

means the opportunity for increasing degree placements, and critically examining the processes of transfer into primary health nursing as the career destination. The obstacles of concern to increasing enrolments will be the international phenomena of 'greying of the faculty' and the very low Tertiary Education Commission funding of nursing education places which is a challenge to quality education. Improving the transfer of nurse graduates into PHC employment is something the health sector must own jointly and work strategically to improve.

In 2009 Finlayson et al. provided an excellent research-based review of the many achievements in the utilisation of PHC nurses since the

strategy implementation, but also reiterated the key issues, which still need addressing if we are to fully utilise this large resource.<sup>1</sup> They identified the funding model as in need of significant review, the importance of leadership, mentoring and governance, attention to recruitment, retention and education. The challenges are therefore not new, but worthy of careful attention in order to attract and retain available graduates in PHC nursing practice.

#### Reference

1. Finlayson M, Sheridan N, Cumming, J. Evaluation of the implementation and intermediate outcomes of the Primary Health Care Strategy Second report: Nursing developments in primary health care 2001–2007. Wellington: Health Services Research Centre; 2009.

## Community physiotherapy workforce issues

**Janet Copeland** Dip PT,  
BA, MHealSc (Rehab),  
MNZCP

**A**lthough Primary Health Organisations (PHOs) were established to provide co-ordinated primary health care involving a range of providers, physiotherapy involvement in PHOs is limited. This means that access to physiotherapy services often is not available for the treatment of chronic conditions (such as osteoarthritis of the knee, for which there is good evidence).

In August last year, the New Zealand Society of Physiotherapists (NZSP) released to members and interested organisations a working party report, *Engaging in Primary Health Care*, in order to raise awareness of physiotherapists' potential contributions to primary health care.

A good example of a physiotherapy-led community programme is the Otago Exercise Programme, for which evidence indicates a high level of effectiveness in preventing falls amongst the frail elderly.

Examples of physiotherapy in primary health published in *Physio matters*, the NZSP monthly newsletter, have included involvement in a

PHO pulmonary rehabilitation team; exercise programmes for diabetics; and PHO community rehabilitation to reduce social/avoidable admissions to hospital/rest homes.

As of March 2009 there were 2993 physiotherapists with a current Annual Practising Certificate (APC): 77% female and 41% between the age of 26 and 35. There is a risk that many of this age group will leave New Zealand to work overseas, or change careers.

Physiotherapists in New Zealand are employed in two main areas—through the provider arms of District Health Boards (DHBs) (29.7%) and in private practices (50%). There are currently workforce shortages in all areas of practice, although the effects of these are felt more acutely in rural areas. NZSP currently has a support network for rural practitioners. It is disappointing that recent government initiatives to overcome workforce issues in rural areas failed to include physiotherapists, who are an essential part of an effective health care team.

**CORRESPONDENCE TO:**  
**Janet Copeland**  
Research and Professional  
Development,  
New Zealand Society  
of Physiotherapists,  
PO Box 27386, Wellington,  
New Zealand  
janet@physiotherapy.  
org.nz

The Maori partner of NZSP, Tae Ora Tinana, is active in addressing Maori under-representation in the physiotherapy workforce and supporting Maori already in the profession, for instance through regular hui and through mentoring of students.

In order to make physiotherapy services accessible to all cultures, NZSP has produced a number of resources aimed at improving members' cultural competence. These include *Guidelines for Cultural Competence in Physiotherapy Education and Practice in Aotearoa/New Zealand*, adopted by the Society after development by the Tae Ora Tinana.

Physiotherapy services are funded through two main streams: Accident Compensation Cor-

poration (ACC), currently the main revenue source for private practices, and the Ministry of Health via Vote Health which funds DHB services. The reliance on ACC funding by private practitioners has left them very vulnerable as is evident with the present blow-out of ACC costs, which some are blaming on costs higher than were anticipated for physiotherapy treatment.

The NZ public has been fortunate to have direct access to physiotherapy, which was recognised by ACC in 1999. Physiotherapists are the first point of contact for 14% of ACC claims, demonstrating the strong position they hold as primary health care providers.

## The workforce shortage disadvantages those in greatest need

A primary health care (PHC) workforce shortage inevitably impacts on the primary care of people. We are all aware of the inverse care law: the availability of good medical care tends to vary inversely with the need for it in the population served.<sup>1</sup> Provision of PHC has undergone a number of changes in the last few years that I believe means there is a risk that care for those in greatest need will be disproportionately affected by the workforce shortage.

A change to capitation funding alters the incentives in caring for needy poor people. Under a fee-for-service system, at least the practice got some money each time the patient came in even if it did not receive a patient co-payment. Under a capitation system, a patient who does not pay co-payments becomes more and more of a drain on the practice the more times they visit.

If there is a shortage of doctors, then practices 'close their books'. This disadvantages people who tend to move more often, which affects poorer

people more as they do not own houses and tend to be more mobile.

In my experience, 'closed books' are usually publicly closed but 'opened' at the discretion of the practitioner; for example, for new babies of existing patients, family members moving to join existing patients, possibly returning 'old patients'. If discretion is being exercised then it is more likely that high needs people who cannot afford co-payments will be turned away, to preserve business viability.

The Kapiti Coast is generally considered a desirable place to live, yet they have been unable to attract sufficient practitioners to open practices there. Why would a practitioner set up practice in a poorer suburb instead? Some communities (particularly rural) have addressed the shortage by building facilities to let to practitioners. Poor urban communities are less likely to have the ability and resources to use this strategy. This will inevitably become a bigger problem as the 'Economic Crisis' bites further and unemployment levels climb.

**Ben Gray** MBChB,  
FRNZCGP

### CORRESPONDENCE TO: **Ben Gray**

Senior Lecturer,  
Department of Primary  
Health Care and  
General Practice,  
Wellington School  
of Medicine and  
Health Sciences,  
PO Box 7343,  
Wellington South,  
New Zealand  
ben.gray@otago.ac.nz