improving access to good quality health and disability support services so that those objectives and priorities can be met for rural people as for other New Zealanders.

The Government's rural health policy works towards making sure that people living at a distance from a hospital can access a full range of services. This means ensuring the recruitment and retention of key health-care providers for local communities. It also means carefully taking into account the specific needs of rural people when dividing up the health dollar. However, to maintain access to services that are safe, of high quality, and operated by sufficiently experienced professionals, people will need to travel for some services.

A lot of work is under way which aims to improve rural health services. This document outlines what is happening in various areas affecting rural health. It begins by looking at the current situation; and then goes through the many strategic, funding, locally driven, educational and collaborative initiatives which are geared towards improving the health of

rural New Zealanders. (Edit this para please - it does not read well). - should we delete it? *We want intro to take up only 1 side of page*

The best solutions come from the most knowledgeable and committed participants. Rural people are very keen to maintain and improve their services. This document is intended to extend their knowledge, especially through identifying the opportunities for rural communities under current policy settings. It shows that the Government shares their commitment to better rural health care.

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RURAL PEOPLE

Age structure

Rural people (those living in rural areas and small towns of less than 10,000 people) make up 28 percent of New Zealand's population. Compared with the rest of New Zealand's population, the rural population has a slightly higher proportion of children (aged 0-14 years) and older adults (both those aged 45-64 years and those aged over 65). The rural population has a lower proportion of young people (aged 15-24) and adults aged 25-44 years.

Maori rural population

Thirty-four percent of the Maori population is rural and Maori people make up around 18 percent of the rural population. Rural territorial local authority (TLA) districts with the highest proportions of Maori (over 40 percent) are the Far North, Whakatane, Kawerau, Opotiki, Wairoa and Chatham Islands. (A map showing rural areas with higher proportions of Maori is provided in Appendix ..) The age structure of the rural Maori population is younger than the non Maori rural population with a significantly higher proportion of children and young people and significantly lower proportions of older adults both in the 45-64 years and the 65 years and older age groups. (Refer Appendix ? for graphs on age structure of rural population).

If room, graphs showing comparisons in age structure inserted.

Health status

Paragraph to be included on comparisons between rural population and the rest of NZ re mortality and morbidity and life expectancy comparisons rural and rest, Maori and non Maori. Refer to graphs in Appendix. (***The only paragraph not yet completed).***

People with a disability requiring assistance

Fourteen percent of people with a disability requiring assistance live in rural areas.* While there is little difference between urban and rural areas in the proportion of people with disabilities requiring assistance (around 10 percent), the proportion of children with disabilities and older people over 65 requiring assistance is lower in rural areas. This is possibly because parents of children with disabilities often prefer to live near specialist heath and disability support services in cities and likewise older people with disabilities tend to shift to the city to be nearer to services and facilities. (Refer appendix ??? for details). The reason for the higher rate of people aged 15-64 years with a disability requiring assistance living in rural areas is not clear.

*Source: Disability in New Zealand Overview of the 1996/97 Surveys, Ministry of Health and Health Funding Authority.

Socio-economic differences

Rural communities in New Zealand are diverse in their demographic, cultural and socio-economic characteristics as well as their geographic features. Some rural communities, as is the case with some parts of cities, have many people living there who experience hardship when measured on a range of factors including income and access to a car. A map in Appendix ?? shows these areas and how this information can be accessed for local communities. There is a close association between socio-economic hardship and poor health.

CURRENT SITUATION

The changing face of rural health and disability support services

Two types of communities are most affected by changing health service delivery in New Zealand: isolated communities with populations of less than 3,000, and communities with small hospitals which are undergoing changes in service provision.

Historically, rural health services have been provided either by general practices as independent businesses, or by Hospital and Health Services (HHSs). Communities of less than 3,000 have difficulty attracting and retaining health services. Such small communities can sometimes only support one doctor. That puts pressure on the doctor, often leading to demanding rosters for 24-hour coverage, and difficulty with relief arrangements.

Hospital-based services in rural and provincial towns have had a strong influence on the work of primary health-care workers in the area. Rural hospitals are changing as the result of safety, quality, equity and cost considerations. Rural hospitals are increasingly focusing their service provision on stabilisation and referral services, some inpatient medical care, birthing level maternity services and community health services, such as mental health teams.

Disability support services have been traditionally provided by district nurses employed by HHSs, home help workers, community-based support services such as IHC, and family, friends and other informal sources of help. A wide range of providers are now contracted to provide home support and other DSS services. However, providing home support services to rural areas, particularly more remote areas, remains a challenge.

In the future, the Government may own fewer health facilities and provide fewer health or disability support services itself but it is **not** reducing its role in funding health and disability services.

Crown's Objectives for the Health Funding Authority

The Crown's primary objective is to improve health status, improve, promote and protect the public health, and to promote the independence of the people of New Zealand.

The Crown's objective for Maori health is to improve Maori health status so Maori will have the opportunity to enjoy the same level of health as non Maori.

Government's priorities for the HFA include the following*:

- improve Maori health status
- reduce the prevalence and impact of mental illness
- improve children's health
- improve access to elective services**.**
- organise high quality services around people - this will involve placing decision making as close as possible to need, local solutions to local problems and better relationships among and with providers**.**
- give consumers greater certainty
- use resources to best effect - through better prioritisation of services funded in terms of equity, need, relative benefits, cost effectiveness and outcome
- innovatively fund high quality, responsive services and
- improve relationships with and between providers.

*Footnote This is a summary only of Government's priorities. The Crown Statement of Objectives can be obtained in full from the Ministry of Health., PO Box 5013, Wellington. - on website? -

Current access to services

Publicly funded service coverage

Each year, on behalf of New Zealand taxpayers, the Health Funding Authority (HFA) spends over $6 billion on health services and services to support people with disabilities. The booklet *What Can I Expect?** produced by the HFA makes it clear what services the Government funds. It is the job of the HFA to assess health needs, consult with communities over priorities and decide where it will do the greatest good with the health and disability dollars the government makes available.

The Crown's Statement of Objectives provides direction to the HFA on the Government's priorities for the health and disability sector. The Crown's objectives and priorities for 1999/2000 (summarised on page x) apply as much to rural areas as to the rest of New Zealand.

The HFA's Funding Agreement with the Minister of Health makes a commitment to ensuring access to services for rural people.

> 'The HFA will ensure people have reasonable geographic access to services as close as possible to where they live, appropriate to the nature of the service.'
>
> 'When determining the availability of purchased services, the HFA will consider and accommodate the needs of people in remote areas in the most practical and efficient way.'
>
> HFA 1998/99 Funding Agreement

Footnote: *What Can I Expect?* is available from the Health Funding Authority Phone 0800 367 8473.

Primary care

Data comparing how rural and urban dwellers use primary health care is not available for the whole country, but research carried out in the Midland region suggests that rural people use such services less frequently than urban dwellers. The availability of GPs across the country varies, with the doctor-patient ratio in rural areas considerably lower than that of many urban areas.

Most people (at least 90 percent) are able to access primary-care services within 30 minutes' travel time, and 99 percent should be able to access such services within 180 minutes. However, within these broad measures, there are communities which struggle to get and keep GPs and primary-care nurses.

Secondary care

Basic secondary care services, such as low-risk general medical and surgical services, are generally available to 90 percent of people within 60 minutes' travel time. The map on page x (facing) shows rural areas located further than 60 minute's travel time from secondary hospitals. More complex, specialist, high-risk services are in most cases available to around 90 percent of people within 90 minutes' travel time. However, there are a range of issues

around provision of services in some of the smaller hospitals, and the effectiveness of co-ordination between services, which need to be looked at.[1]

Disability Support Services

People with disabilities may require basic on-going services such as home support, as well as provision of equipment and more specialised disability support services (DSS). By their nature, home support services for people with disabilities need to be provided on a frequent and often ongoing basis and this proves a challenge when delivering them to widely dispersed people in sparsely populated rural areas.

DSS services, especially specialised services such as those for people with complex/dual/multiple disabilities, have traditionally been in short supply in rural area.. Ongoing difficulties of access to these services means that some people with disabilities shift to cities to enable them to access services. .

Issues for rural health services

Community-based services and hospital services face similar problems in rural areas:

- the recruitment and retention of appropriately skilled professionals
- the maintenance of skills and service quality
- ensuring that practitioners have a sustainable lifestyle for themselves and their families.

There are a number of safety issues in rural settings that need consideration:

- isolation
- solo practice
- lack of peer support
- non-identification of errors
- limited training/skill maintenance/upskilling opportunities
- poor equipment maintenance
- constantly having to decide between the inconvenience for the patient and family of travelling to an appropriate service, and the risk of providing an inadequate or unsafe service locally.

In addition, particularly with the increasing specialisation of modern medicine, it is not possible to afford expensive new technologies in every health facility. Some centralisation of services is necessary for safety and economic reasons.

Measures being taken to address issues affecting rural areas are outlined in the following sections.

[1] For information to issues concerning the provision of services in smaller hospitals, refer to the Hospital Services Plan released by the Minister of Health in September 1998.

MAINTAINING AND IMPROVING RURAL HEALTH AND DISABILITY SUPPORT SERVICES

Planning and funding better health services

Primary Care Strategy

A General Practice Working Party in 1997 identified some key areas where rural general practice needs support. These related to improving:

- the recruitment rate to rural practices
- the retention rate of rural practitioners
- the care given by rural practitioners.

Opportunities identified to improve the support of rural general practice included:

- promoting rural practice as a positive career choice
- easing the fear of rural entrapment
- targeting the rural bonus relative to a rurality scale
- facilitating locum cover for rural practitioners
- strengthening teamwork in rural practice
- facilitating appropriate professional development for rural practitioners
- formalising support for rural nurses working in isolation
- ensuring high-quality co-ordinated emergency care.

Responses to the draft rural health policy suggested that these are still key issues of concern to a wide range or rural practitioners.

The HFA is currently working with the sector to develop a primary care strategy. It builds on and responds to the consultation on the draft strategy for general practice services released for consultation in 1998. The primary care strategy has a broader focus and will include consideration of:

- primary medical and nursing services
- community and home nursing
- primary mental health
- community health services
- management of referred services including laboratories, pharmacies, imaging, physiotherapists and specialist medical services.

It will also consider linkages to community mental health services, Maori health, well child services, palliative care, maternity and DSS. It will allow increased flexibility about how services are best provided in rural and urban areas.

Other key aspects of the HFA's primary care strategy currently under development are:

- recognition of primary care as the cornerstone of the health sector
- a pragmatic focus on health outcomes such as practice population programmes focused on prevention and early detection, management of chronic diseases and improvement of Maori health status.
- a focus on the alignment of incentives impacting on decision makers towards better delivery of care, for example expansion of budget holding for pharmaceuticals and laboratory services
- continued encouragement of Independent Practitioner Associations, but seeking to encourage involvement of a wider range of providers and also consumers and contracting that allows new alliances to form
- increased collaboration between personal and public health providers
- a focus on quality and on the right people providing the right care
- an analysis of barriers to good care delivery, for example access to accident and emergency services
- a strong focus on information management.
- better management of patients through the processes of primary and secondary care
- recognising good features of the rural environment for example linkages between GPs and home based services that may be transferable to urban areas and
- an enabling and flexible framework to support local solutions to local problems

The role of the HFA will be in:
- supporting local programmes and solutions
- identifying transferable solutions
- identifying some key disease management programmes and
- setting and monitoring consistency of service delivery standards.

It is envisaged that the primary care strategy will provide enhanced flexibility for practices to work with communities to respond to local needs with local community based solutions. As part of the primary care strategy, the HFA is examining workforce issues and health care provider development. This includes looking at the specific needs of rural communities.

A rural premium, currently 10 percent of the subsidy level, is likely to continue to be paid to rural practices, although the way in which it is targeted is under review (see below).

Patea and District Medical Community Trust

Patea community used to struggle to keep one GP in the town. But the Patea and District Medical Community Trust changed that, and now the town has a two-GP service plus access to the after-hours service at Hawera Emergency Department.

Chairman David Honeyfield says Patea had a long history of trying to retain solo doctors. 'Doctors would usually stay 6 to 12 months and then move on. It was becoming increasingly hard to replace them…The main difficulty is that Patea is a doctor-and-a-half practice – for one doctor it is too much work; for two it is not quite enough.'

The community took the bull by the horns and worked towards solving the problem themselves. They formed a community trust in 1991, rallied together public donations, and now, seven years later, their medical centre caters for 2733 patients. The practice is self-supporting and works in well with the health centre, which was built for the use of all community health groups in 1995 through a trust and Taranaki Health Ltd joint venture.

'Now the doctors work at the Hawera Emergency Department to make up the other part of their income, which means we have a good working relationship with the Taranaki Emergency Services. It also enables our doctors to have contact with other specialists and keep their skills in use,' says David. 'It works well for the community because they have access to a GP in their own area and don't have to travel for half an hour for medical services, and it works well for the doctor because they are not working in isolation.'

'If the Trust had not been formed we would not have had GPs in Patea. It's working really well - a true success story"

Rural GP Premium

The HFA currently pays a 10 percent premium on subsidised GP consultations and 25 percent premium on travel payments for practitioners working in designated rural areas.

However, the designation of a rural area has become outdated and the HFA has been working with the Rural GP Network and other interested groups to develop a more appropriate means of recognising the increased costs associated with providing rural general practice.

Factors that may be taken into account include: the degree of isolation of the practice; the proximity of other practitioners; after-hours cover; proximity of centres for continuing medical education; and the amount of travel required to reach patients within the rural area.

Rural Pharmacy Allowance

The HFA has introduced a rural pharmacy allowance in recognition of the need to ensure that rural people continue to have access to pharmacists and pharmaceuticals. The rural pharmacy allowance is paid to pharmacies that meet a number of criteria including distance (more than 15 kilometres) from the nearest other pharmacy, distance from centres for Continuing Professional Education centres, and the number of pharmaceutical line items claimed each year.

Nurse practitioner services

Nurse practitioner services offering basic primary care, health promotion and referral services perform a valuable role in some rural areas where the nearest GP may be some distance away. Rural nurse practitioners are an integral part of delivering primary care to rural communities.

Primary health care nursing service at Takapau.

The Takapau Health Centre was nurse Anne Lloyd's dream.

In 1989 the local post office closed and Mrs Lloyd asked a local businesswoman to explore the idea of the community buying the building and establishing a health centre.

A telephone appeal organised by the Lions Club generated enough money in four months to buy the building and two years later a fully equipped health centre opened with one part-time nurse.

Nurse Practitioner Ingrid Cheer says the then Hawkes' Bay Area Health Board and in particular Waipukurau Hospital have supported the concept since it started.

"Sadly, Mrs Lloyd passed away a few months after the centre was opened. Her dream was developed into a valuable community asset providing a range of nurse-led health services".

In 1989 the local doctor left Takapau. Ms Lloyd, concerned the community was losing a key resource, came up with the idea to buy the post office and turn it into a health centre.

Today there are approximately 4000 contacts made each year via telephone, face-to-face consultations and group activities.

"Our focus is on picking health problems up early, maintenance of health and health promotion and screening. We also work towards empowering our patients and helping them get access other services. Working in closely with other health providers is crucial to the centre's overall functions"

The centre, managed by the Takapau Community Health Charitable Trust, now has one full-time and one part-time multi-skilled registered nurse working, as well as a voluntary administrator. There is also an outreach clinic in Norsewood.

Tending to a large rural isolated community where there are no other locally based health services or public transport, the centre co-ordinates visiting health professional clinics, provides regular clinics such as hearing, asthma, podiatry, cervical screening and CPR classes and use internet services to ensure ready access to information. The service has a licence to sell a small range of pharmaceuticals and has equipment such as blood glucose meters, wheelchairs and crutches available. There is also transport assistance to GPs and other health services via the Friends of the Health Centre (a voluntary group).

"The community's support never ceases to amaze me and at times it is most humbling" says Ms Cheer.

"I believe it's been a success because the community feel they own the centre. Local control and local solutions to local problems in a depressed areas are huge attributes to community moral."

The Hospital Services Plan

A dependable public hospital sector remains at the heart of health strategy. This is made clear in the Hospital Services Plan which was released by the Minister of Health in September 1998.

The Plan responds to the need for greater certainty about hospital services, and places special emphasis on the needs of rural and provincial communities. It is part of the Government's general health strategy, which is motivated by the ideal of timely access to quality, cost-effective health care for all New Zealanders.

The Government has invested $920 million over the last five years modernising our public hospitals. It plans to invest up to $1 billion more over the next three years.

The Plan sets out a framework that describes five kinds of hospital facilities. These range from health centres to tertiary facilities where the most complex care takes place. The range of facilities together provide a network of expert health coverage. The Plan outlines where services are currently provided and will continue to be provided until at least September 2001. The Government has made a firm commitment to maintaining the current distribution of services for that period.

This does not indicate that all changes to hospital services are being put on hold. The Government expects public hospitals to continue looking for ways to improve the quality of care.
Many evolutionary changes are underway in consultation with local communities and these will continue. Government's commitment is to provide access to services - it is open to the

idea of using alternative providers and facilities. The modernised health system provides that freedom to innovate.

There are outstanding issues for some small hospitals and for centres with fast growing populations. Some large urban centres, especially in the North Island, are straining to meet the needs of growing populations and additional services will need to be provided in these locations. Some smaller hospitals have problems affecting service quality (for example, difficulties recruiting medical staff). Some provide services that are costly because of the low numbers of patients being seen. These issues will be addressed at existing hospitals. The hospitals are not under threat.

Ways to organise the services to improve quality and get better value for money need to be considered. For example, bringing in overflow patients from larger population centres is one method to consider for improving value for money. It may also improve service quality for local communities, and avoid long waits for those coming in from the larger centres. Effective linkages between health professionals in rural hospital services and secondary hospitals are essential.

In organising hospital services, the government needs to balance five main objectives:

- giving people timely access to reliable services close to where they live wherever possible, as long as quality can also be assured
- ensuring that safe, quality hospital services can be sustained in a particular location over time
- upholding fairness in allocating the hospital dollar across the country
- spending those dollars wisely
- acknowledging the special problems of accessing better care and better service in rural areas.

The Government is committed to providing rural hospital services and already pays a significant premium to recognise the extra costs involved.

The Government will work with communities, providers and other key groups over the next three years to address the outstanding issues. The current distribution of services will not be changed during that time. The main aim is to determine how services can be adapted to ensure that quality and access to services are maintained. This provides a window of opportunity for communities to get involved in shaping their health services and developing innovative solutions to current problems.

Opotiki Health Facility

It has been three years in the making, but the Opotiki Health Facility opened on schedule in March 1999. The health facility is owned by the community, Pacific Health Ltd and Whakatohea. Replacing the hospital, it provides health services for the Opotiki District – around 10,000 people.

'It is an important community asset, allowing people access to health services in an area where those services are quite hard to access.' Heather Thompson, health facility co-ordinator said. "While the old hospital was a beautiful site and was loved and revered by the community, it was just not economical"

'The community wanted to retain the old hospital, but there has been a shift of emphasis to retaining services within the community. To do this we needed a facility which provides all the same services, but as a more economic unit.' The new health facility has two maternity beds, one swing bed, three GP beds, an x-ray service, a laboratory and an assessment and A&E unit .

Rural Hospital premium

A rural premium of $15 million was paid to HHSs for the additional costs of running small hospitals in 1998/99.

This was the first time that there had been an attempt to develop a consistent and fair approach to a rural premium right across the country. While it is not yet perfect, it is a step in the right direction towards a transparent and equitable rural premium.

Of this premium, $6 million was allocated to hospitals which provide 24 hour acute cover but have a workload less than what is financially sustainable for that level of service. The remaining money was negotiated on a case-by-case basis, recognising each region's unique characteristics.

In future years this payment will be refined. It is aimed at making support for health services in the regions more transparent, so that everyone knows what is being paid for and why.

Mental health care

Mental health services available in rural areas tend to be general services, with access to more specialised services requiring referral to the main centres. Rapid response to mental health crises is more difficult in rural areas. Often other services are used while the specialised mental health services are being mobilised.

Hospitals serving rural areas have in recent times established crisis teams or psychiatric emergency services that are mobile and can cover rural areas. As crisis teams develop, emergency service coverage is extending into more rural areas.

The Government is seeking to improve the mental health workforce via its Mason funding.[2] This work is being further enhanced by the HFA's provider development activities. The range of community-based mental health services is expanding with the effect of the Mason money, and should result in better rural mental health services.

East Coast Mental Health Services - Te Puia

Enthusiasm and passion are the main fuel for the East Coast Mental Health Service, which strives to provide East Coast people with a service that is moulded to their needs, says Team Leader Rose Kahaki.

The Mental Health Service serves a population of 6000 from the vast area running between Potikirua in the north to Anaura Bay in the south of the East Coast. An area where there is no public transport and high levels of poverty and unemployment.

"When it first started we did not know much about mental health at all. Mental health issues had been dealt with at GP level and then transferred out to other areas like Porirua and Tokaanui. We were

[2] Funding made available by the Government for mental health services subsequent to the 1996 Mason Inquiry into Mental Health Services.

pretty new on the block. So the service was born out of the needs of the community, from bottom up," says Ms Kahaki.

"Our vision was to meet or exceed the expectations of consumers and their families."

It has progressed from being a back ward unit for long staying acute patient overflow from Gisborne in 1992 to an integrated service which provides community based, primary and residential mental health and social care.

It began with one nurse in the community once day a week, then that grew to five days a week. Nowadays the majority of care is community based and includes home visits to clients and their families by a mobile multi-disciplinary team including key workers, doctor psychiatrist and activities co-ordinator. The service also offers specific social work, family support for clients with dual diagnosis alcohol and drug/social service counselling and advocacy. A 24 hour service is available for crisis and early intervention and for families in need of intensive home-based support and for respite, sub-acute and crisis admission.

"Because the service has been community lead, this means prevention mechanisms were put in place early on - before it had even become a cliché in health speak.

"We go beyond the perimeters of the job description but then that's what it's all about. We challenge the concept of the health professional remaining aloof to the struggles and realities of consumers and acknowledge that we as a team are very much part of the East Coast community.

"The service works because of the commitment and energy that we have put into our vision. We have put things in place because there was a need, and those elements of our service reflect what's real and what makes a difference for our clients."

Improving access to disability support services (DSS)

The HFA has encouraged a variety of solutions to the problems of access to DSS for rural people. In some areas, home support and other providers have been asked to ensure that their service covers people living in both rural and urban areas of a defined area. In other areas, the emphasis has been on using existing services, such as the rural health centre as the basis for delivering DSS. In some instances the same professional may deliver DSS as well as other services.

One of the problems in the past has been that rural people have not had access to information on available disability support services, nor known how to access them. New Zealand Disabilities Resource Centre, Palmerston North, now has an 0800 number which provides information (0800 ENABLE) or refers people to their nearest regional disability information centre.

Since 1 July 1997, all people with disabilities, regardless of location, wanting to access services first have their needs assessed. Information on services is also provided as part of the needs assessment and service co-ordination or planning processes. Needs assessors and service co-ordinators travel to clients' homes in rural areas. The uptake of DSS by people in rural areas has increased as a result of putting these systems in place. Even so, rural people use services less frequently than those living in urban areas. Accredited assessors for equipment and other more specialised assessors or providers also travel to homes where at all possible.

Training and Support Vital for Care Workers
Suggest another title - *Meeting the challenge of providing DSS in rural areas*

Care workers have to be excellent problem solvers and communicators says Jill Kersey, Unit Manager of Nelmar, a private agency which provides home support to people around the top of the South Island.

Nelmar is based in Nelson but has offices in Blenheim and Motueka, and coordinators in Golden Bay and Picton to ensure it is as close as possible to its rural clients.

"We cover a wide geographic area. We have one client who lives at the base of the Heaphy Track so when our careworkers have to work in such isolated conditions it is important they have the right competencies and knowledge," says Jill.

For this reason every Nelmar careworker has some orientation training to ensure they know the basics such as, lifting and legal requirements. Nelmar also runs ongoing seminars - last year there were 99 - for its staff and is currently working with the New Zealand Qualifications Authority to provide training for careworkers who want to study towards its National Certificate in Support of Older Persons.

"A lot of our clients are older people who may not have very much contact or family support and sometimes care workers are the only ones to go into homes so it is so important to match the right careworker with the client. This is even more difficult when you are providing a service to rural areas because it can be hard to recruit people who live near by," she says.

There is no doubt careworkers in the country face different challenges to their city counter parts.

"Some of our care workers have to cross a multitude of obstacles to even get to the client's house. The care worker has to drive for miles in the country up unsealed roads and tracks and in some cases even climb fences and cross paddocks," she says.

Jill's philospophy is that rural people should not pay more for their care than those in urban areas and for that reason Nelmar provides home support in towns and is expanding in Wellington to generate business to subsidise its rural clients.

Jill is noticing that an increasing number of their clients are requiring more complex care such as help with their showering and toileting. She puts this down to people being discharged from hospital earlier and people wanting home based care.

"It is not very often that people want to be in residential care. People in rural areas need to have a choice of service provision but there is no doubt that the funding has to recognise the unique challenges or rural communities and factor in the additional cost of the travel and isolation," she says.

Travel and accommodation assistance

The HFA provides travel and accommodation assistance to patients who have to travel. At present this varies regionally but generally focuses on Community Service Card holders or those younger than 16 years. Assistance is provided via financial contributions to travel and accommodation costs for those having to travel long distances or frequently for secondary-care treatment.

People with disabilities also have access to transport assistance, although having services available locally is particularly important to these people, who find it difficult to travel when needing to get services regularly.

The HFA will have consulted on and developed a fair, transparent and nationally consistent patient travel and accommodation policy by 30 June 2000.

Improving acute and emergency services

The Government is committed to ensuring a safe backbone of acute and emergency services throughout the country. It is an essential requirement of our publicly-funded system. To achieve this a significant amount of work is in progress.

Acute Management System

The aim of the 24-hour clinically integrated acute management system is to ensure that people get "the right care, at the right time, in the right place, from the right person". The framework for the acute management system is outlined in *"Roadside to Bedside*", released in March 1999. *Roadside to Bedside* was developed by the Ministry of Health in conjunction with the HFA, the Accident Rehabilitation and Compensation Insurance Corporation (ACC) and health professionals. .

The key elements of the 24 Hour Clinically Integrated Acute Management System are:

establishing five regional networks involving all hospitals and providers involved in trauma and emergency work

- transferring patients with acute health needs to the nearest hospital capable of providing definitive care
- ensuring appropriate and timely access to resuscitation and stabilisation services for all emergency trauma patients
- integrating all services involved in the management of acute health needs
- ensuring an appropriate emergency transport system
- using nationally consistent and agreed guidelines, protocols and standards
- developing the workforce to maximise the current expertise and skill mix of health professionals and
- providing hospitals and health professionals with access to opportunities involving telecommunications.

The acute management framework is not about centralising the provision of emergency services but ensuring rural health professionals are supported and well-linked into a network of providers. The network, once developed will also provide rural populations with certainty about their ability to access the most appropriate place of care within the optimal timeframe.

The HFA is leading the implementation of the framework, supported and guided by a National Advisory Committee composed of health professionals, ACC and the Ministry of Health. The HFA will also be establishing regional teams to develop the backbone of the first networks and a number of clinical focus teams that will focus on development areas such as pre-hospital care, Emergency Department care and obstetric emergency care.

The HFA is planning to implement the backbone of the first two networks, improve the integration of ambulance contracting and commence the national roll-out of the PRIME scheme by 1 July 1999.

The PRIME scheme

The PRIME (Primary Response in Medical Emergencies) scheme aims to ensure high-quality access to medical emergency treatment. GPs and practice nurses will be available for emergencies and will be provided with extra training and equipment.

This scheme is a good example of different agencies working together to provide better services, as it has had the support of ACC, the HFA, the New Zealand Rural GP network and the Order of St John which has done much of the training and orientation.

It is being , implemented progressively New Zealand wide. The PRIME scheme, once fully implemented, will give rural people more security about the immediacy, quality and co-ordination of their emergency services.

Ambulance services

One of the highest priority areas that will be addressed as part of the implementation of *Roadside to Bedside* is ensuring better co-ordination of services.
The HFA and ACC, with the New Zealand Ambulance Board and the Ministry of Health will be looking at ways of working together to achieve a more nationally consistent and co-ordinated approach to contracting for emergency ambulance services, to take effect from 1 July 1999. Special consideration will be given to how the needs of rural populations and those ambulance providers covering rural populations can be addressed through this process. The national implementation of PRIME will also assist in ensuring that volunteer ambulance officers are supported by specially trained health professionals when attending an accident or emergency.

Community-based initiatives

Government. health agencies will work in partnership with communities over the next three years to find solutions to the problems they face.

These solutions are likely to revolve around organising services around patients, better relationships between providers, local solutions to local problems, and having decisions about resources made as close as possible to need.

Health centres

The health centre model is becoming more common in rural areas. This type of facility generally provides an integrated range of services including primary and community health services. It is usually a community service base (for example, for public health nurses, district nursing, home help and mental health teams) with facilities for visiting specialists, and treatment (for example, physiotherapy, public health and pharmacy services). Sometimes it will also have general practice and/or maternity beds.

A number of health centres are run by public hospitals. However in some places local community groups or groups of health providers have developed health centres to replace hospitals traditionally owned and run by the public health system.

Despite initial community concern regarding the closure of old hospitals, there is increasingly widespread support for these new health centres.

A good example of health centres in action is the new nine bed community hospital that opened in Dannevirke in 1997. While the hospital itself is owned by local health providers and other private individuals, the services are publicly funded by the HFA. The new hospital works with the town's GPs to provide medical inpatient care and includes x-ray and ultrasound facilities, physiotherapy and a medical laboratory. MidCentral Health also provides a range of services from the facility.

Dannevirke's Solution

The best advertisement for the Dannevirke Community Hospital is that staff are happy in their work, says manager Sharon Wards.

"My philosophy is if you keep your staff happy, then your patients will be happy too."

"Originally Dannevirke wanted its hospital on the hill come hell or high water but that was not happening.
We rallied for the new service through constant public relations, talking to the public and working through the issues that arose. Dannevirke Community Hospital opened its door in September, 1997 and now the community is right behind us."

"It's worked well with all services being utilised."

"We had the opportunity to make this place work, and everyone's attitude and time has made it the success it is. It was a huge change in thinking for many of the staff from big hospital bureaucracy to a small, patient-focused environment. But it did not take long for staff to make this their own baby."

"What we have is a purpose-built facility with no wasted space. Administration costs are kept to a bare minimum and most resources are going towards staff and patients. We have tried to design services which are focused on the needs of the community."

For example, there are GP-managed beds to provide convalescence following surgery and for medical problems which don't require specialist intervention.

The hospital houses eight GP beds, three maternity beds, x-ray facilities, Medlab and Homecare 2000. MidCentral Health are also in the building operating public health district nurses, specialist outpatients, mental health and occupational therapy.

Integrated care

Integrated care means a variety of things to different people. To some it means simply an emphasis on improved co-ordination between services; to others it can mean providing a whole range of services for a whole population from one budget.

Integrated care in its various forms seeks to deliver health services to people and to communities in a co-ordinated way. It looks at the bigger picture when providing health care, so that the community's need for preventative and educational services are also taken into account.

The objectives for integrated care are better co-ordinated and more health and disability support services within existing resources, covering:

- a range of services
- more than one provider
- well developed, effective collaboration between providers
- a single pool of funding and
- a particular population.

The Government is encouraging communities and local providers to consider a variety of integrated care arrangements. Integrated care developments can allow local people to have a greater say in their own local services and find the solutions that serve them best. Such approaches are expected to help communities to resolve some of the difficulties in maintaining effective health services experienced by rural communities.

Because rural communities tend to be small, they may already have some of the ingredients for successful integration, such as existing relationships between key players. It is acknowledged that sometimes strong parochialism and existing health provider relationships can run counter to regional attempts at integrated solutions. However, where community and professionals are able to work co-operatively, initiatives seem to have moved forward faster in small communities than in cities.

Kaitaia Maternity Service

The Kaitaia Maternity Service incorporates all the maternity services in a region spreading from Mangamuka to North Cape.

The majority of the region's roads are unsealed and access to some areas is difficult during the winter months. The service has to deal with these elements as well as significant population factors like having a high percentage of Maori women - 45% of the women aged 15 to 44 years - and a high proportion of young families, many of them on low incomes.

"We didn't want to create competition in this area" says Donna Mayes, Kaitaia Maternity Services Manager. "GPs and practice nurses have a long history of working together and we wanted to continue that relationship, ensuring that our service that met the needs of rural women. We wanted to make a service where the midwives and GPs had security of income, collegial support working as a team, and flexibility in how the services were delivered."

The midwives provide antenatal care, and do home deliveries as well as looked after the maternity service at the hospital. GPs provide the medical backup throughout the pregnancy as need and choice demands.

The maternity service provides senior midwife cover at the Kaitaia hospital maternity unit and Northland Health provides support staff. The service also works in closely with community groups such as Plunket, Ringa Atawhai and iwi-based health groups.

"Our midwives work long hours, they are dedicated, providing one-on-one follow-up and a holistic approach to care where they help their client with other social services like WINZ, housing and finance."

"It works well. The midwives love their work, the GPs don't feel threatened, and women rave about the service. While the day stay rate is the highest in the country, in terms of outcomes the service is looking good," says Ms Mayes.

"We are too isolated to operate in a competitive environment. Our drive was to get focused on how to meet the needs of women and we made a decision to leave the politics behind. Our satisfaction is in seeing women in the region receiving good care".

An important driver has often been a real or perceived threat to existing facilities and services (especially the local hospital and specialist services). The formation of Independent Practitioner Associations and other groups interested in integrated care such as Healthcare Aotearoa and Mäori Integrated Care groups have also assisted in the process in some areas.

The earliest rural integrated care initiative was in Hokianga This is not a typical initiative because of the Hokianga's special area status and its strong history of health-care activism, but it has been accepted as a very successful development for the local community.

Developments have also moved quite rapidly in some small community towns with outdated existing facilities that were confronted with change. Balclutha, Ranfurly and Gore are examples in the south and Dargaville and Kaeo in the north.

The HFA has a number of rural-based integrated-care projects under way. One of these is with Kaipara Care in Dargaville for the multi-disciplinary management of diabetes, child asthma and frail elderly in a rural bi-cultural environment. There is also interest from communities such as West Coast, Eastern Bays and Southland to find ways for community based providers, the hospital and local government to work together.

The Government is keen to foster a variety of different approaches that may be able to achieve the purposes of integrated care in rural communities. Some integrated care arrangements could mean changes to people's choice of service providers. Because of this, it is important that the following points are observed:

- if an arrangement will cover everyone living in an areas, then very careful and responsive consultation will be required
- if people will have to make a choice of which arrangement to join, then it will be crucial they know what they are signing up to and they can make free choices
- people must be protected against organisations refusing to enrol individuals purely because of their need for services
- Maori aspirations must be recognised and addressed
- accountability and monitoring of access will be needed
- there must be provision for ensuring that national policies are complied with and
- extra costs for an integrated approach must be evaluated against the benefits.

Balclutha looks to the future

Balclutha's integrated Healthcare Facility opened its doors to the community in December 1998.

Brian Dodds, Board of Clutha Health Incorporated's chairman, says it has been a challenging task bringing the community around to accepting the new facility as the key health service.

In December 1991 a campaign to fight for the retention of surgical services at Balclutha hospital started. Three years later these remaining surgical services closed down and the Hospital Support Committee rallied to find alternatives which would secure sustainable health services in the Balclutha.

"In the beginning we were all fighting for what we had; then we stepped back and thought shouldn't we be looking to the future?

"There was divided opinion on it. Concern about whether or not we should, as a community, be taking on the responsibility for the provision of health services," says Mr Dodds.

In August 1997 the group presented a business plan, centred on a new facility in Balclutha, to the community and members of the committee spoke to as many community organisations as possible to gain the support they needed to get the project underway.

"It's been a big change for the community to accept but we are confident that the quality and range of services which the new facility offers will do much to overcome the remaining opposition."

Now the focus is on ensuring the continuing provision of the best health services by the drawing together of local health personnel and through better co-ordination and co-operation improving the services to the community.

Clutha Health Incorporated has been formed to own the facility on behalf of the community. It is an Incorporated Society with a board membership of ten. (Five of whom are generally elected, three appointed by the people who work in the facility, one by the Clutha District Council and one by the Minister of Health.)

The incorporated society, in turn, has appointed a board of five directors to the Clutha Community Health Company Limited which holds the contract to provide health services.

The facility includes seven general inpatient beds, two observation beds, four inpatient beds with specialist geriatric supervision, a maternity facility ward, two post natal beds and two more beds to cope with overflow, five suites for general practices, X-ray services, a laboratory, physiotherapy and an outpatients department where visiting clinicians and speciality nurses will conduct clinics. District nurses, occupational therapists and a medical social worker will also work from the facility.

Family health teams

Family health teams are currently being piloted in Waitakere, Eastbay and Otago. The pilots aim to provide a comprehensive family health team concerned not only with specific health problems, but also with broader social and cultural factors. This would involve, for example, assisting parents to get help from the appropriate services. It would also involve supporting and speaking for families, and co-ordinating different services for them if necessary. This concept, once evaluated, could be a useful model for application in rural areas.

Developing and maintaining skills in rural areas

Appropriate and well-maintained local skills for front-line care are critical to rural health.

This requires, firstly, that health professionals with the right training are recruited, and retained in rural areas. Practitioners in rural and provincial areas need to have a very wide understanding of a large number of topics and a wide range of skills. This is a large part of the enjoyment, and the challenge, of rural practice. They need to have, for example, an understanding of community health systems, skills in initial assessment and emergency care, understanding of chronic disease management, and have especially well developed communication skills.

Once health professionals have been recruited to rural areas, it is important that they can continue their professional development. This is needed for the safety of their practice. It also helps overcome any sense of professional isolation. This brings in other issues, such as the need for locum support, and an attractive lifestyle for the rest of their family members.

The recruitment, retention and ongoing education of rural health professionals have all been difficult issues for many years, and they are being faced clearly and positively. There are a variety of ways the current situation can be improved, and the Government is keen to see this happen. There are already a number of local and national initiatives aimed at supporting the needs of local communities, including improvements in rural practices and the development of nurse prescribing. These generally involve improving training available for GPs and nurses in rural health centres, giving more attention to ways of retaining health professionals in rural locations and making sure locums are available for them.

Clinical education, training and ongoing support

Undergraduate medical and nursing education includes attention to the basic knowledge and skills required in rural practice. This level of education imparts a general competence. More specific skills and experience are usually postgraduate activities.

The universities and polytechnics involved vary in the extent to which they take account of the needs of rural communities when they recruit medical and nursing students. Health-care funders, providers and communities need to express their requirements to education providers, however rural health is already an area of increasing focus in medical and nursing education. Ongoing support and training of rural practitioners is also vital. A variety of initiatives are being developed to increase the support available to rural practitioners. Examples of developments in clinical education, training and ongoing support are presented below.

- In early 1999, the HFA approved support for a Director of Rural Health based in the South Island. The rural director will work with South Island rural GPs to promote rural practice and liaise with training providers. Consideration is being given to supporting a similar post for the North Island.

- The General Practitioners' Vocational Training Programme (GPVTP), purchased by the HFA through the Clinical Training Agency, is being re-oriented to be better at recognising rural health needs.

  From the year 2000 it is to have a greater emphasis on working as part of a multi-disciplinary team delivering care to individual patients, and on carrying out proactive health programmes to improve the health and wellbeing of the people of that practice. The GPVTP will also investigate ways to enhance the recruitment and retention of trainees in rural practices.

- The Dunedin School of Medicine is working towards establishing a rural health network. This network will be supported by the Dunedin School of Medicine, which will provide administrative support and specialists visiting rural areas for teaching purposes.

  Part of the School's new approach to rural training includes undergraduate fieldwork in rural areas. It is proposed that through their training, students will be attached to practices in rural areas for periods of up to seven weeks.

- A new multi-disciplinary Diploma in Primary Rural Health is being offered by the University of Otago. This is directed towards increasing the skills of nurses and doctors in rural areas to allow them to enhance the skills necessary in rural practice. The Clinical Training Agency is aiming to fund approximately 30 training places each year.

- The Goodfellow Unit (Department of General Practice, Auckland Medical School) is contracted to provide education and peer support to rural GPs and practice nurses in the Midland region.

- The Christchurch School of Medicine Department of Public Health and General Practice has a locum support service for practitioners in rural areas. A similar scheme is provided by Southlink Health Independent Practitioner Association network. Both of these schemes offer relief for rural practitioners to make it easier for them to get away for study and annual leave. It is anticipated that more programmes such as these will be developed.

Multidisciplinary Diploma of Rural Health – Christchurch Medical School

Jean Ross and Dr Martin London, directors of Christchurch's Centre for Rural Health established in 1994, are adding another string to their bow of rural specialist services.

With a good knowledge of rural practice issues and a broad rural health practitioner database, the rural health centre, urged on by the Central Training Agency, is introducing a Diploma of Rural Health for GPs and nurses as part of its integrated rural health support package.

'We were aware of the challenges experienced by rural health professionals and their families in Canterbury and Westland. Research showed they were isolated and the consequent impact this had on the delivery of health services to rural communities,' says Jean.

The centre was initially set up to improve the quality of patient care in rural practices, but it has moved forward to emphasise the team approach for effective health delivery.

'The basis of the diploma is to advance the skills of the practitioner so they are clinically able to take on the diverse roles encountered in a rural environment and how to adapt their work practice to fit in with the community. On completing the diploma, GPs and nurses will either be in a better position to stay in the rural environment or have the ability to decide it is not for them.'

Advanced Rural Primary Care is currently run for rural nurses but will broaden out to include GPs next year. It covers clinical assessment and procedural skills to manage rural patient pre-hospital emergency care, develops advanced health assessment skills for nurses, and extends clinical skills relevant to rural practitioners.

The Rural Communities and Team Function paper starts in 1999. It develops an understanding of rural communities and skills to optimise the experience of life in a small community. The emphasis is on effective team function and integration in rural communities.

The third paper, Applied Clinical Rural Practice, begins in 2000 and is based on placement in active rural practices with supervision and mentor input.

- Wider GP networks can offer more opportunities for fostering professional development. For example, the Northern Rural General Practice Consortium Inc, (which has a membership of 54 GPs and 53 practice nurses comprising 95 percent of all rural general practices north of Wellsford) employs a professional development facilitator to provide

continuing medical education programmes and other ongoing training and development for its GP members. It also employs a practice nurse facilitator to provide continuing education, peer review and support services to its practice nurse members.

- A further proposal under development by the Dunedin School of Medicine is the provision of a nationally recognised qualification for medical practitioners who staff rural hospitals. Learning aims would include the management of medical emergencies, resuscitation, stabilisation and the transfer of patients to base hospital..

Nurse prescribing

Currently, the Medicines Act 1981 limits the prescribing of prescription medicines to medical practitioners, dentists and midwives. In May, 1998, the Minister of Health announced that Cabinet had agreed to amend the Medicines Act to enable the making of regulations to:

- extend prescribing rights to nurses and other defined groups of health professionals
- designate health professionals who are able to select and administer specific prescription medicines, for particular classes of patients, when acting in accordance with standing orders. (Standing orders are instructions for the initiation of treatment by specified health professionals, for particular classes of patients, in specific situations).

Nurses in rural practices may be one area in which granting limited prescribing rights is a useful and cost-effective complement to the services provided by rural GPs. In many rural areas there are excellent working relationships between health professionals who support each other's work in the community. Extending prescribing rights in such an environment can strengthen the team and increase people's access to timely services.

The Ministry of Health has established working groups comprising nurses, medical practitioners and pharmacists to define scopes of practice and the generic classes of medicines that it may be appropriate for nurses to prescribe in the areas of child health (in the context of and family) and care of the elderly. The information provided by the working groups and wider consultation will form a basis for evaluating the benefits of safely extending prescribing rights.

The Centre for Rural Health at Christchurch Medical School has received funding .from the HFA to undertake work on the administration of prescription medicines for rural nurses under standing orders.

Mäori provider development

Maori providers have an important role to play in rural service delivery. One example of how the Government is encouraging workforce development of Maori health professionals to meet the needs of Maori is through the Mäori Provider Development Scheme.

The Government has committed funding over three years for Mäori provider development to support the sustained growth of quality Mäori providers of health services and to enhance the ability of Mäori providers to deliver effective health services. A key element of the Mäori Provider Development Scheme is to improve integration and co-ordination of health and disability services for Mäori, so services are easier for Mäori to use and are provided in ways which minimise the financial barriers to healthcare access. The establishment of mobile service delivery units, particularly for dental, primary care, child and youth health and mental health services which move within rural communities at specified intervals, aims to decrease the access and cost barriers that many rural communities face.

Te Puke Karanga Hauora Trust

As part of Pipiriki Marae, Te Puke Karanga Hauora Trust provides nursing services and health education services to isolated communities on the Whanganui River. These communities have populations which are predominantly Maori. Te Puke Karanga Hauora Trust also co-ordinates services provided by other health professionals.

. The centre considers kaumatua wisdom and support a big bonus. Management has a monthly meeting with the community to discuss proposals and receive input. Manager Pet McDonnell says the service is a major asset for the community, taking in Tieke to the north and Jerusalem (Hiruharama) in the south, and all surrounding areas.

'We've been going for 2 years and I think we can now say the local community views the service as its own service; as a community-owned service.'

The centre services about 200 people, 'depending on who's home,' and a number of tourists in the summer. Flexibility is the name of the game, she says; whanau may come home for a weekend and stay for a month.

"The old people now have access to a nurse at their doorstep, day or night. Someone is always on hand 24 hours a day. We have a vehicle for when people need to get to Wanganui Hospital's accident and emergency service quickly or to take them to the doctor at Raetihi. We also have a helicopter arrangement with the local Department of Conservation office and through them we have radio access to Tieke Marae, which we also service.

"We are currently devising an emergency plan for Tieke with Department of Conservation staff, and local people with boats who know the Whanganui River like the backs of their hands. 'The area is very isolated – you couldn't expect an outsider in a helicopter to necessarily find Tieke quickly in an emergency.'

Pet believes the service has given local people more of a sense of security than they had before. 'In the past, if you had a heart attack you'd get to hospital, but if you had an asthma attack, you'd probably just cope as best you could. Now, we can get people to hospital quickly and safely.'

Primary health services in low income areas

In November 1998, new Government funding was announced to provide start up capital and ongoing support for up to seven new primary health services in areas of high health need. Healthcare Aotearoa, a national network of primary health providers which are not-for-profit and community controlled, has been contracted to administer the fund. A quality improvement programme and administration is also included within the two year contract. The new primary health services, which must be not for profit, will provide services to low income populations with high health needs in either rural or urban areas.

Flexibility and innovation

Rural health requires an innovative and flexible use of the health workforce. This is because of the historical difficulties associated with attracting and keeping rural health professionals and because of the broadening range of health needs they have to cope with. Flexibility and innovation are ways to keep the focus on the needs of the community.

Because rural providers are often small, collaboration among them will be important. New approaches to meeting rural health needs, such as minor surgical training for GPs, are a good example. Some independent practitioner associations provide examples of such collaborative efforts.

The Ministry of Health is promoting increased flexibility in the health labour market by facilitating health-care employers' efforts to develop their workforce. It is also reviewing occupational regulation and training policy to see if these can be changed to increase flexibility.

Local solutions to local problems

"If you have seen one rural community, you have seen one rural community."

Dannevirke Community Hospital Manager Sharon Wards says local solutions to local problems are the way to go as no rural community is the same as another. But that doesn't mean communities shouldn't learn from each other and with that in mind Mrs Wards set about establishing the Rural Health Network.

"The future is for rural health initiatives to solve their own health problems for their own communities, but those communities need support. We bit the bullet and did it ourselves - no one else was going to do it for us."

The network's inaugural conference was held at Dannevirke in August. 1998. Delegates included managers, nurses, GPs and allied health professionals from both public and private sectors of rural health facilities. The conference developed a forum for sharing information about rural health services and best practice in the changing health environment.

Mrs Wards said common issues related to centralisation of health services and the different models of service provision.

"It was great, we learnt heaps. And the biggest plus was that we now have a list of contacts and in each area there is someone to talk to about the issues surrounding rural health initiatives."

A newsletter, with a detailed list of contacts, is being published as a resource kit for all those involved.

Networking, partnership and technology

There are a variety of ways of using our health resources more effectively through networking and partnership between providers and between welfare agencies Modern technology is an especially useful tool for people to work together. It means that networking can now occur over distance, greatly reducing isolation for all who use it.

The Strengthening Families programme

The Government supports inter-sectoral initiatives that recognise the range of causes behind poor health and disability. The Strengthening Families strategy arose from concern about inter-generational cycles of disadvantage and their impact on children and families. There was also recognition by the health, education and welfare sectors that there were many common areas of concern, for example common clients in common areas of New Zealand.

Service co-ordination at the local level - In each community, a local approach has been developed to help people at the front line work more closely together. This is achieved through interagency case management, identifying gaps and overlaps in services and joint initiatives to use resources more effectively. The initiative first involved health, education and welfare agencies and has now expanded to include other government agencies and community groups.

Local level co-ordination began with a pilot in 1996 and there are currently 54 local co-ordination groups covering the whole country, including rural areas, for example the Bay of Islands, Central Hawkes Bay and Buller/Westland. Client feedback confirms that the collaborative approach is beneficial. In addition, the sectors have developed greater understanding of each other's services, and this provides opportunities to develop other inter-sectoral initiatives.

As part of the Strengthening Families strategy, a more preventive approach is being explored in three priority areas (Northland, East Cape and Porirua/Hutt Valley). The number of priority areas is likely to increase.

Family Start Programme - A national stocktake of health, education and welfare services available to children and families at risk identified intensive home visiting programmes as an effective means of working with families of young children. The Family Start service aims to build the strength and capacity of families and to ensure their children have the best possible start in life. Family Start is currently being trialled and evaluated in Whangarei, West Auckland and Rotorua. It is anticipated that rural areas with identified need would be included in any expansion of this service to other areas.

Telemedicine

Telemedicine is being trialled and increasingly used to allow specialist expertise to be more widely accessible. An early example was the Waikato teledermatology service, which involved communication between Health Waikato and one of its satellite hospitals, Taumarunui. This has now been extended to involve GPs and is part of an international trial. As well as diagnosis, telemedicine can include distance prescribing, and nurse field workers supported by telecommunication links with doctors.

Teleradiology

The use of telephone and computer technology to gain access to radiology services provides significant opportunities to rural hospitals and health centres. Reading x-rays and CT scans remotely can be of particular value in determining whether or not a patient must be transported to another centre or not.

It can also be of assistance where it is not feasible to have an on-site radiologist. Difficulty in recruiting a radiologist led Coast Health Care to contract with a Christchurch-based radiology service allowing urgent x-rays to be scanned through to Christchurch and a consultation provided within 20 minutes. A radiologist and a sonographer visit Greymouth Hospital weekly. This initiative has increased the quality of radiology services and reduced the need to refer West Coast people to Christchurch.

The acute management system described earlier will rely heavily on effective communication links and provider networks.

Visiting specialists and service networks

The different levels of health and disability services need to be connected and to support each other through service networks. A good example of this in operation is the increasing use of visiting specialists in rural areas. This means that services are received by patients in their communities, and that the service is provided by a health professional who is experienced and

has access to wider support networks. The visiting-specialist services are particularly well received by DSS consumers, who need to use these services often.

Hospital in the home

Provision of hospital level care in the home may be an option for rural people in the future. A pilot project in Taranaki has .commenced . which .provides highly skilled nursing services to patients in their homes. Home-based care is being provided. to patients who would normally be admitted to a hospital. Setting. . This initiative is being trialled with patients relatively close to a base hospital, but if it is successful, consideration could be given to whether this type of service could be used by rural people, provided skilled nursing, medical oversight and allied services were available.

Hospital and Health Services best practice

The creation of the *Directory of CHE Initiatives Towards Best Practice: Acknowledging success and learning from one another,* was facilitated by the Ministry of Health in order to assist dissemination of best practice expertise and experience across HHSs. Sharing knowledge of what works and what does not is expected to help HHSs to improve the effectiveness and efficiency of their services. The directory includes a variety of rural initiatives from around New Zealand, such as teleradiology and rural nurse specialists.

Information sharing concerning rural initiatives

A group of rural practitioners who attended the Action for Health and Independence Conference in 1998 were enthusiastic about a proposal to set up and maintain a website for sharing information about rural initiatives. The Ministry of Health is pursuing this proposal with the view to the website including an interactive component to facilitate the active exchange of ideas and information.

Certainty and transparency

The booklet *What Can I Expect* has been produced by the HFA so that members of the public and those working in the sector can be clear about what services Government funds. It is based on a more detailed service coverage document agreed annually between the HFA and the Minister of Health and is designed to give people certainty about the services they can expect to have access to, irrespective of where they live.

Booking systems and the priority assessment criteria used to run them will ensure that priority is given to those in most need and most able to benefit, regardless of where people live This system will also provide certainty and timeliness for people needing surgery.

The Hospital Services Plan also seeks to provide certainty and direction for communities.

Rural public health

There are a number of public health issues of particular importance in rural areas.

- sewage disposal
- water supplies (sufficiency and quality)

- exposure to agrichemical spraydrift
- exposure to zoonotic diseases (for example, leptospirosis)
- injuries and injury-related fatalities (people in rural areas experience a high rate of motor vehicle injuries and fatalities, and farm injuries)
- the health consequences of serious housing need (particularly affecting Mäori)
- emergency management (particularly floods).

These issues relate to vital aspects of the rural infrastructure. Local, regional and national government are working to protect and enhance the public health by modernising and maintaining safe systems. - *check public health group*

More generally, there are difficulties associated with maintaining public health services in rural areas, due to the large distances involved and the relatively small workforce to cover vast areas.

SUMMARY

New Zealand has always faced particular challenges in the delivery of health services to its citizens because of its population distribution and geography.

These have been intensified by changes in hospital services that have occurred world-wide. Many things hospitals were needed for in the past are now done in a doctor's surgery. Many treatments a small hospital used to perform are now done in larger hospitals, where the equipment is more modern and the staff more specialised. There is increasing evidence about the effectiveness of services and where they can be best carried out. The quality of service now demanded by patients cannot be provided in every small rural hospital.

Change to the provision of health services in rural areas is inevitable. Due to safety, quality, equity and cost considerations there has already been a reorganisation of services in some rural hospitals. The types of services are also affected by changes to the rural population, and in the pattern of illness (including an increase in chronic conditions).

The Government wants to ensure that there is a comprehensive network of services to cover even the remotest areas, to ensure access to the right care at the right time and in the right place. This is demonstrated by the Hospital Services Plan, and a range of other initiatives.

Another key aspect of the Government's rural health policy plan is the emphasis on quality. To achieve higher-quality rural health services, all involved need to work together as interdependent parts of one whole service. Only then can there be an integrated, comprehensive, high-quality system of providing health services to the rural areas of this country.

There are a number of initiatives currently underway which will contribute to achieving improved rural health and disability support service delivery. The Government wants to work in partnership with communities to take the next steps in creating for themselves the best rural health and disability support services to meet the needs of each community. .

Communities will be central to developing solutions that fit local needs, to achieve improvements to rural health services. Centrally imposed plans are no substitute for the creativity and motivation of those who know local circumstances.

The Government recognises a lot of work has been done by some communities, who are now reaping the rewards of that effort. It is now time for other communities to have a vision of how they want their health services and drive their communities towards that vision. Communities can run health services to meet local needs.

NEXT STEPS

Later in 1999, the HFA will be releasing a strategy to develop a framework that healthcare providers and rural communities can use to maintain and improve rural health services.

Individuals or organisations wishing to discuss health and disability support service issues and possible solutions for their community should contact:

(To be advised).