NEW ZEALAND RURAL GENERAL PRACTICE NETWORK

NetworkNews

Autumn 2011 | Vol 17

Promoting the networking, support and advocacy of the rural general practice workforce

Thanks for the Support

see page 2

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Family's role in rural general practice paramount – award recipient

Long-serving South Westland GP Martin London is the recipient of the 2011 Peter Snow Memorial Award.

The accolade was announced at the New Zealand Rural General Practice Network's annual conference in Wellington in March (17-20).

Martin was nominated under the "Innovation or Service" category, which recognises his "outstanding service to rural general practice and to rural communities for many years, and his endless enthusiasm and drive to help retention and recruitment of rural health professionals".

"I'm delighted and honoured particularly to be in the company of those who have received the award before, which is wonderful. I was aware of Peter Snow and all the wonderful stuff he had done over many, many years but I never actually met him and I have enormous regret about that. We might have passed each other at conferences but I never sat down and had a yarn with him. I am sad about that because he was a remarkable fellow."

Martin also paid tribute to the role of the family – partners, spouses, children - in rural health.

"Rural health is always a family affair and ultimately what makes it work is if it's working for the family we stay and if it's not we go or fall apart. When we are looking at retention we've got to remember how important that is. It was particularly nice that the conference was focusing on that this year.

"We need to particularly support the relatively newly arrived practitioners, as the older ones already have their coping mechanisms and networks established but are there a whole load of new practitioners who are isolated?"

He invited doctors and families to contact the Network about how it can help or assist them.

"If we go right back to the origins of the Network the people who weren't coping were not so much the practitioners but the impact on the families of what the practitioners saw as their role in rural health."

Martin is the South Island representative on the Network Board and has been a rural GP since 1983 and a salaried practitioner since 2005. He is a Clinical Senior Lecturer at the University of Otago for the Rural Medical Immersion Programme, convener and founding member of the Network (1990) and intermittent board member since that time. Martin is on the Rural Premium Review Panel and Chair of the Network's Membership Committee. He pioneered the original rural GP locum service via the Centre for Rural Health (Christchurch) in 1996. He is also on the reference group for Health Workforce New Zealand's review of Training for General Practice. Martin holds a MB ChB (Bristol 1977), a Dip.Obst. (Otago) and is a Fellow of the Royal New Zealand College of General Practitioners.

THANKS FOR THE SUPPORT: *Dr Martin London (right) and wife Karol to whom he paid tribute for much of his success as a rural GP.*

The Peter Snow Memorial Award was set up to honour the life and work of Dr Peter Snow who passed away in March 2006. Dr Snow was a rural general practitioner based in Tapanui. As well as caring for his patients Dr Snow was past-president of the RNZCGPs and was a member of the former Otago Hospital Board and District Health Board. He was enthusiastic and active in seeking knowledge to improve the health and safety of rural communities. His work contributed to the identification of the chronic fatigue syndrome and he was influential in raising safety awareness on issues related to farming accidents.

Message from the Chair

Stepping in to fill big shoes no easy task

By Dr Jo Scott-Jones

Taking over the role of Chairperson of the New Zealand Rural General Practice Network from Kirsty Murrell-McMillan was always going to be a difficult task.

Kirsty has been a significant force in the primary health sector during the three years she has worked on our behalf, and has developed strong working relationships both within New Zealand and internationally.

Her stewardship has seen the organisation maintain the NZLocums' contract and protect the Rural Premium funding from the undertows of devolution.

Kirsty was the Network's first nurse leader in line with the move to recognise the general practice team. This allowed an increased range of members and equal status to rural nurses and was seen as controversial at the time.

As a nurse Kirsty has been exemplary in ensuring that rural general practice teams remain at the forefront of healthcare delivery policy, and has asked me as a GP to follow in the direction she, and her predecessor Tim Malloy, led.

Kirsty's decision to step down was not taken lightly, however the pressure on her family time, the necessary hold she put on her own academic and clinical career, and a decreasing golf handicap eventually took its toll.

She has challenged us in her leaving statements to maintain nursing issues as a clear focus as we move forward as an organisation and it is the Board's conviction that the whole rural general practice team needs support and advocacy. The team remains at the core of what we do.

Along with my own appointment as "interim" chairperson, until elections at next year's AGM, Rachel Hale, nurse practitioner has been appointed deputy chair, Sharon Hansen, nurse practitioner, secretary, and David Wilson general practitioner, treasurer.

March's Network conference and AGM raised a number of issues for us to consider over the next few months.

In rural settings the link between the social determinants of health and health outcomes are not clouded by the crowd of people, or supported by the range of allied health and social welfare networks available to urban dwellers. A conference presentation from solo rural police officer Geoff Smith illustrated clearly the linkages and common issues shared across our disciplines and clearly there are issues that would benefit from a whole range of community response – for example the scourge of cannabis in our communities affects family health, legal, education and employment sectors.

Dr Jo Scott-Jones.

Conference participants also pointed out that rural hospital nurses, rural pharmacists, physiotherapists and other allied health providers lack a national organisation representing their interests and views.

There was a call, echoed at the AGM, to consider the need for an organisation bringing together all sectors involved in rural health under the umbrella of a single organisation, and the Network Board will continue to explore this issue.

We also faced significant challenges last year in securing the NZLocums' contract and this has prompted a review of the security of our revenue streams. As a membership organisation we are reliant on the membership fee to enable us to do our advocacy work, next year we are introducing a practice-based membership fee to ensure that all practice employees can legitimately be part of the Network's support systems, and also hopefully to increase our capacity to continue our work on your behalf in the future.

We will also explore other options for revenue generation, building on our capacity and expertise developed through the NZLocums' work. Watch this space!

Finally the review of the Rural Ranking Score (RRS), which has taken two years thus far, continues.

I have to thank members across the country for responding to requests for information, which have enabled us to model how the proposed changes may impact on rural communities. We have data from 93 per cent of rural practices, unfortunately not all felt able to share financial data with us, but we still have the ability to assess the impact of proposed changes reasonably well.

The new RRS is aimed at directing the Rural Premium funding to practices rather than practitioners. This will enable practices to continue to innovate about how they provide services, and it is weighted to support those practices that provide 24-hour services to their populations.

Further work and remodelling needs to be done, in particular to adapt the weighting to support practices with high after-hours and casual workloads due to seasonal variations. This newsletter will provide further insight into the work as it stands.

We are grateful to the Ministry of Health and DHBs for their patience as we continue to work to make this change, one which will last as long as the first RRS. If we do it right this time we will have a system we can rely on for another 10 years.

See RRS overview – page 5

Inaugural Pat Farry scholarships announced

HELPING HAND: *University of Otago rural medical immersion students (from left) James Heaton and Matt Restieaux, with Pat Farry Rural Health Education trustee Sue Farry and Oueenstown Medical Centre chief executive Dr Richard Macharg and student Thomas Kuperus.* PHOTO NIGEL THOMPSON

Three University of Otago medical immersion students are the first recipients of the Pat Farry Rural Health Education Trust scholarship.

Dunedin School of Medicine student Thomas Kuperus, University of Otago Christchurch campus student Matt Restieaux and University of Otago Wellington campus student James Heaton will share $5000 the trust received from the Queenstown Medical Centre.

The trio filed a joint application to attend Monash University for two weeks' rural studies in July 2011.

All three are fifth-year medical students based at Wakatipu Medical Centre and Lakes District Hospital in Frankton until October as part of the rural medical immersion programme developed by the late Dr Pat Farry aimed at encouraging post- and under-graduate students to pursue careers in rural health.

The education trust was set up by Dr Farry's widow Sue and his brother John in March 2010. Dr Farry died suddenly while working as a locum in Twizel in October 2009. He was 65.

The trust is chaired by John Farry (Pat's brother) with trustees Sue Farry, Dr Stuart Gowland, Dr John Hillock, Dr Branko Sijnja, Kirsty Murrell-McMillan and Michele Wilkie.

Trust patron announced

Meanwhile, leading Otago University academic Dave Gerrard has been appointed first patron of the Pat Farry trust. The appointment was announced at the recent NZRGPN conference in Wellington.

Associate Professor Gerrard is director of development and alumni relations in the office of the vice-chancellor, having been associate dean to the faculty of medicine and the Dunedin School of Medicine since 2000.

His publications and areas of medical research include paediatric sports medicine, undergraduate medical education, sports injury prevention, bioethics and anti-doping strategies in sport.

Prof Gerrard (OBE CNZM) is the immediate past chairman of Drug-Free
Sport New Zealand, present chairman of the New Zealand Drowning Prevention Council and holds positions with international sports medicine committees, including the World Anti-Doping Agency and the International Swimming Federation.

He was an Olympian in 1964, a gold medallist in swimming at the 1966 Commonwealth Games, an Olympic team physician, as well as Chef de Mission and medical commissioner for a period of eight Summer Olympics.

Rural Ranking Score review update

Network CE Michelle Thompson gives an overview of progress to date.

The top priority for the Executive Board and management of the Network for 2011 is to lead the development and implementation of a new Rural Ranking Score (RRS) which:

Better reflects the current reality for both rural general practices and DHBs; acknowledges the diseconomies of scale for small practices; is aligned with the current policy environment and supports new service delivery models and greater collaboration between providers.

The RRS was developed by the Network in 1995 as an objective measure of rurality, which could be used to allocate funds on a nationally consistent basis to where they were most needed.

The RRS is the method by which the rural funding streams flowing through the National PHO/DHB Agreement are currently allocated (including the Rural Premium and Rural Bonus). There is also an additional $5M after-hours funding which is paid direct from the Ministry of Health to rural practices. It is the Ministry's intention to devolve this funding to DHBs in the future.

The original purpose of this funding was to support and sustain an appropriate level of primary health care for rural communities. Given that rural general practice is the mainstay of primary health care in rural communities, the funding is largely used to support the retention and recruitment of the rural general practice workforce.

The current RRS applies solely to individual general practitioners and is based on a range of factors including travelling time from the surgery to the nearest major hospital; on-call roster obligations; responsibility for major trauma; travel time to nearest GP colleague; travel time to most distant practice boundary; and whether the GP holds regular off-site clinics.

In order to access this additional funding under the current RRS formula, a GP must have a RRS of at least 35 points, with the maximum possible score being 100. The closer a GP is to 100 points the more funding he/she receives. DHBs can also award discretionary points to enable a GP to meet the points' threshold on a case by case basis.

The current RRS is based on a number of historical assumptions that are no longer valid:

- Each doctor has similar enrolled populations, i.e. same level of need
- Each doctor provides similar services in addition to First Level Services
- Doctors will work together cooperatively in rosters, i.e. efficiency of after-hours cover
- Nurses are not directly involved in the RRS process.

There have also been some significant changes occurring since the introduction of the RRS such as:

- Funding formula has changed from individual to population-based
- Nurses as well as doctors now provide after-hours cover
- Unit of service provision has become the practice not the doctor
- Change in health policy direction. *Better Sooner More Convenient* calls for: a whole of system view (primary care and secondary care); devolved funding arrangements and new service models - all within a financially constrained environment.

The Network believes the solution is to retain the concept of the RRS as an objective measure of rurality and the benchmark for allocating rural support funding on a nationally consistent basis but revise it so that it better reflects reality and intended policy direction.

Key components of the revised RRS:

- "In or Out" rule – practice is 35kms or more by road from a base hospital
- Practice-based not practitioner-based
- Based on enrolled population – i.e. practice size
- Recognises actual services delivered – with significant emphasis on the provision of urgent after-hours care.

If a practice satisfies the "In" Rule then its funding will depend on the types of services provided and the size of its enrolled population.

If a practice is between 30kms to 34kms from a base hospital and is located in an area defined as rural by Stats NZ and/or has extenuating circumstances such as high needs' populations, geographical isolation, retention and recruitment difficulties, poor roading or large hinterlands, then the Network proposes to seek special consideration from the DHB on behalf of the practice.

If a practice is less than 30kms from a base hospital and does not have any extenuating circumstances as described above it will not be eligible for any rural funding support through the RRS.

What happens next:

The Network is still in the process of gathering and analysing data and considering feedback received from rural general practice since the AGM. Once we are confident the model is right we will then:

Commence good faith discussions with the Ministry of Health and DHBs with a view to finalising the new RRS within the next two months.

We will also need to:

Explore implications of the new RRS on eligibility for other funding streams such as the ACC rural contract, rural teaching ability and MPSO stock;

Agree change management process for the announcement and implementation of the new RRS.

Our guiding principles for the forthcoming negotiations are that:

- This funding is to support the provision of rural health care of which 24/7 primary care services is a core component.
- The allocation methodology needs to be clear, timely and ensure the capacity and capability of rural general practice.

...continued on page 16

Conference 2011 – the show must go on!

More than 290 delegates gathered in Wellington in March for the New Zealand Rural General Practice Network's annual conference despite the forces of Mother Nature.

The four-day event, which featured a varied programme of workshops, keynote speakers, concurrent sessions, awards night and social evening, almost didn't get out of the starting blocks after the February 22 earthquake. This natural catastrophe impacted widely on the medical and civilian community not only in and around Christchurch but also New Zealand, as well as organisation in the lead-up to the conference.

It was with great relief that delegates were finally welcomed to Wellington by local iwi manawhenua (Wellington tribal authority representatives) from Te Atiawa-Taranaki Whanui.

Tributes were made during the opening to the victims of the Christchurch earthquakes and other disasters that have beset the country during the last year.

The Network's interim Chairperson Dr Jo Scott-Jones then took to the podium to officially welcome delegates and inform them of the resignation of Chairperson Kirsty Murrell-McMillan after almost three years in the role.

Dr Scott-Jones paid tribute to Ms Murrell-McMillan saying she was instrumental in merging the Rural Nurses National Network with the Network into the organisation as it is today.

"This controversial move in both nursing and GP circles, recognised the symbiosis of the relationship that rural practitioners have in their daily working life.

"Kirsty's personal crusade has been to ensure the development of rural teams as a way of sustaining a rural workforce."

Ms Murrell-McMillan intends to complete her nurse practitioner training, spend more time with her family and improve her golf handicap - all of which are near impossible while holding down the heavy demands of the Chairperson's role, said Dr Scott-Jones.

...continued overleaf

Ivan Howie, Martin London, Leonie Howie, Paul Leslie and Karol London.

Darran Lowes, Rao Fu, Annie Sylvester, Buzz Burrell and Ruveena Kaur.

Gytha Lancaster and Rachel Hale.

Sarah Swale, Simone Flight, Campbell Murdoch and Sue Farry.

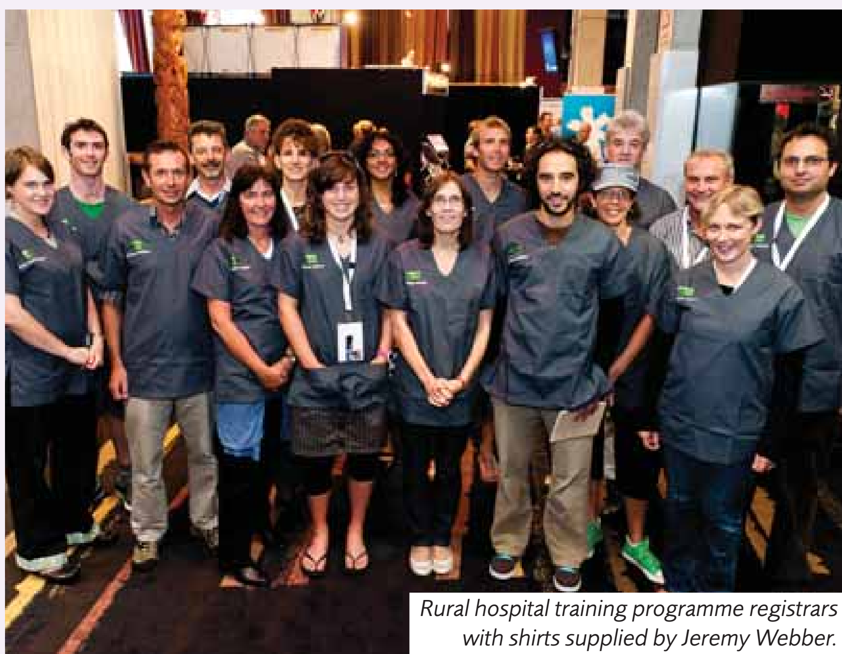
Tim Malloy and Peter Snow Memorial Award recipient Martin London.

Janne Bills, Sue Burton, John Burton and Lewis Gray.

MC Steve Hoskin.

Mike Northmore, Emma Reid and Emalene Pearson.

Deb Bailey, Andrea Judd, Howard and Sue Wilson.


Rural hospital training programme registrars with shirts supplied by Jeremy Webber.

Linda Reynolds and Herewini Neho.

Conference 2011 – continued...

Opening keynote speaker Celia Lashlie enlightend and entertained the audience with her accounts and anecdotes of dealing with hundreds of teenage boys and how adults and parents might deal with them during their journey through adolescence.

Minister of Health Tony Ryall then took over the hot seat and addressed delegates, complimenting and thanking rural general practitioners and the Network who acted quickly to support Christchurch GPs and their teams.

He also acknowledged the work the Network is doing on the revised Rural Ranking Score and other workforce issues.

He also touched on issues including the new and wider Rural Immersion Programme and rural broadband before fielding questions from the floor.

Live feeds to Balcutha and Taupo courtesy of Mobile Surgical Services enabled people unable to attend the conference to question the Minister.

Friday night's Welcome Function saw the 2011 Peter Snow Memorial Award presented to South Westland GP Martin London. Dr London was nominated under the "Innovation or Service" category which recognises his "outstanding service to rural general practice and to rural communities for many years, and his endless enthusiasm and drive to help retention and recruitment of rural health professionals".

Saturday saw roving GP Richard McCubbin and partner Deb Howell speak on their and their family's experience working in rural general practice and living in a rural community.

Former rural police officer Geoff Smith gave a moving account of his time living and working in South Canterbury. (Presentations can be accessed on the Network's website www.rgpn.org.nz or by request).

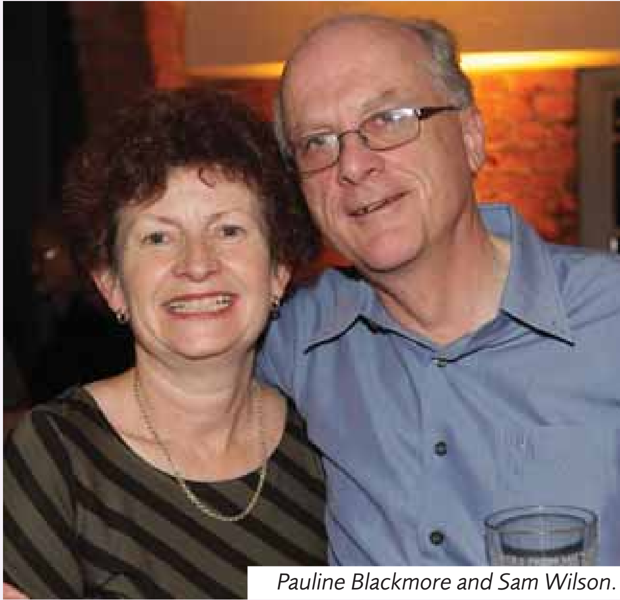
Delegates gathered at the Brewbar on Wellington's waterfront to mix and mingle, dine and dance on Saturday evening.

The winner of the Early Bird prize draw – tickets for two to WOW in Wellington including airfares and accommodation courtesy WOW, Air New Zealand and the Network was Dr Manjur Morshed from Taumarunui Medical Centre.

Thanks to the delegates, sponsors, exhibitors and organisers for making this year's conference a success.

Tim Hanbury-Webber, Janne Bills and Charmaine Hanbury-Webber.

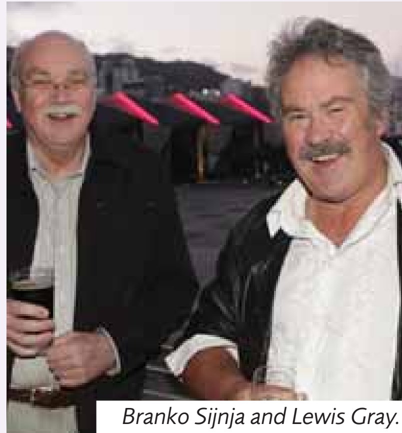
Dr Pragati Gautama in operation on the dance floor.



Pauline Blackmore and Sam Wilson.

Sabine James, Emalene Pearson, Rochelle Murphy, Jane Laver and Emma Reid.

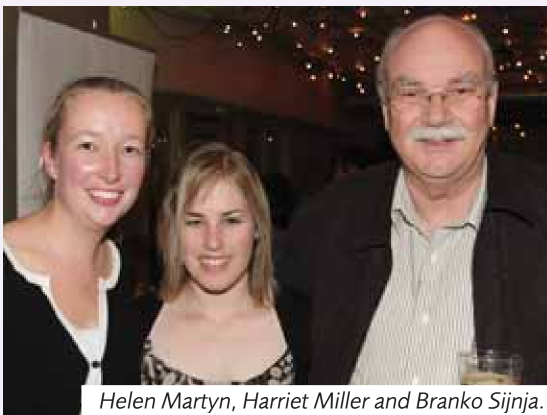
Stuart and Judith Gardiner.



Branko Sijnja and Lewis Gray.

Liz Komen, Richard Davies and Kathryn Millard.

Rob Visser and James Reid.



Helen Martyn, Harriet Miller and Branko Sijnja.

Helen Martyn, Sudhvir Singh, Rao Fu, Sarah Masterton.

WONCA conference 2011 – a week with the movers and shakers in international rural health education

By Network Chairperson Dr Jo-Scott-Jones

I have to admit that I had never thought about what WONCA stood for before former chairperson Kirsty Murrell-McMillan invited me to join her and Network CE Michelle Thompson at the combined World Rural Health and 2011 Asia Pacific Regional Conference in Cebu, an island of the Philippines in February.

WONCA, as it transpires, has nothing to do with chocolate, but is the acronym chosen by the World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians. Now that makes WONCAAAGP/FP to me, and even more confusingly they call themselves the World Organisation of Family Doctors, which makes them WOFDers, not WONCAs. But I digress.

As an international organisation that represents and acts as an advocate for its constituent members with world bodies such as the World Health Organization, WONCA aims "to improve the quality of life of the peoples of the world through defining and promoting its values and by fostering, and maintaining high standards of care in general practice/family medicine by promoting personal, comprehensive and continuing care for the individual in the context of the family and the community, encouraging and supporting the development of academic organizations of general practitioners/

HOUSE CALL: *New Zealand delgates visited the birthing unit in Tacloban to observe health service delivery.*

family physicians, providing a forum for exchange of knowledge and information between member organizations of general practitioners/family physicians, and representing the educational, research and service provision activities of general practitioners/family physicians before other world organizations and forums concerned with health and medical care".

This has to be one of the longest sentences in the world, but full of amazing sentiments.

Over the past few years Tim Malloy and Kirsty have developed a relationship with the WONCA working group on rural practice, which I was able to participate in as an observer during this year's conference.

The conference proper was replete with amazing plenary speakers – not least Richard Roberts and Barbara Starfield from the USA, Iona Heath (UK) and my personal favourite Lucie Walters from "Oz", who described the rural educational programme she runs in Mount Gambia South Australia where all levels of medical training occur.

I came away from the speakers with a further understanding of the value we provide as front line health professionals and a reiteration of how important it is for us in rural health to "grow our own". But the

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main benefits came from the relationships built up during the week through spending time with the movers and shakers in international rural health education.

The working party on rural practice was engaged in a review of the *Melbourne Manifesto* – a statement on the ethical recruitment of doctors into developed countries. Not only is this clearly relevant to us because of our recruitment contract, but on a personal level I have a colleague – sourced by NZLocums after many years of recruitment efforts - from the Philippines, who is soon to become a partner in my practice, so it was really interesting to hear how that host country struggles to keep its doctors on its shores. The measure of a Filipino family's success is to send a member overseas for work.

During the post conference rural workshop we visited the most amazing rural clinics and a rural medical school, where despite extremely poor resources, knowledgeable and effective doctors were being educated, and tied through a promise of service back to their small rural communities for many years, but it remains true that most doctors trained in the Philippines do not work there.

The Cebu Strategy to advance the statements made in the *Melbourne Manifesto* took most of the spare time the conference had to offer me, as I worked alongside other members of the working party to develop a five-point plan of action, about which no doubt you will hear more.

- To develop measurable indicators for the *Melbourne Manifesto* (a score card)
- To promote social accountability of medical education
- To improve support for health care professionals and education programmes
- To engage with recruiting organisations
- To market the manifesto.

The working party also discussed issues around non-communicable diseases in rural health and the next World Rural Health Conference in Ontario October 2012, at which the Network I think should be represented.

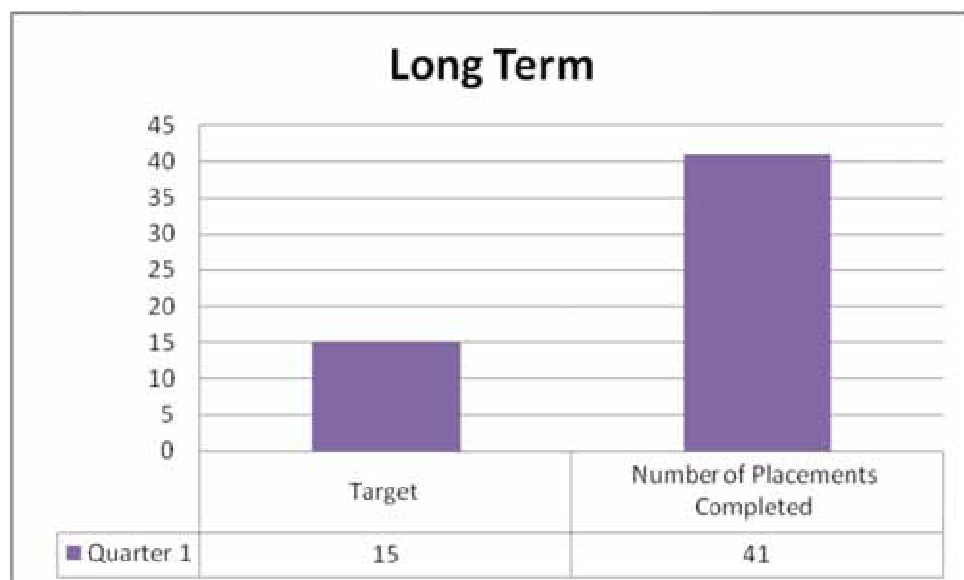
It was a real privilege to be able to attend this conference. It is a shame that the working party on rural general practice has no nursing representation, nor is there any intention in the future to consider this as part of their strategy - "we are an organisation of family doctors" - but if we can keep hanging on in there – who knows, we may yet drag them into the 21st century.

NZLocums' first quarter targets exceeded

There are two components to the Ministry of Health's Recruitment Contract managed by the Network: Rural Recruitment Service (long term) and Rural Locum Support Scheme (short term).

The following figures and bar graphs show the NZLocums performance against recruitment contract targets for the first quarter of 2011.

- Rural Recruitment Service – the purpose of this service is to assist eligible rural providers (currently those with a rural ranking score of 35 or more) with recruitment of long term or permanent General Practitioners and Nurse Practitioners (with prescribing capabilities). Our target delivery for the first quarter of 2011 was 15 placements, against which we made 41 placements (273% above target).
- Rural Locum Support Scheme – the purpose of this service is to ensure that eligible providers (currently those with a rural ranking score of 35 or more, but excluding those in Northland) can access up to two weeks locum relief per 1.0FTE, per annum. Our target for the first quarter of 2011 was to complete at least 75% of applications received, against which we delivered 96% (21% above target).



She's been everywhere …

By Rob Olsen

South African-born roving GP locum Busi Mnguni has seen a fair chunk of New Zealand since coming to work here in January 2008 – 62 locum placements to be exact – from the Catlins to Kaitaia.

But the working lifestyle in rural New Zealand that Busi (pictured) has come to love is on hold this year while she wades into her vocational training (GPEP1). Now based in Hamilton she will study until the end of 2011, with more to follow to gain her vocational registration.

"You know … the only place I haven't been to is the south western part of the West Coast of the South Island. I haven't been to Milford Sound."

"I've tried to see as much of the country as possible, some places twice. They are all different in different ways but if I could I would buy myself a section in Martinborough.

"I was there in May 2008 and celebrated my birthday, and I rang my family back in South Africa and told my husband that this is the first town I have been in where people actually dress like him … immaculately … he is in men's clothing."

Her husband's family started a men's clothing shop in Soweto where he worked as a teenager. He has travelled extensively on business while Busi mostly remained at home studying and raising a family. The couple have three boys and the second eldest, aged 25 has followed Dad into the rag trade and owns his own company.

"None of them wanted to do medicine, in fact one of them said to me he didn't understand why someone would want to do six or seven years at university and then do night calls, it doesn't make sense."

"I love what I do," says Busi who trained in Johannesburg at the University of the Witwatersrand. She is also a trained nurse having completed a three-year diploma in general, then a year studying midwifery, worked 11 months in intensive care, then on to medical school to study medicine. "I always wanted to be a doctor but didn't have the money then."

…continued on page 16

Docs come from far and wide

Recruiters at NZLocums are well used to dealing with doctors from varied cultural backgrounds but one recent group had a definite United Nations look.

Of the nine GPs going through NZLocums' three-day Orientation course in Wellington on this occasion, one was from Egypt, one from Singapore, one from Germany, one from Canada, one from the US, one from The Netherlands and three from the UK.

Orientation sees GPs, recruited from abroad, cover topics and subjects such as ACC, Medtech32, IRD and tax in New Zealand, WINZ, Pharmac, Medical Council, cultural responsibilities to patients in New Zealand and an introduction to the Treaty of Waitangi during the three days they are in the Capital before joining practices around rural New Zealand.

Pictured (from left, back row) is Mark Feeney from the UK (Wanaka Medical Centre), Jenny Maybin, also form the UK (Dunstan Hospital), Rorie Brown from Canada (Tararua Health Group), Belinda Wee from Singapore (Fiordland Medical Practice), Aida Mikail from Egypt (Otorohanga Medical Centre), Mikael Bedell from America (Winton Medical Centre) and (seated) Wim Lucassen from The Netherlands (Waihi Health Centre), Martyn Thornington from the UK (Picton Medical Centre) and Mark Mikus from Germany (Coast to Coast Health Care).

New student rep on Network Board

University of Auckland Grassroots Rural Health Club representative Alisha Vara has taken over from counterpart Darran Lowes as student representative on the Network Board.

As part of her role on the Board 20 year-old Alisha (pictured right) will coordinate the four rural health groups across both medical schools – Auckland and Otago - and promote student involvement in rural health.

"I would like to see the rural health clubs more involved in promoting what medical students want to achieve in their potential rural careers."

Alisha is now a fourth year student at Auckland medical school. "I am super excited about being on the Board and carrying on the great work Darran has done for medical students."

Alisha says her role on the Board is motivated by being able to encourage medical students to get involved in rural health. "Medical students are supposed to reflect the demographics of New Zealand and encouraging more students to enter rural health careers is crucial for a sustainable work force," says Alisha, who grew up in rural South Island.

Alisha says she chose medicine as a career because of the challenge of diagnostic problem solving and being able to meet people from all walks in life.

Ideally, she'd love to settle down in a rural hospital or clinic. "Growing up in the country was a lot of fun, and since I've entered my clinical years the challenges and the strong community-based values of rural health have really appealed to me."

Outgoing student representative Darran Lowes says being on the Board for the past year has been a fantastic opportunity to learn more about the great work that the Network does and to work with the various student rural health groups around the country.

"Handing over my role to Alisha has given me some time to reflect on my work with the Network over the last year. A couple of highlights would be helping to organise part of the NZRGPN Conference in Wellington and learning some very useful strategic planning techniques. I look forward to staying in touch with the Board and seeing the Network's partnership with students grow."

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There's something abuzz in Raetihi

By Rob Olsen

Dr Jim Corbett describes himself as "a bit of a hobbyist" with bee keeping and honey making high on the agenda. But there's more.

In fact Dr Corbett describes himself as a "compulsive hobbyist". "I'm a bit of a farmer, furniture maker, picture framer, forester, saw miller, developer and I have been a keen golfer. My work [as a doctor] gets in the way, but it's a great job.

"I always thought I'd be a farmer instead of a doctor and bee keeping is one way of being a farmer."

Dr Corbett hails originally from South Auckland but has lived in Raetihi for 24 years. He graduated from Otago University in 1983 and went on to do a year as a house surgeon in Dunedin and Timaru, followed by a family medicine training programme in Northland prior to settling in the small central North Island town.

Why Raetihi? "I like being my own man and making my own decisions and the job in Raetihi came up with a free surgery and house. I had no money so I took it on. I only planned to stay three to five years."

Dr Corbett's interest in bee keeping and honey making blossomed soon after his arrival in Raetihi. "A friend was a bee keeper and ran a hobby class, so I went along. I began with one or two hives and had up to 20 at one stage, although I only have five now."

Disease and lack of maintenance are the main reasons for the decline in the number of hives he keeps. "If you don't do the maintenance, the bees don't like it and when you're busy with work that's what happens."

Known as Alpine Meadow Honey, Dr Corbett makes his honey at home where he has a dedicated extraction room and all the "necessary equipment". Once taken from the hives, the honey goes through a sieving process when all the "bee parts and bits of wax" are removed and the honey put into containers. There is no pasteurisation or sterilisation involved. "It's a natural process done in strictly hygienic conditions," he says.

His bees provide enough honey for his family, to sell and to give away. "I give away about half the crop."

Honey making is a seasonal practise. Throughout winter nothing happens then

PLAN BEE: *Raetihi has been home to Dr Jim Corbett for almost 25 years, during which time he has developed a healthy alternative interest in beekeeping. "I'll have heaps to do in my retirement. My wife would like me to retire today. I'd like to retire as soon as I can … perhaps in 10 years."*

throughout summer there's a "burst of activity" - putting the hives out, feeding, and then extracting and preparing the honey. Then the hives are put away for winter. About three to four days work in one-hour blocks are involved for his scale of operation.

Asked if his honey is good for you, he replies, tongue-in cheek: "I make some wild and unsubstantiated claims … it's an elixir of youth and will heal all ailments."

Dr Corbett still attends the bee club, which sees anywhere from four to a dozen people turn up.

"There are quite a few bee keepers in the community and renewed interest here and perhaps nationwide in it. It's a bit like the fresh interest in gardening, which perhaps has something to do with the recession."

RUSH HOUR: *Two local lads chose a more traditional mode of transport on the day the Network visited Raetihi. PHOTO: ROB OLSEN*

Rush hour in Raetihi

By Rob Olsen

The small central western North Island town of Raetihi is relatively stress-free if you're a commuter. So much so the now outdated mode of transport – horseback – is still an option for some members of the community.

While visiting Waimarino Health Ltd and Dr Jim Corbett and his team, with Network Board Member Kim Gosman, I spotted two local lads meandering down the main street on horseback. The pair casually rode down both sides of the main road stopping to chat then moved on at a leisurely pace to their destination – wherever that might have been.

A quiet spot today, Raetihi has a population of about 1035 (2006 census). However, it has seen more prosperous times. According to *WelcometoRaetihi.com* Raetihi (originally called Makotuku from the river flowing at the town's edge) became the focal point for travellers going between Whanganui and Waiouru. A thriving settlement emerged to serve timber workers and travellers. A trip north from Whanganui was not for the faint-hearted. The scenic "River Road" passing through Pipiriki was treacherous with primitive tracks and long falls if you left the track. Those who completed the journey to Raetihi found hospitality, accommodation, blacksmiths and saddlers for weary horses and supplies. The great fire of 1918 (200 homes were destroyed) was a big setback for the community. The eventual loss of numerous mills (there were up to 150 at one stage) slowed the timber industry but it continued successfully into the 1940s. While farming and forestry remain, it is tourism that provides the next glimmer of hope for the town.

Raetihi is part of the Waimarino district, which stretches from Mount Ruapehu to the Whanganui River encompassing Pipiriki, Karioi, Horopito, Waiouru, Rangataua, Ohakune (and Raetihi).

The building at the top right of the photo is Theatre Royal, one of New Zealand's first cinemas, which is currently used for live theatrical performances.

Network offers free Membership to rural Canterbury practitioners

In a gesture of support and goodwill following the recent earthquakes, the Network will reimburse current year fees for Members and will offer free 2011 Membership to rural practitioners who are not Members in Canterbury and South Canterbury regions.

"It's a gesture to show our support to rural general practices in the two regions and to demonstrate our continued contribution to relief and assistance in the wake of the Canterbury earthquakes," says Network Chief Executive Michelle Thompson.

The Network will be contacting practices during the next few weeks regarding the Membership offer.

"We are also keen to know if practices have any other ideas or requests about how the Network can support or assist them to get back on the road to recovery over the coming months," says Michelle.

Several GPs/Members worked in the Canterbury region post the September 4, 2010 quake and several locums were also diverted to the area to provide interim relief.

Any enquiries can be made to Network Communications and Membership Manager Rob Olsen on 04 495 5887, 021 82 2468 or email rob@rgpn.org.nz

She's been everywhere

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In 1984 she began her medical training and qualified in 1991, raising three children along the way. "My first child was born when I was a student midwife and the other two in 1985 and 1990."

Her medical internship began in June 1991 and finished in May 1993, and she worked as a house officer and senior house officer in obstetrics and gynaecology. Busi had her own practice in Soweto for 10 years.

Then she decided to try something different and came to New Zealand. She began work in Whitianga with Dr David Wilson in May 2004 where she remained until December 2007. It was through David that she came in contact with NZLocums.

"At the start of 2007 I said to David, you know what, I've come a long way, and I might as well stay and travel and explore New Zealand. I want to see what other people do in other parts of the country and meet different communities. He said to me 'why not'."

After working through the permanent residency process with the help of NZLocums, Busi resolved to work a minimum of one week and a maximum of four weeks in one place, "and not the South Island in winter, I don't like the cold weather".

"That's how it started … I have enjoyed myself."

She admits she has missed her family terribly at times.

"When I started in 2004 – I had never been away from my boys – after two months I went into David's [Wilson] office and said I don't think I can continue, I miss my babies and he said, 'don't tell me you are going to resign?'" She didn't and subsequently her two eldest visited New Zealand for two weeks followed by the youngest several months later. All have been back since. Her husband is yet to do so.

During her time in New Zealand Busi has returned to Johannesburg every winter to see her family. "I don't do any doctoring there. I prepare myself for cleaning the house, the windows, and cooking the meals."

"I love being a rural GP. I wasn't one in South Africa. I worked in the city in Soweto and it was very busy. I enjoyed it but what I am doing here now I love with all my heart.

"I've had a great time."

The 52 year-old says she will probably return to Johannesburg to retire.

Rural Ranking Score update

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- Rural general practice must play a key role in how the available funding gets utilised – this is in line with clinically-led service development and to ensure the optimum retention of primary care services for rural communities.
- There must be adequate lead-in time for practices to implement the new RRS.

Rural Health Alliance Team

The Network is proposing that a national Rural Health Alliance Team be established comprising rural clinical leaders, managers and DHB representatives to:

- Provide leadership
- Monitor effective outcomes for rural communities
- Problem solving/disputes resolution
- Lead change management processes across the country.

It is hoped that a RRS based on objective measures will help minimise the grey areas around interpretation and, ideally, any dispute resolution processes should occur at the local level. However, if agreement cannot be reached then the parties could come to the Rural Health Alliance Team for guidance, support, or mediation.

Rural Proofing Tool

The other resource the Network has been working on in the background - with the intention it be released in tandem with the RRS - is a Rural Proofing Tool (RPT). This is aimed at keeping rural issues at the forefront of funding and planning agendas. The tool is an adaptation from the Ministry of Agriculture and Fisheries' Rural Proofing Tool and the work undertaken by the Commission for Rural Communities in the UK. The RPT explains why rural communities require special attention to ensure equity of access and outcomes and provides a solutions checklist for health funders and planners.

Rural New Zealand set to receive Broadband boost

Telecom and Vodafone have had their joint proposal to deliver world class Broadband to rural New Zealanders accepted by Government.

The Rural Broadband Initiative (RBI) will provide 100Mbps services to 95 percent of rural schools, and a minimum 5Mbps broadband service to over 80 percent of rural households, within six years.

Telecom and Vodafone are building open access infrastructure. All RBI-funded fibre and wireless components will be available on an equivalent basis to access seekers and wholesale customers, so any party can offer services over the new infrastructure.

Through the extension of Telecom's existing fibre infrastructure and the building of open-access infrastructure, approximately 750 rural schools and six hospitals will have the benefit of 100Mbps connections.

Vodafone is building an additional 154 cell towers which, when linked to the Telecom fibre network, will deliver high speed broadband services wirelessly. Each tower's infrastructure will allow open access for other operators to co-locate on.

Both Telecom and Vodafone will be making significant investments of their own, to complement the $285 million of Government funding.

Rural customers will have not only faster data services but also a much wider choice of technologies and suppliers for these services.

Both companies will now begin a period of engagement with rural stakeholder groups before build work begins in July.