New Zealand Institute of
RURAL HEALTH

Discussion Paper

for

Moving Forward in Rural Health

Prepared by

New Zealand Institute of Rural Health

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1. Executive Summary

This paper was prepared by the New Zealand Institute of Rural Health following a review of the Implementation of the Primary Health Care Strategy into rural New Zealand. The 2002 paper prepared for the Ministry of Health by a rural expert advisory group, contained some 50 plus recommendations. It is pleasing to note that almost all recommendations have been addressed with some activity. What is of concern is that large numbers of the strategies implemented have not resolved the most significant issues present in the sector today. The Institute contends that all is far from well in the New Zealand Rural Health Sector and much work is required to sustain safe and high quality health services to rural communities.

The sector has received increased funding but not enough to comprehensively address training and service issues. In the Primary sector access to service is variable, there is a wait of up to two weeks to get a routine GP appointment in some rural towns e.g. Greymouth. In other towns new arrivals can not get enrolled in a practice and have to pay casual consultation rates. e.g. Balclutha. Accepting the issues that rural hospitals have in recruiting and retaining staff, their other major problem is securing enough funds to run services. The current population based funding formula does not adequately fund rural services e.g. West Coast, where a recent study has clearly demonstrated this fact. Constant under staffing and under funding in recent years has seen the public service exiting large numbers of rural (particularly hospital) services, leaving rural communities to pick up the responsibility for managing and subsidising service delivery e.g. Dunston, Gore and Balclutha.

The matter of clinical safety in rural hospitals has generally run under the radar until an issue so significant that it cannot be ignored, occurs. Running services with reduced numbers of qualified staff, high numbers of locums and under tight fiscal constraint increases the risk of clinical safety being compromised. Identified by rural staff at forums and on survey are the difficulties of accessing ongoing education and development, further exposing the rural population to service delivery that does not reflect best practice. At some point the personal commitment and skill of health professionals is not enough to ensure the safety of the consumer.

The professional issues of the rural workforce are well accepted but responses have been inadequate to address, in a timely manner the very obvious issues. Recent examples of decentralisation of postgraduate nursing education funds 'ring fenced' rural to District Health Boards has slowed the momentum of study completion rates for rural nurses. This devolution was a 'policy' decision, that may be but, official information requests to this time have failed to produce any evidence that these funds are being spent on rural nurses (as of 9 June 2008). The 2008 academic year will see an expected 21 nurses graduate with rural focused qualifications, 2007 saw 30. With the funds now decentralised and no information available from District Health Boards re funding of rural nurses the numbers into the future are unknown, yet anecdotally we hear that rural nurses are not being comprehensively supported to study.

The Institute particularly wishes to identify the following issues where it believes action is urgently needed to respond to and support the rural sector.

Issue One
The Declining Rural Health Workforce

Between 2000 and 2005 (Rural Workforce Surveys) the rural general practice workforce reduced by 170 (32%). We know midwife numbers have declined as have rural pharmacists. The lack of current information about the rural workforce and trending data is a barrier to better understanding and responding to this decline. The workforce needs to be regularly monitored and information available to all interested parties, so they may respond appropriately.

Issue Two
The Role of the Rural Hospitals.

The country lacks a common vision on the role of rural hospitals, little service modelling has occurred and even less evaluation of these models. There are as many as 45 hospitals, that may be classed as 'Rural Hospitals'. Evaluation of these multiple models is critical to support and guide future development.

Issue Three
The failure to conclude and implement National Projects of Rural Significance

- The After Hours Working Party and subsequent District Health Board After Hours Plans

At this time twenty District Health Boards have submitted plans to Ministry of Health, which pose solutions to rural (and urban) after hours service delivery. This project is now in its third year and after hours was identified as a critical issue some twelve months prior to the establishment of the working party.

- PRIME Review

This critical first response service for rural New Zealand has been under review by various parties since 2003. While the model works reasonably well in the South Island, coverage in the North is variable and absent in a number of areas, and the issues of payment and education remain largely unresolved.

- Rural Ranking Score Review (RRS)

Identified as needing review as early as 2004. The review finally commenced in late 2006, early sector involvement was sought but at sub committee point the review seemed to disappear and to date no outcomes have been notified. This to an issue that significantly effects rural general practitioners and the RRS continues to be used as a proxy for rural.

Issue Four
National Transport Assistance Programme

There are multiple reasons why access to services is poor for rural New Zealanders, but of particular concern is the current National Transport Assistance Programme. This programme is designed to support rural New Zealanders to access secondary services at distance. It does not adequately compensate, it is available to limited numbers, it assumes transport is available to all New Zealanders (public or private transport), it further assumes that rural New Zealanders can afford to pay for the transport and then seek reimbursement and finally the claiming process is daunting to even the most expert form filler. The Institute knows of at least 15 District Health Boards that run complementary programmes and would allocate more funds as their rural communities repeatedly request, but feel constrained to work inside the national contract/framework.

Issue Five
A Rural Health Strategy

The Ministry last developed an implementation plan for the rural sector in 2002 and this plan served well as a framework for ongoing activity. It is time for a new rural strategy, Rural health needs:

- Specific indicators and targets
- Current workforce information with ongoing monitoring
- Resolution to the long standing issues
- Focus from Funders and Policy setters on matters rural
- A framework for ongoing development and prioritised activity

All these requirements and the other matters raised in this paper could be addressed in a Rural Health Strategy.

2. Introduction

The development and implementation of the Primary Health Care Strategy (PHCS) into New Zealand in February 2001 brought to focus particular challenges for rural communities and their service providers.

The rural expert advisory panel was commissioned by the Ministry of Health and presented its report in 2002. Report made some 60 plus recommendations to the three agencies with shared responsibility for the implementation of the Primary Health Care Strategy, the Ministry of Health, District Health Boards and Primary Health Organisations.

The Institute recently reviewed these recommendations and found that despite significant focus and activity on these recommendations a number of desired outcomes have yet to be achieved.

3. Current Situation in the Rural Health Sector

3.1 International

The issues facing the New Zealand rural health sector are similar to those faced in other countries.

Australia has in the last 15 years committed many millions of dollars to provide services to rural communities and to encourage and support health practitioners to work and live in rural/remote Australia. Many of these strategies have been implemented in New Zealand e.g. scholarships to students in health sciences, increases in medical student numbers, rural immersion medical and nursing training streams and financial incentives for rural practice.

Recently visiting New Zealand from Canada as the keynote speaker of the New Zealand Rural General Practice Network conference, Professor James Rourke identified features of the Canadian rural health environment which included a shift away from the solo GP model and a slow response by government to workforce issues. Similarities between Canada and New Zealand were the disappearance of the solo independent business model of general practice being replaced by a government and community sponsored team approach with GP's working in cluster groups alongside nurses and allied health professionals in new, purpose built facilities provided by either local communities or government. Canadian GPs receive capitation payment (from government) with additional payments for on call work, hospital based services and meeting health gain targets.

Dr Rourke also identified the need for more doctors in rural practice. He stated, as is acknowledged in New Zealand, this will require increased numbers of medical students from rural areas, more rural specific training, improved financial incentives for rural practice, stable rural group practices with appropriate facilities and healthcare teams and community support.

3.2 New Zealand

Rural Models of Care are changing in New Zealand, both by design and necessity. The implementation of the Primary Health Care Strategy reshaped primary service delivery during the 2000's and produced a range of different service models. Some of these models are discussed below in section 3.2.1.

3.2.1 Models of Care

General Practices

There has been the emergence of many very local solutions. In itself not a bad thing, but these models are often service provider focused rather than consumer focused. It was signalled in the Primary Health Care Strategy that Primary Health Organisations would be providers particularly in relation to general practice i.e. they would own practices and employ doctors and nurses. This has occurred in some areas, naturally in the old Ministry of Health special district areas e.g. Hokianga and East Coast, and in rural areas very slowly, often occurring when the resident general practitioner(s) indicated he/she/they were leaving as they did not have a sustainable income over time. At this time approximately 75% of rural general practices remain private businesses.

The previous model saw direct funding from Ministry of Health to general practitioners. The current model sees funding flow from Ministry of Health → District Health Boards → Primary Health Organisations → General Practices → General Practitioners. Little wonder practices are commenting on the increase in bureaucracy (Rural Health Workforce Survey 2005.) On a more positive note General Practices are involved in significantly more preventative and promotion services, e.g. Diabetes initiatives, chronic care

management and school healthy eating programmes which see nurses, in particular increasing interaction with their communities.

The focus on multidisciplinary team work is well accepted by the rural health providers and professionals but is tempered by a number of factors - in particular the desire of health professionals to practice in rural areas, barriers to rural practice including professional isolation, difficulty in accessing ongoing education and family priorities, while HPCA requirements for competency are simpler for those who work with peers and with large volumes of consumers.

Rural Hospitals

The role of rural hospitals is a rich tapestry and part of New Zealand rural folklore, together with rural schools and churches they have been the hubs of rural communities. As constraint hit the health sector in the 1980's these hospitals were seen as early money saving targets by administrators while the business model of the 1990's saw closures which were in part due to changes in the professional workforce model, increasing specialisation within services, the continued urban drift of the population and service planning.

The rural hospital of today is a many and varied entity. Some of the more common features being:

- Community owned and operated
- Little or no open surgery
- Outpatient visiting specialist services
- Inpatient services for maternity, aged care and general practitioner admissions
- MOSS or GP medical staff
- Base for co-location of community health service providers

Some rural hospitals provide significantly more services then those listed while others have become primary care centres with limited beds attached. What this means is that the service available to rural New Zealanders locally is not at all consistent.

The Surgical Bus

This service provides to consumers the opportunity to access surgical services locally, in particular paediatric dental, ENT services and scoping and microscopic services which are supervised from distance. In addition the bus provides education to health professionals while on site. Much of the paediatric service is provided to consumers that cannot access service through their local District Health Board - either, as the service is not able to be delivered within acceptable waiting times or it does not reach the priority threshold. The question to be asked is what is the cost and outcome effectiveness of this service and is the service an answer to increasing access to services for rural New Zealanders.

3.2.2 The Workforce

Critical to the well being of rural New Zealanders is their ability to access health care. This is in part dependent on the availability of rural health professional staff. Much is written and stated about the shortage of this workforce in particular doctors and midwives, but the lack of recent comprehensive data on the rural health workforce frustrates efforts to quantify and monitor these groups and other rural health professionals.

Most often rural data is gathered as part of a single profession survey while the most recent rural workforce survey commissioned by the Ministry of Health presented a point in time picture rather than comparison's with earlier surveys. Generally accepted from data collected and anecdote between 2000-2008 is that the rural workforce is ageing

and there is a reduction in the full time equivalent in groups such as doctors, midwives and pharmacists

Developing the Workforce
Research, mainly from Australia shows that there is a number of factors that influence professionals to practice in rural areas post registration. While the research is focused on doctors the findings are transferrable to other professions. The positive influences/factors are:

- Rural origin of the individual
- Positive rural learning experiences during training
- Rural focused curriculums of learning
- Positive rural role models

New Zealand has acknowledged and accepted this research and is currently implementing a number of the above initiatives. However it is fair to say that despite national workforce party recommendations to support the implementation of the above, at this time it is individual institutions of learning taking up these initiatives individually rather than a national rural training framework driving the needed changes.

There is dislocation between education and health such that while funding for 40 more medical rural origin students (rompe scheme) was achieved in early 2000's there was no recognition in that it costs considerably more to provide learning experiences in rural than in the traditional urban setting, especially in IT, travel and accommodation while the rural professional trainers have had little or no assistance in developing their own training skills or facilities to accommodate students.

Multidisciplinary Team
The primary health care strategy in 2001 presented a picture of increased integration and streamlining of primary health care delivered by multidisciplinary teams. In rural there is some evidence of structural integration, especially where Rural Trusts have purchased facilities and co-located health providers in a single facility, however there is plenty of evidence of continued 'silo' professional service delivery.

There is some information from the 2005 rural workforce survey that states rural practices are most likely to have access to St. John Ambulance, Home Help or Physiotherapy services, hardly a comprehensive list.

Commonly heard from GPs and nurses and evidenced in the 2005 Workforce Survey, is that it is increasingly hard to get access to speech language therapists and podiatrists with increasingly long wait times for occupational therapists and dieticians. 36% of practices report some improvements such as communication, integration and team work of primary health care workers since the primary health care strategy has been introduced. 53% report no change; this group often commented they had good integration pre the introduction of the strategy. Thus it can be concluded that the greatest barrier to multidisciplinary teamwork is not professional resistance but the lack of availability of some professional groups to participate in the model of service delivery.

Nurse Practitioners
There has been a disappointingly slow uptake of the nurse practitioner registration with some 48 now registered with as few as 14 (May 2008, New Zealand Nursing Council) of these working in either primary care or rural settings. The reasons for slow uptake as identified by nurses are the long academic journey, the Nursing Council of New Zealand registration processes and the lack of roles identified or available.

While the primary health care strategy flagged nurse practitioners as one of the solutions to the declining rural workforce. It is noted that over 70% of the nurse practitioners

have narrow scopes of practice and work attached to secondary and tertiary services. The recently published Rural Nursing - Aspects of Practice (Editor Jean Ross) gives some evidence of the journey of a number of rural nurses to expert nurse and on to nurse practitioner.

Initially there was much concern and some opposition from the sector and the medical profession to the nurse practitioner role, as nurse practitioners were portrayed as taking over roles vacated by GPs. Nurse practitioners are not doctors and do not practice in the medical model, rather the model promoted by nurses is one of collaboration, working with their medical colleagues in non traditional ways to respond to much needed services in rural New Zealand to provide sustainable health services for rural communities. While some nurse practitioners will and do practice alone the intent is that they do not practice in isolation and that they will create a team environment with their medical and allied health colleagues to ensure holistic and comprehensive care to rural New Zealanders.

General Practitioners

Current data on rural general practitioner numbers is not readily available. The most recent publically available data from rural workforce surveys shows the following:

Year	General Practitioner Numbers
2000	528
2001	467
2002	477
2005	358

In 2005:

- Over 10% of rural GPs who work after hours worked 1:1 or 1:2 on call
- 21% of rural GPs indicated they did not do after hours call
- 73% of rural GPS were over 40 years of age
- 29% of rural GPs aged 50 or less plan to leave rural practice within 5 years

The implication of the ageing GP workforce, the increasing feminisation of the workforce and the emergence of the X and Y generation on the rural GP workforce is that increasing numbers of practitioners will be needed to meet the work conditions and work life balances, the new generation of GP will demand. Some of this may be balanced by changes in the model of service delivery i.e. using multidisciplinary teams, but the reality is currently that the rural GP workforce is not being developed at a fast enough rate to prevent ongoing and increasing shortages.

Unqualified Workforce

The emergence of Iwi as providers responding to identified need in their local areas and population has seen a significant rise in the number of unqualified workers in frontline rural health service delivery. A sample of five providers (by New Zealand Institute of Rural Health) revealed that between 60% and 80% of frontline staff held no formal health professional qualifications. Primary Health Organisations e.g. Waikato Primary Health Organisation now run workshops for unqualified frontline staff to address areas such as ethical behaviour, communication, confidentiality, as well as clinical skills.

This workforce change is also evident with increasing personal and home support services having moved from the traditional District Health Board provider to NGO providers who engage largely unqualified staff to deliver these services. At this time this workforce is completely unregulated and works to no national or common standard.

Community Volunteers

Any rural community forum attended by Institute staff in the last twelve months at some point comes to address the issue of shortage of rural volunteers. Most commonly recognised and publicised are shortages of volunteers in St. John Ambulance and Rural Fire Services. Other examples are organisations providing meals on wheels having difficulty in recruiting drivers to deliver meals and Rural Service Clubs e.g. Lions, Rotary with declining memberships, increasingly undertaking projects to support their communities. The rural economy is struggling to support the release of volunteers during paid employment periods to respond to community need. St John Ambulance and the Fire Service both report incidences where volunteers have been asked by employers to turn on call pagers off while they are at work.

Government policy sees local communities empowered to manage their own future, this places pressure on local populations to volunteer and lead education and health services (and others) in their districts and with the forecast downturn in the economy the situation of community volunteers can be expected to further deteriorate with communities less able to sustain the voluntary workload.

3.2.3 The Rural Consumer

Defining the rural consumer is dependent on the definition of rural, this paper speaks to the matter of definition of rural later in the text, however for this paper the Statistics New Zealand definitions of highly rural, rural with low urban influence, rural with moderate urban influence, rural with high urban influence are accepted and thus the New Zealand rural population is 14.2% of total population (2006 Census). The 2006 Census and other sources give information on the rural sector

- Highly rural population have the second highest medium income
- Rural Maori population earn below the medium income
- Rural populations are less likely to access secondary services (Rural Women New Zealand 2001)
- Little variation between rural and urban populations in the likelihood of contracting cancer or diabetes
- 70% of New Zealand has access to broadband, rural populations are less likely to have timely access (Telecom New Zealand)
- The rural population is ageing and is under represented by under 15 year old group
- Higher than national average (14%) of Maori live in rural New Zealand particularly in the North Island.

The 14% of the population that is rural occupy some 80% of the land mass thus making the delivery of both effective and efficient health care very difficult when using the current population based funding formula, even allowing for the factor of rurality in the funding model.

The rural population is pragmatic and does not expect to access all services locally but there are a large number of rural communities now voicing real concern that the most basic of services-first response, primary care and maternity may not be available locally. Slow sector response to resolving PRIME and 24 hour cover services is creating further uncertainty and each exit of a health professional particularly doctor, midwife or pharmacist is met with increasing concern by the local population.

The National Travel Assistance (NTA) that came into effect in January 2006 designed to provide consistency for people accessing transport and accommodation assistance has regretfully proved to be almost unworkable for many needy families and individuals. It is complex, cumbersome and slow and fails to meet the needs of those who might find themselves eligible.

4. Rural Health Sector Issues

The Institute has identified a number of ongoing issues in the rural health sector, those issues discussed below are not new issues nor are they issues that to date have not received some or much input both financial and other in an attempt to solve, but regretfully they remain significant impediments to quality rural health service delivery. It is interesting also to note that almost all of these issues identified below are embraced in the recommendations of the Rural Expert Advisory Group report (2002).

4.1 The Importance of Rural Health

Between approximately 1999 and 2005 high priority was placed by government and the sector on addressing the pressing issues of remuneration and retention of rural general practitioners. While initiatives such as the rural recruitment and retention funding, reasonable rostering and national locum schemes did slow the outward flow of rural general practitioners the major problem of retention of the rural work continues with the loss of approximately 32% of rural GP workforce between 2000 and 2005. Since 2005 there appears to have been less priority on addressing rural needs and the establishment of a 'Rural Desk' at the Ministry of Health has not led to the raising of the rural profile as yet.

The challenging question for rural New Zealand and the health team that support them is what importance is placed by Government, Policy makers and Funders on the 14% of the population who are rural New Zealanders.

4.2 Information Technology and Communication

Technology has a huge role to play in addressing the tyranny of distance and isolation. It has taken considerable time for the major supplier of telecommunications lines to respond to rural dissatisfaction. In fact the threat and reality of regulation has been required to accelerate progress toward enhanced access for rural New Zealand. Still at this time speed and cost of access remain real barriers to significant numbers of rural businesses and households being able to participate in online activity. Cell phone coverage remains patchy and the cost of satellite linked communication devices and services are a prohibitive price for many.

4.3 Access to Services

The last decade has seen a reduction in the range of health services available locally to the rural population. As discussed earlier some of this caused in part by the need to achieve financial targets and the changes in professional expectations and requirements. The establishment of the 0800 Healthline has been accepted positively with evidence of steady increase in utilisation especially from rural areas. What however is not clear or consistent throughout the country is access to services out of hours. Numbers of rural general practice services now run clinics into the evening and on weekends and this has reduced the overnight call out rates significantly, but still the provision of overnight services remains largely unresolved and the protracted Working Party and District Health Board processes mean that local models have emerged that are inconsistently funded and delivered. The other factor in access is the ability of consumers to travel to access services. The down turn in the economy, employers' difficulty in releasing staff (often for a full day) and the increasing price of petrol are impacting on consumer ability to access services at distance.

4.4 Rural Health Status and Indicators

Lack of accurate rural focused information makes it difficult to prioritise rural activity and to focus on solving problems. District Health Boards have few if any specific rural reporting requirements or targets with the Primary Health Organisation reporting still evolving. The identification and collection of specific rural indicator material would provide accurate and timely information to inform policy prioritisation and funding. Additionally the evaluation of strategies implemented to address the recommendations of the expert rural advisory panel would identify areas still requiring focus to fully achieve solutions.

4.5 Definition and Measurement of Rural

Statistics New Zealand provide the most commonly used definitions for rural, which include the less than positive definition of rural being ''non-urban'', and differential definitions describing the degree of urban influence on rural. The issue of definition is further confused in health as a commonly used proxy for rural in the New Zealand health sector is an area where the general practitioner has a ''rural ranking score'' of over 35 points. This ranking arrived at through scoring of a number of criteria, was created to inform penalty payments for GPs working rurally. It is not an exact science and in recent years has been used as a measure to access and allocate considerable funding. The delay in release of the review of the RRS and its use as a determinant of rural are of significant concern.

The development of a rural index has been a worldwide debate. The United Kingdom has mesh blocks down to 1 km and found the system unhelpful. New Zealand went down the GIS mapping route but the Institute understands work stopped in the early 2000s and now mesh blocks are used in census material but seem to have no practical applications in the rural health model.

4.6 Models of Care

The Primary Health Care Strategy proposed a framework of models of care but early implementation of the strategy lacked detailed guidelines and parameters for development, for new models of care. Rural New Zealand now has multiple models mostly driven from a 'way we were' or 'this is what we have so this is the only way we can work' approach rather than a vision of a model that will respond to and provide the kind of services a community needs. The rigidity of professional frameworks and contracts further stifles innovation and development of new models of care.

Multiple providers, multiple contracts, multiple sites of delivery are some of the challenges to efficient and effective delivery of rural health services. Integration of service delivery, flexible work practices and organisation structure are key to developing improved models of care.

4.7 The Workforce

This paper has earlier described the situation of some of the rural workforce and acknowledges that there has been a focus on addressing the workforce issues. However decisions and implementation of those decisions needs to accelerate if the workforce is to be maintained and indeed grown to meet need. In particular the implementation of well discussed strategies as follows:

1. Growth of trainee numbers across the professional groups.
2. Implementation of rural curriculums in health training
3. Remuneration and rewards to acknowledge the international market
4. Flexible working conditions to achieve work-life balance.
5. Creation of an environment were the health professional is valued and their ability to deliver services enhanced (i.e. structural, ownership, contractual)

5. Where to from here for rural

5.1 Ministry of Health Long Term System Framework

The recommendations by the expert panel in 2002 have served as a good framework but now require updating. As the Ministry develops its long term plan consideration needs to be given to the development of a specific rural strategy that outlines the outcome targets for rural health and the key steps to achieve those targets. Rural health is worthy of more than a paragraph attached to each generic strategy or target and in fact if the desired gains are to be made then dedicated rural planning, funding and resources will be necessary.

5.2 Rural Health Strategy

As identified above the development of a rural strategy would provide a clear implementation pathway for the next decade and beyond. When developed the strategy would define the sector, streamline activity and avoid duplication and repetition of work and funding. Further the development of a strategy would provide an opportunity for consultation with and feedback from a significant economic force - rural New Zealand. Currently the rural sector agencies and entities are expected to work collaboratively not competitively (difficult in a environment that features competitive tendering and finite resources) to achieve outcomes stated in various strategies. The development of a Rural Strategy would provide a framework and targets which would give clear focus to the workings of rural health organisations.

5.3 Measuring and Monitoring the Rural Health Sector

In compiling this paper it was hard to pull out recent rural dedicated information. A regular monitoring programme would provide ongoing current information on which to base decision making, policy and funding. Monitoring of the rural workforce, rural health status, specific rural indicators and existing recommendations should be considered.

5.4 Models of Care - What is working

The proliferation of different models of care has occurred as a result of the need to respond to local environments. It is timely to consider analysis and evaluation of these models to provide guidance and direction to the sector on future development. Of particular interest is the role and function of rural hospitals, rural community trusts, single/integrated health centres and the role the rural community now plays in service delivery.

5.5 The Rural Workforce

While it is acknowledged that considerable focus on recruiting and retaining the rural workforce has occurred since 2000 the majority of the money and attention has been on the medical workforce. There must be continued commitment to enhancing recruitment activities in both undergraduate and postgraduate arenas and innovative and creative solutions to retaining and building the number and range of health professionals practicing in rural New Zealand.

6. Consultation with the Rural Sector Key Stakeholders

The Institute intends to seek input and feedback from key stakeholders on this paper. The purpose being to present the outcome of this consultation to Policy Makers and Funders in seeking to influence and lobby for the development of a Rural Health Strategy or Framework. When developed this strategy will provide a clear vision and pathway for rural focused and interested organisations, and hopefully lead to early implementation of identified priorities.